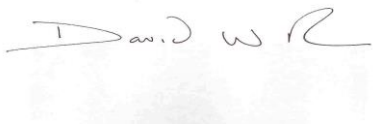
Public Document Pack

Health and Wellbeing Board

Wednesday, 17 January 2018 2.00 p.m.
The Halton Suite - Select Security Stadium, Widnes



Chief Executive

Please contact Gill Ferguson on 0151 511 8059 or e-mail gill.ferguson@halton.gov.uk for further information.
The next meeting of the Committee is on Wednesday, 28 March 2018

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

Part I

28th March 18
4th July 18
3rd October 18
16th Jan 19
27th March 19

All meetings are at 2.00 pm in the Halton Stadium, Karalius Suite.

HEALTH AND WELLBEING BOARD

At a meeting of the Health and Wellbeing Board on Wednesday, 4 October 2017 at The Halton Suite - Select Security Stadium, Widnes

Present: Councillors Polhill (Chair), T. McInerney, Woolfall and Wright and N. Atkin, M. Barker, P. Cook, A. Crookall, G. Ferguson, T. Hill, S. Johnson-Griffiths, M. Larking, C. McBride, D. Nolan, E. O'Meara, D. Parr, H. Patel, R. Strachan, S Wallace-Bonner and S Yeoman.

Apologies for Absence: S. Ellis, T. Hemming, A. Magee and C Samosa.

Absence declared on Council business: None

ITEM DEALT WITH
UNDER DUTIES
EXERCISABLE BY THE BOARD

Action

HWB10 MINUTES OF LAST MEETING

The Minutes of the meeting held on 5th July 2017 having been circulated were signed as a correct record.

HWB11 CQC LOCAL SYSTEM REVIEW OF HEALTH & SOCIAL CARE IN HALTON

The Board received a presentation from Sue Wallace Bonner, Director of Adult Social Services, on Care Quality Commission's (CQC) recent Local System Review (LSR) of Health and Social Care in Halton. During the summer, CQC were commissioned by the Secretaries of State for Health and Communities and Local Government to undertake a programme of targeted system reviews in 12 Local Authority areas; Halton was selected as the first area of one of these LSR's.

It was noted that the LSR's were aimed at looking at how people moved between health and social care, including delayed transfers of care, with a particular focus on people over 65 years old. The reviews included an assessment of commissioning across the interface of health and social care, of the governance systems and processes in place in respect of management of resources.

The Board noted that the CQC spent 7 days in Halton carrying out various visits, held a series of focus groups, undertook case tracking and conducted a variety of interviews. An initial report on the outcome of the review was received by the Authority on 22nd September and the series of findings, together with areas highlighted for improvement were outlined to the Board. Following receipt of the CQC final report a System Action Plan would be developed and this would be submitted to a future meeting of the Board

RESOLVED: That the presentation be noted.

HWB12 PRESENTATION WELL NORTH UPDATE -CHRIS CARLIN

This item was deferred to a future meeting.

HWB13 PUBLIC HEALTH ANNUAL REPORT 2017 WOMEN AND GIRLS' HEALTH

The Board considered a copy of the Public Health Annual Report (PHAR) 2016/17. Each year a theme was chosen for the PHAR. For 2016/17 the PHAR focussed on the health of women and girls in Halton. This topic was chosen as female health was not improving at the same rate as male health. It was also chosen to highlight key topics pertinent to female health and issues local women and girls believed to be the most significant areas for their health.

RESOLVED: That the contents of the report be noted and the recommendations be supported.

HWB14 BETTER CARE FUND PLAN 2017 -2019

The Board considered a report of the Director of Adult Social Services, which provided information on the Better Care Fund (BCF) 2017 – 19 submission. The submission built upon the work undertaken in previous years, reviewed the BCF Plan 2016/17, reported on the integrated plan of action and outlined how the Plan would meet each national condition.

The Department of Health and NHS England, in partnership with the Local Government Association and the Association of Directors of Adult Social Services, were keen to see progress in the 2017/19 submission of various schemes and system changes that would support the key metrics. Therefore, in order to streamline the process, NHS England had reduced the amount of performance metrics that required reporting to four:

- Management of delayed Transfers of Care;
- Non-elective admissions to hospital;
- Admissions to residential and nursing care homes; and
- Number of people who were still at home 91 days after discharge from hospital (reablement).

RESOLVED: That the Board noted the content of the report and the associated documents.

HWB15 TOBACCO CONTROL STRATEGY 2017/22

The Board considered a report of the Director of Public Health, which presented the final draft of the Halton Tobacco Control Plan – A Smokefree Future. It was reported that in Halton good progress had been made in reducing the harm smoking caused with fewer young people starting to smoke and a smaller number of adults now smoking. The number of people in Halton who smoked had reduced significantly from around 30% in 2001 to 16.6% in 2016. However, it was noted that more work was needed and the following considerable challenges still remained:

- Smoking rates in Halton were higher than for England as a whole.
- Smoking was the leading cause of preventable death and disease in Halton and was one of the most significant causes of ill health, particularly due to cancer, coronary heart disease and respiratory disease.
- Smoking was the primary reason for the gap in life expectancy between rich and poor in our communities.
- Smoking rates were high among some social groups for example routine and manual workers, those with a mental health condition, pregnant women, those with long term health conditions and those with drug and alcohol addictions.
- Smoking costs the local Halton economy £37.9 million each year. This was considerably more than was generated through tobacco duty (£17.2 million) per year.

The Halton Tobacco Control Plan recognised the scale of Halton's tobacco challenge and offered systematic plans to tackle it in response to both national and local requirements. The Plan built upon the effective work that had been undertaken by partners locally and had been written in collaboration with all partners agreeing to the

vision, outcomes and actions. The Plan would be monitored by the Halton Tobacco Alliance and outcomes would be reported to the Healthy Lifestyles Board, Health and Wellbeing Board and all other relevant bodies.

RESOLVED: That

1. the contents of the report be noted; and

2. the strategy outcomes, objectives and actions be supported.

HWB16 SEASONAL FLU PLAN 2017/18

The Board received a report of the Director of Public Health, which presented the annual Flu Plan. The Plan included an overview of the annual seasonal influenza vaccination campaign for the 2017/18 flu season and implications of this for the local health and social care partner agencies. Details of the uptake of flu vaccination in Halton for previous years were outlined in the report.

It was noted that the main changes to the programme this year was to extend the offer of flu vaccination to children of school year 4 and the transfer of responsibility for the vaccination of 4 years olds from GP practice to school providers. Within Halton Council, the programme to vaccinate staff would be extended from front line Health and Social Care staff to include an offer to care home and domiciliary care agency staff.

RESOLVED: That

1. the content of the Annual Flu Plan and the changes to the national flu vaccination programme for 2017-18 be noted; and

2. each individual agency note their requirements in relation to the programme.

HWB17 INTEGRATED COLD WEATHER PLAN 2017/18

The Board considered a report which detailed the Halton Integrated Cold Weather Plan. The Plan highlighted the local public health plan to prepare for, alert people and prevent major avoidable effects during severe cold weather episodes.

Members were advised that the Plan linked with severe weather plans within Halton CCG and key provider

organisations. It aimed to capture the work that was undertaken by the Council with regard to prevention and awareness activity for cold weather. In addition, it detailed the cascade arrangements for the cold weather alerts that were received from the Met Office as part of the Cold Weather Plan for England and the actions that would be carried out by the Council as each of these levels were triggered.

RESOLVED: That the content of the Integrated Cold Weather Plan be noted.

HWB18 HEALTHWATCH HALTON ANNUAL REPORT 2016/17

The Board considered a copy of the Healthwatch Halton Annual Report 2016/17. The report highlighted initiatives which had taken place in 2016/17, governance arrangements, future plans for the next twelve months, finances and the role of Healthwatch in the community.

RESOLVED: That the Healthwatch Halton Annual Report 2016/17 be noted.

Meeting ended at 3.02 p.m.

REPORT TO: Health & Wellbeing Board

DATE: 17 January 2018

REPORTING OFFICER: Director of Commissioning

PORTFOLIO: Health and Wellbeing and Children, Young People and Families

SUBJECT: Well North Programme

WARDS: Borough-wide

1.0 PURPOSE OF THE REPORT

This report provides the Halton Health and Wellbeing Board with information and progress updates pertaining to the Well Halton Programme

2.0 RECOMMENDATION: That

1. **The Board note the contents of the Well Halton presentation and review the draft plan; and**

2. **Feedback comments to the Director of Commissioning**

3.0 SUPPORTING INFORMATION

Well North is a partnership between Public Health England (PHE), The University of Manchester and Manchester Academic Heath Science Centre; Local authorities, NHS organisations, business (both big and small), community, voluntary, and enterprise organisations.

The well north principles are to:
- Address inequalities by improving the health of the poorest, fastest
- Increasing resilience at individual, household and community levels
- Reducing levels of worklessness.

Well Halton is one of ten regional ‘pathfinder’ sites across the North, we are adopting a ‘place based’ approach that builds upon the unique nature of our borough and capitalises on Halton’s many assets.

Unique projects are being develop in various neighbourhoods, each being co-produced with the local community, VCSE providers, agencies and Private Sector partners.

PIDs were developed in June 2016, however funds were not released until April2017 due to legal issues at the Well North Hub level. Despite the delays in funding, significant progress has been made against the PIDS and an overarching Well Halton Plan has now been developed.

4.0 POLICY IMPLICATIONS

4.1. The Well Halton Programme is an opportunity to be innovative, further develop the One Halton concept and add extra impetus to other 'place based' schemes such as Healthy New Towns

5.0 FINANCIAL IMPLICATIONS

5.1 The initiative provides investment in the borough.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children and Young People in Halton

Improving the Health of Children and Young People is a key priority in Halton and will be addressed via the Well Halton programme.

6.2 Employment, Learning and Skills in Halton

Enterprise, learning and employment are fundamental to the Well North approach. These areas will feature heavily in our activity

6.3 A Healthy Halton

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

6.4 A Safer Halton

Well Halton takes a holistic approach and will address issues around nuisance behaviour, isolation and other impactors upon community safety

6.5 Halton's Urban Renewal

The environment in which we live and the physical infrastructure of our communities has a direct impact on our health and wellbeing; Well Halton recognises the broad context of issues that impacts upon resident's health & wellbeing including the physical environment

7.0 RISK ANALYSIS

This bid does not present a risk.

8.0 EQUALITY AND DIVERSITY ISSUES

The Well North programme will strive to engage with cohorts of Halton's community whom traditionally haven't accessed primary care services.

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

Document	Place of Inspection	Contact Officer
Well Halton Plan	Appendix A	Leigh Thompson

REPORT TO: Halton Health and Wellbeing Board

DATE: 17th January 2018

REPORTING OFFICER: Director of Adult Social Services

PORTFOLIO: Health and Wellbeing

SUBJECT: Update on developments in Halton Adult Mental Health Services

WARD(S) Borough-wide

1.0 **PURPOSE OF REPORT**

1.1 This Report provides the Board with an update on some of the changes to service delivery that have been taking place in Halton in the past two years.

2.0 **RECOMMENDATION: That Board members note the contents of this report.**

3.0 **SUPPORTING INFORMATION**

3.1 Context of local developments

3.1.1 Late in 2015, a whole-scale review of the ways in which mental health services were delivered across the footprint of the 5BoroughsPartnership NHS Trust (covering the local authority areas of Halton, St Helens, Knowsley, Warrington and Wigan) was commissioned by the combined Clinical Commissioning Groups covering that footprint. Although the 5Boroughs (now re-named as the North West Boroughs) was the main provider of specialist secondary care mental health services, the review was intended to be whole-system, across all key organisations, including the CCGs themselves, the local authorities and the voluntary and independent sectors.

3.1.2 The review – which became known as the Tony Ryan report, after the independent consultant who received the contract to do the work – covered both the Acute Care Pathway (which worked with adults with defined mental illnesses) and the Later Life and Memory Services, which largely support people with dementia and related conditions. It came up with sets of recommendations covering five key areas:

- The interface between primary and secondary care - the ease with which people could move between levels of service
- Services for people with personality disorders or complex emotional conditions – these were seen as people who often took up the greatest levels of resource and could have the highest levels of need and risk. This is reducing the numbers

of people who are admitted to hospital in the first place, and for those people who are admitted, their lengths of stay are being reduced
- Establishing a whole-service model with clear roles and responsibilities across all areas
- Stepping down from inpatient services (including people placed out of borough)
- The future bed base

3.1.3. These themes, and the recommendations that came from them, were largely accepted by the CCGs and their partner agencies, and work streams were therefore set up to put the recommendations into place. As a secondary issue, but no less important, there was a strong sense from the review that the services provided by the 5Boroughs were less responsive to local need than they should have been, and it was recommended that a firmer local management structure was put in place for each area.

3.2 Pan-North West Boroughs developments

3.2.1 Following the publication of the Tony Ryan Report, work took place across the North West Boroughs Trust footprint to develop a clear service pathway for people with personality disorders, to ensure that people with the most complex needs get the assessments and service responses that they need. This has now been implemented across the Trust.

3.2.2 A similar piece of work took place to review the use of inpatient beds across the Trust. As a result of this, the decision was taken to close the older people's mental health ward at the Brooker Unit, and transfer patients to wards at Hollins Park, Warrington, or to a new facility at Atherleigh Park in Leigh. This has caused some difficulties for family members and staff in terms of accessing these wards, but there is a facility for family members to be supported with their transport arrangements if necessary. The changes that have taken place are considered to be offset by improvements in service quality. In particular, older inpatients with mental illnesses are no longer having to share ward facilities with younger adults, and there is a greater level of professional expertise available in these new services, with an improved emphasis on individuals' physical health issues.

3.3 Halton developments

3.3.1 "Step up and step down services": considerable work locally has taken place to implement the recommendations of the Tony Ryan Report in a way which creates positive change for the people of Halton. NHS Halton Clinical Commissioning Group, supported strongly by Halton Borough Council, has led task-and-finish groups with all key partners to establish clear care pathways through the

mental health system. One group has looked specifically at early intervention and prevention, identifying the services and supports that can help to divert people from more intensive interventions; the second group has focused on services and supports which help people to step down more quickly from secondary care and regain their independence. This work has led to a clear understanding of the various processes and resources available to support both aims, and has clarified roles and responsibilities of the organisations involved in the processes. This in itself should result in greater efficiency for people with mental health needs in being able to access the help and support they need as quickly as possible.

3.3.2 Redesign of North West Boroughs services: Within the North West Boroughs NHS Trust, there has been considerable local redesign. A new local management structure has been developed which is specifically designed to relate more closely to local strategic and operational planning processes. Services which were previously shared with other boroughs – such as the Assessment Team – are now specific to Halton; there has also been a move to refocus the delivery of non-inpatient services on the two towns of Widnes and Runcorn, rather than covering the whole of the borough.

3.3.3 The delivery of mental health social work: Parallel to this, there have also been some changes to the delivery of social care services for people with mental health problems in the Borough. The social work service itself was previously delivered as part of a formal partnership arrangement with the North West Boroughs. Under this arrangement, social workers were full members of the multidisciplinary Recovery team in the Brooker Centre, delivering care and support to people with complex and long-term mental health needs. Social workers were acting as care co-ordinators under the Care Programme.

3.3.4 The partnership arrangement has now lapsed, and the opportunity was taken to review the way in which the social work service relates to the North West Boroughs services. Overall, there were many positives in the way in which health and social care services worked together to deliver effective services for people with complex mental health needs. There were some elements of the service, however, which were in need of improvement: the focus of social workers on the care co-ordination role, for example, meant that other core social work business was being diminished, and the need to enter client data on two different electronic systems – those of the council and the North West Boroughs – meant that there was a real risk that key information could be missed.

3.3.5 As a result, the social work service has withdrawn from acting as formal care co-ordinators, although all social workers are full members of the multidisciplinary teams and continue to work within the Care Programme Approach (the national framework for the delivery of care and risk management in mental health). Social

workers, too, now only use a single electronic recording system – that of the Borough Council. Clear care and referral pathways have been developed to ensure that there is no delay in accessing social care services, the teams continue to be located together, team managers from both services meet together regularly and joint work continues to take place. Social workers are, however, more able to spend time ensuring that people's social care needs are fully met, and are also able to engage more in early intervention and prevention.

3.3.6 The use of the Mental Health Resource Centre: An example of the continued strong working between the North West Boroughs and the Borough Council is shown in the next development: the redesign of the Mental Health Resource Centre in Vine Street, Widnes. Opened in 2006, this Centre was intended to be a multi-purpose mental health centre, and for a while contained the MIND day service, the Council's Mental Health Outreach Team and the Community Bridge Building Team, and a (then) 5BoroughsPartnership nursing team. Over time, however, as needs changed, both the NHS nursing team and MIND left the Centre, and for a time it was considerably underused.

3.3.7 Recognising this underuse, the Borough Council, along with NHS Halton CCG and the North West Boroughs, has invested capital monies to make better use of the Centre. The upstairs offices still contain the Mental Health Outreach Team and the Community Bridge Building Team, but the rooms have been adapted to allow flexible working, with the effect that half the mental health social work service is also based there. Downstairs, the building is being adapted to take in the North West Boroughs Assessment and Home Treatment Team, with clinic rooms for appointments with psychiatrists and other specialists, and with the development of a crisis room to support people who are in a mental health crisis but who do not immediately require inpatient treatment. This combination of community-based support services, social workers, mental health nurses and doctors will allow a real interchange of specialisms and quick and easy referrals and support between the services.

3.3.8 In relation to this, a new approach is being established to describe the way the services all work together. Instead of having a formal partnership agreement – which then requires the establishment of a Board to manage the agreement – three approaches are being put in place:

- A Statement of Intent, which describes how the organisations will work together and what they are trying to achieve
- A formal and refreshed Information-Sharing Agreement, which allows the safe and appropriate transfer of information between the organisations
- A lease arrangement, which describes how the council and NHS staff will work together in the buildings owned by the respective organisations.

This approach means that all key elements of working together will be described and agreed, whilst reducing the need to have costly and time-consuming Board meetings.

3.3.9 Redesign of the Mental Health Outreach Team: this team of skilled mental health support workers has for many years worked with people with severe and enduring mental health needs, supporting them to live in their own homes in the community. The focus of the work has been long-term, encouraging people to take increasing responsibility for the management of their own lives, and supporting them to remain as well as possible. Most of the client group – apart from a very small number of people who had been inpatients at the time of the closure of Winwick Hospital in the late 1990s – were also people who were involved with the psychiatric services at the Brooker Unit.

3.3.10 Although very well regarded as a service, over time it became clear that new developments in the delivery of mental health services – and social care services in general – were impacting on the way in which the Outreach Team was working. There were more opportunities for people with complex mental health problems to be supported in the community (such as the use of direct payments), and it became clear that the long-term service delivery approach should be reviewed.

3.3.11 At the same time, the Outreach Team set up a pilot programme with a small number of surgeries in Halton, offering more time-limited and focused interventions for people with less complex needs, with the intention of intervening at an earlier stage in their mental health pathway, and trying to prevent referral on to more specialist services. This pilot proved to be very successful for the people who used the service, and the GPs who were involved in the pilot were enthusiastic about it.

3.3.12 Given the success of this pilot, and following a more structured review of the operation of the Outreach Team, it was decided to redesign the team's work, to provide short-term, more outcome-focused interventions. People with less complex mental health needs, known only to primary care services, and those with much higher levels of need and with continuing involvement from the North West Boroughs, can all still be referred for support. The difference is that the interventions they receive will be focused more on what they want to achieve over a period of time to improve the quality of their lives, and a structured personal plan will be developed with them. For those people who require longer-term support, this will be provided by means of a care and support package identified through an assessment of need under the Care Act. This redesign has now taken place and positive results are being reported.

3.3.13 Other Halton issues:

- Bed pressures: as with all other areas of the country, there is considerable pressure on the use of inpatient beds for people with complex mental health needs in Halton. There are robust bed management processes in place in Halton, with full involvement of health and social care staff, which are designed to ensure that people do not stay in hospital unnecessarily, but can be discharged with levels of support in the community which are appropriate to their needs. In addition, the North West Boroughs has developed four more inpatient beds locally, which are intended to reduce some of the pressures on bed availability
- Dementia: one local target is that the dementia diagnosis rate for people known to primary care services should be 67%. For some time, Halton's performance has fallen below that figure, but changes in the way the single point of access for dementia works have now meant that the diagnosis rate is 75%. In essence, this means that more people are getting an earlier diagnosis of dementia, which in turn can lead to more positive interventions for them over time
- Halton Women's Centre: this small, but again very well-regarded service, has for over ten years provided support to women with lower level mental health needs in the Borough, and is the only one of its type in the North West. Recently, its parent organisation ceased business, and the service has been drawn in to the Borough Council on a temporary basis, whilst a review takes place. It is hoped that proposals will be developed which can support the Centre to develop and provide a wider service to local women

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 and Young People in Halton

None identified

6.2 Employment, Learning and Skills in Halton

None identified

6.3 A Healthy Halton

Each of the measures described above is addressing the health needs of a large number of Halton residents, whether they are receiving specialist interventions form secondary mental health services, or are receiving less intensive lower-level supports from primary care services. The measures are designed to continue to manage people with the highest levels of need and risk, whilst providing increased support and earlier intervention to try to reduce the likelihood of people needing greater support.

6.4 **A Safer Halton**

None identified.

6.5 **Halton's Urban Renewal**

None identified

7.0 **RISK ANALYSIS**

7.1 None identified

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None identified

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

9.1 None identified

REPORT TO: Health & Wellbeing Board

DATE: 17th January 2018

REPORTING OFFICER: Director of Adult Social Services

PORTFOLIO: Health & Wellbeing

SUBJECT: Care Quality Commission (CQC) - Local System Review (LSR) of Health & Social Care in Halton

WARD(S): Borough-wide

1.0 PURPOSE OF REPORT

1.1 To receive an update following CQC's recent LSR of Health & Social Care in Halton.

2.0 RECOMMENDATION: That the Board note the contents of the report and associated appendices.

3.0 SUPPORTING INFORMATION

3.1 As members of the Board are aware in August 2017, CQC undertook an LSR in Halton which examined how people move between health and social care, including delayed transfers of care, with a particular focus on people over 65 year old.

The Review included an assessment of commissioning across the interface of health and social care and of the governance systems and processes in place in respect of the management of resources.

Although the Review did not include mental health services or specialist commissioning specifically, they did look at the experiences of people living with dementia.

3.2 The final report from CQC was published on 12th October (see ***Appendix 1***) following a Quality Summit which took place at the Stadium on the 11th October, which was attended by representatives from across partner agencies.

3.3 In summary, overall, CQC found that there was a strong commitment and shared vision across the Local Authority and Clinical Commissioning Group (CCG) to serve the people of Halton well.

They found well established, positive relationships across the health and social care system, underpinned by a high level of trust.

There was evidence of robust analysis of need to support resource allocation and the setting of priorities within the local authority and the CCG.

There was a specific Joint Strategic Needs Assessment for Older People and there was good evidence of partners meeting individuals' needs in terms of health and wellbeing, social inclusion, social prescribing and transport.

Preventative approaches were well thought through and embedded.

There were a wide range of effective initiatives that were supporting people to remain socially included, maintain their own health and manage their long term conditions.

There were also some excellent examples of shared approaches and local agreements that supported local people in having timely access to services and support that met their needs in a person-centred way.

CQC also found a range of support services that encouraged staff to work across organisational boundaries to better provide holistic care to people requiring services.

There was positive involvement of service users, families and carers in the development of strategies and some excellent examples of social prescribing that helped people deal with bereavement, loneliness and concerns about their safety at home.

Finally the Local Authority provided strong support to carers with input from the carer's centre who supported approximately 5000 carers, including 528 carers supporting people living with dementia.

3.4 However, there were some areas identified by CQC where they felt improvements could be made and as a system we were required to submit a system wide action plan to CQC by 9th November (see ***Appendix 2***).

3.5 Working collaboratively across our statutory partners and with support from the Social Care Institute for Excellence, an associated Action Plan was developed in response to the issues highlighted within the report.

For ease of reference, the issues highlighted within the report have been themed under the following headings within the Action Plan:-

- Strategic Vision and Governance;
- Delayed Transfers of Care (including user experience);
- Key Actions for Winter 17/18
- Workforce;
- Market Capacity and Capability;
- Commissioning; and

- Patient Flow.

3.6 Progress against the actions outlined in the Action Plan will be monitored over the next few months via the Board and Halton Borough Council's Management Team.

4.0 POLICY IMPLICATIONS

4.1 None associated with this report.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 None associated with this report.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

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

6.2 **Employment, Learning & Skills in Halton**
None identified

6.3 **A Healthy Halton**
All issues outlined in this report and its associated appendices focuses directly on this priority.

6.4 **A Safer Halton**
None identified

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

7.0 RISK ANALYSIS

7.1 None associated with this report.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None associated with this report.

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

9.1 None under the meaning of the Act.

Halton

Local system review report

Health and Wellbeing Board

Date of review:
21-25 August 2017

Background and scope of the local system review

This review has been carried out following a request from the Secretaries of State for Health and Communities and Local Government to undertake a programme of 20 targeted reviews of local authority areas. The purpose of this review is to understand how people move through the health and social care system with a focus on the interfaces between services.

This review has been carried out under Section 48 of the Health and Social Care Act 2008. This gives CQC the ability to explore issues that are wider than the regulations that underpin our regular inspection activity. By exploring local area commissioning arrangements and how organisations are working together to develop person-centred, coordinated care for people who use services, their families and carers, we are able to understand people's experience of care across the local area, and how improvements can be made.

This report is one of 20 local area reports produced as part of the local system reviews programme and will be followed by a national report for government that brings together key findings from across the 20 local system reviews.

The review team

Our review team was led by:
Delivery Lead: Ann Ford, CQC
Lead Reviewer: Wendy Dixon, CQC

The team also included:

- Members of the executive team
- Three CQC reviewers,
- Two CQC strategy leads,
- One CQC analyst,
- One CQC Expert by Experience; and
- Three specialist advisors (two former local government directors of social service and one Clinical Commissioning Group board member).

How we carried out the review

The Local System Review considered system performance along a number of **'pressure points'** on a typical pathway of care with a focus **on older people aged over 65.**

We also focussed on the interface between social care, general medical practice, acute and community health services, and delayed transfers of care from acute hospital settings.

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across three key areas:

1. Maintaining the wellbeing of a person in usual place of residence
2. Crisis management
3. Step down, return to usual place of residence and/ or admission to a new place of residence

Across these three areas, detailed in the report, we have asked the questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive?

We have then looked across the system to ask:

- Is it well led?

Prior to visiting the local area we developed a local data profile containing analysis of a range of information available from national data collections as well as CQC's own data. We requested the local area provide an overview of their health and social care system in a bespoke System Overview Information Return (SOIR) and asked a range of other local stakeholder organisations for information. We also developed two online feedback tools; a relational audit to gather views on how relationships across the system were working, and an information flow audit to gather feedback on the flow of information when older people are discharged from secondary care services into adult social care[1].

During our visit to the local area we sought feedback from a range of people involved in shaping and leading the system, those responsible for directly delivering care as well as those who use services, their families and carers. The people we spoke with included:

- Staff members including social workers, GPs, discharge coordinators, therapists and nurses
- Senior leaders and managers in the local authority, the Clinical Commissioning Group (CCG), Warrington and Halton Hospitals NHS Foundation Trust, St Helen's and Knowsley Teaching Hospitals NHS Trust, Bridgewater Community Healthcare NHS foundation Trust, the North West Ambulance Service and North West Boroughs

- Local Healthwatch, voluntary and community sector (VCS) services
- Local Residents attending the Halton Direct Link service (the local authority's walk in advisory service)
- Service users in the acute hospitals in both A&E and the discharge lounges

We reviewed 26 care and treatment records and visited nine services in the local area including acute hospitals, intermediate care facilities, a hospice, a care home, a nursing home and 2 GP practices.

The Halton context

Demographics

- 15% of the population is aged 65 and over.
- 98% of the population is categorised as White.
- Halton is in the most deprived 20% of local authorities in England.

Adult Social Care

- 18 active residential care home locations:
  - 17 rated good
  - 1 rated requires improvement
- 8 active nursing care home locations:
  - 5 rated good
  - 3 rated requires improvement
- 5 active domiciliary care agencies:
  - 4 rated good
  - 1 rated requires improvement

GP Practices

- 12 GP practices rated good
- 1 GP practice rated outstanding
- 2 are currently unrated

Acute and community Healthcare

Hospital admissions (elective and non-elective) from Halton are largely split between two NHS acute hospital trusts:

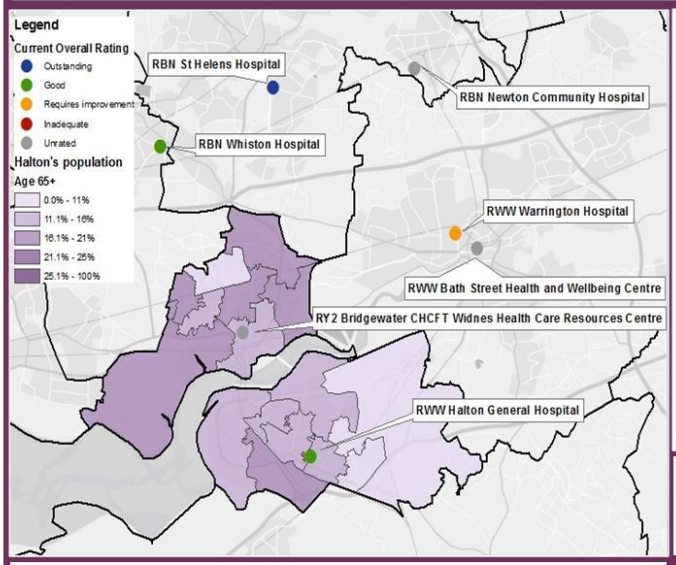
- Warrington and Halton Hospitals NHS Foundation Trust (RWW)
  - Receives 49% of Halton's admissions
  - Admissions from Halton make up 25% of the trust's admissions
  - Currently rated Requires Improvement overall

- St Helens and Knowsley Teaching Hospitals NHS Trust (RBN)
  - Receives 43% of Halton's admissions
  - Admissions from Halton make up 16% of the trust's admissions
  - Currently rated Good overall

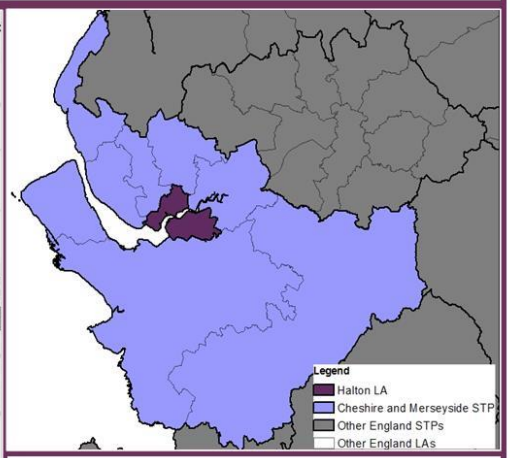
Community services are provided by:

- Bridgewater Community Healthcare NHS Foundation Trust (RY2) - currently rated requires improvement overall.

Acute and Community hospital locations as at 29/09/2017; ASC and PMS locations as at 29/09/2017
Admissions percentages from 2015/16 Hospital Episode Statistics.



Map 1: Population of Halton aged 65+ and location and current rating of acute and community healthcare organisations serving Halton.



Map 2: Location of Halton LA within Cheshire and Merseyside STP. Halton CCG and the HWB cover an almost identical footprint.

Summary of findings

Is there a clear shared and agreed purpose, vision and strategy for health and social care?

- Overall, there was a strong commitment from the local authority (LA) and the clinical commissioning group (CCG) to serve the people of Halton well.
- The local authority and CCG had a clear vision for the borough that had been shared with its strategic partners and was well understood by their staff at a managerial and operational level. There were also well established, positive relationships across the health and social care system with a shared dialogue between the CCG and the local authority underpinned by a high level of trust.
- Local NHS acute trusts, although not located in the borough, participated in the wider system planning.
- As there was not yet a cohesive interface or alignment between the local authority's and CCGs vision for the borough, the Local Delivery System (LDS), the Sustainability and Transformation Plan (STP), and a developing accountable care system, there were opportunities for system partners to think more widely and include the Local Delivery System (LDS) and the Sustainability and Transformation Plan (STP) in the overall system strategy to strengthen the position of the Halton community and give local partners a stronger voice within the system footprint.
- Work was required to develop a wider system vision for the STP footprint and develop a common framework for prioritising actions, and for specifying accountabilities and shared governance arrangements.
- This was recognised by the system leaders who were working towards a more robust approach to alignment at the time of our review.
- There was agreement across partners to develop an accountable care system (ACS) in the future, however this agreement had not yet manifested into detailed plans and actions. Discussions were ongoing at the time of our review.

Is there a clear framework for interagency collaboration?

- There were well established, positive relationships across the health and social care system with a shared dialogue between the CCG and the local authority, underpinned by a high level of trust.
- The Joint Strategic Needs Assessment (JSNA) was well thought out and had underpinned operational delivery plans and desired outcomes .All partners were sighted on what was important to older people and carers when moving through the interface of health and social care. There was a specific JSNA for older people and there was good evidence of partners meeting individuals'

needs in terms of health and wellbeing, social inclusion, social prescribing and transport. However, a joint commissioning strategy for older people's service provision had not yet been fully developed.

- There was evidence of robust analysis of need to support resource allocation and the setting of priorities within the local authority and the CCG. The local authority had a strong track record of financial management and delivering services for older people based on quality outcomes within budget.

- Joint preventative approaches were well thought through and embedded. There was a wide range of effective initiatives that were supporting people to remain socially included, maintain their own health and manage their long term conditions.

- There were some excellent examples of shared approaches and local agreements that supported local people in having timely access to services and support that met their needs in a person-centred way.

- The seven-day Rapid Access Re-ablement Service (RARS) and the five- day Rapid Clinical Assessment Team (RCAT) had been developed to reduce avoidable hospital admissions, which in 2016/17 had been above the comparator average. Similarly the numbers of delayed transfers of care were higher than the comparator average for the same period. System leaders were confident that the recently implemented RARS and RCAT teams' approach, coupled with the implementation of elements of the high impact change model, would secure improved performance in respect of avoidable admissions and further reductions in the numbers of delayed transfers of care.

- It was evident from the range of joint initiatives from the local authority and the CCG that there was a shared understanding and collective responsibility for meeting the needs of the local population. There was a strong commitment from partners to work collaboratively and efficiently for the benefit of local people.

- We found that the Health and Wellbeing board provided senior officers with high levels of support. However, as a forum to challenge and support the system's joint strategic approach, the Health and Wellbeing Board lacked rigour and required improvement to support and challenge the local system's transformation agenda and monitor progress more robustly.

- We found examples of poor monitoring of commissioned services which were having an impact on the quality of service provision, such as the intermediate care service provided at Warrington and Halton NHS Foundation Trust.

- Initiatives were not always connected and joined up to inform whole system performance. For example, GP practices were not always aligned with the system wellbeing strategies for example the enhanced care home model was not fully embedded with all GP practices

- Although recent DTOC figures were improving (figures for June 2017 indicate that the average daily rate of delayed transfers of care in Halton had dropped to 8.8 delayed days per 100,000 population,

below the England figure of 13.8 and below Halton's comparator average of 10.80), there were a number of challenges in the timely provision of appropriate rehabilitation services and intermediate care to support and maintain further reduction. Some people with complex needs were experiencing considerable delays.

- The local authority and CCGs had transformation plans for domiciliary care and care home provision in Halton. Both these elements of provision were challenged in terms of their capacity to meet demand

How are interagency processes delivered?

- The framework for interagency working was supported by separate organisational strategies; however we did not find evidence of this being co-ordinated into a system wide approach by the STP.

- There were shared performance metrics between the local authority and the CCG which were scrutinised at the Executive Partnership Board. However these were not aligned with all system partners.

What are the experiences of front line staff?

- Senior leaders were visible, accessible and approachable.

- Staff felt supported by their line managers and were encouraged to influence the design and delivery of services.

- There were systems and processes in place to support staff development and professional competence.

- There was work planned with staff in the independent sector in terms of promoting peoples safety and injury prevention.

- There was good support available to staff underpinned by regular training to manage adult safeguarding issues including issues of abuse and neglect.

- From interviews with system leaders and operational staff it was evident that leaders across respective agencies were working together to implement systems to support interagency and multi-disciplinary working and encourage staff to work in cohesive teams.

- We found a range of support services that encouraged staff to work across organisational boundaries to better provide holistic care to people requiring services

What are the experiences of people receiving services

- The experiences of people receiving services in Halton varied.
- We found a very positive approach to maintaining people's health and wellbeing in their own homes and services designed for older people to keep them socially included, active and able to manage their long term conditions.
- There were some excellent examples of social prescribing that helped people deal with bereavement, loneliness and concerns about their safety at home.
- We observed a number of assessments carried out by different teams during the course of the review. We saw good examples of person-centred assessments, including those for people experiencing memory loss. Clinical, social and cultural information was included in assessments which covered all aspects of what was important in people's lives. Care plans were developed with the inclusion of the person, their families and carers.
- Halton had a high uptake of personal health budgets and direct payments for all adults compared to the England average and Cheshire and Merseyside regional average. The Halton Disability Partnership delivered a service to support people through the process of accessing and using direct payments.
- The local authority provided good support to carers with input from the carer's centre that supported approximately 5000 carers, including 528 carers supporting people living with dementia.
- However, some older people from the Halton area had less satisfactory experiences when they were admitted to hospital; they were often experiencing long waits in A&E before being admitted to a ward.
- Once ready for discharge, some older people were subject to delays in their transfer home or to a new place of residence. In some cases people had suffered avoidable harm or detriment as a result of the delays, such as the development of a pressure sore. In the main, delays were attributed to the lack of provision of care packages in the community or the availability of long term care placements.
- In response there were a number of new initiatives planned to improve the experience of older people and at the time of our review performance in delayed transfers of care was improving. Nevertheless further work was required to maintain this improvement and ensure that delays did not increase as a result of winter pressures.
- Continuing Healthcare (CHC) was provided through a joint local authority and CCG budget that had been established for a number of years. Securing CHC funding was not considered to be a primary cause of delayed transfers of care. The NHS CHC figures for all adults showed that in Q1 2017/18 both the referral conversion rate (% of newly eligible cases of total referrals completed) and assessment conversion rate (% newly eligible cases of total cases assessed) were higher than the

England and Cheshire and Merseyside regional averages. This indicated that Halton's processes for identifying people eligible for CHC were working well. However, there were delays in completing the process as the data for all adults in Q1 2017/18 also showed that for Halton CCG 25% of referrals for standard CHC were completed within 28 days, lower than the England average of 57% and the Cheshire and Merseyside regional average of 73%.

Are services in Halton well led?

Is there a shared clear vision and credible strategy which is understood across health and social care interface to deliver high quality care and support?

As part of this review we looked at the strategic approach to delivery of care across the interface of health and social care. This included strategic alignment across the system, joint working, inter-agency and multi-disciplinary working and the involvement of people who use services, their families and carers.

We did not find a cohesive interface between the local authority' and CCG vision for the borough, the Local Delivery System (LDS), the Sustainability and Transformation Plan (STP), and the emergent accountable care system (ACS).

The local authority and CCG had a clear vision for the borough that had been shared with its strategic partners and was well understood by its staff at a managerial and operational level. There was a strong commitment to joint working across the health and social care system. Leaders were visible and accessible, staff felt engaged and included in planning for the future. They were well supported by leaders in the development and design of services.

Strategy, Vision and partnership working

- We did not find a cohesive interface between the local authority's and CCGs vision for the borough, the Local Delivery System (LDS), the Sustainability and Transformation Plan (STP), and the emerging plans for an accountable care system (ACS).

- There were opportunities for partners to think more widely and include the Local Delivery System (LDS) and the Sustainability and Transformation Plan (STP) in the overall system strategy to strengthen the position of the Halton community and give local partners a stronger voice within the wider system.

- There were a range of plans across different organisations that were targeted at achieving the strategic aims in addition to the action plan within the wellbeing strategy.

- The local authority and CCGs had a clear vision for the borough. System leaders were working to promote a wider shared vision but there was a lack of clarity on the wider system interface; some leaders referred to the vision for the borough, others to the LDS and the STP.

- Interviews with system leaders indicated that partnerships and relationships at a local level were strong, particularly between the local authority and the CCG. Primary care engagement had previously been challenging but was seen to be improving, facilitated by the GP Federations. However, improvement was needed across the system in terms of understanding the role and potential of the federations.

- A review of the minutes of the Health and Wellbeing Board and discussions with senior leaders indicated that the function of the Health and Wellbeing Board could be improved as a forum to challenge and support the system's joint strategic approach and drive changes in practice.

- There was further work to be done to strengthen the HWB Board's challenge function to ensure the change agenda is developed and implemented in a timely way.

- Capacity and demand within the hospital system was overseen at an LDS and A&E Delivery Board level. This involved predictive modelling of activity, links to the A&E work streams and the wider out of hospital demand management work within the Local Alliance. The Local Delivery System (LDS) is the system that will deliver the Sustainability and transformation plans (STPs) developed for the area of Halton and make them operational.

- Planning for winter pressures was aligned with the North West boroughs and local plans had started via the A&E Delivery Board in the weeks prior to our visit. The local authority's divisional manager was also the urgent care lead for the local authority and the CCG, and was an active member of the Mid Mersey A&E Delivery Board, representing both organisations. This appointment was well received at an operational level and the divisional manager was seen as visible and supportive across the CCG, local authority and local NHS Trusts. There was an opportunity to replicate these joint posts at a more strategic level to better support the alignment of plans and the integration of services as well as establish joint governance and performance management arrangements.

- Winter planning was underway in all partner organisations however though we found a winter plan was being developed at a strategic level we found no evidence of this begin shared to system partners

- Winter plans across different organisations were collated at the A&E Delivery Board, however, operational staff in services felt that overarching plans were not fed back to them and consequently they were only aware of their own operational plans and not the wider support for winter pressures planned across the system.

Involvement of service users, families and carers in the development of strategy

- Halton OPEN (Older People's Empowerment Network) was a network of over 1000 older people that was established in 2001 and had become the collective voice of people aged 50 and over who live and work in Halton. The network was designed to support older people to influence and

encourage the development of services that can help to improve the quality of life and wellbeing of all older people in Halton.

- Halton OPEN members were engaged in new approaches and represented on boards for frailty pathway; Older People's Delivery Board and GP patient participation group boards. The network was also engaged in the process for transforming domiciliary care and will also have representation on the forthcoming Domiciliary Care Board.

- Halton OPEN has been engaged in discussions about health and wellbeing, finances, public transport, information provision, and reducing social isolation. The Director of Adult Social Services (DASS) met with the group regularly.
- Halton Carers Centre was used to gather carers' views and has fed into work such as the development of Halton's dementia strategy and associated implementation plan.

- Halton People's Health Forum was a key group supporting local engagement and involvement in service redesign. They have supported the development of the urgent care centres and aspects of enhancing healthcare in care homes, particularly with regard to GP realignment.

- The local authority started work on the development of an end-to end-pathway of care for frail older people, as part of the 'One Halton' approach.

- Older people have been involved in the development in the needs gap analysis for the older people's pathway, 'Living and Aging Well in Halton'.

- The Bridgewater Community NHS FT that serves the Halton area had undertaken engagement activities with local populations and staff on the future of community health services, which included a 'Big Conversation' event.

- North West Boroughs Healthcare NHS Foundation Trust undertook an engagement exercise in respect of changes to the bed provision for people with dementia. Plans were changed as a result of this engagement, ensuring better travel arrangements, improved community services as well as a more flexible approach to bed based service provision for older people.

- The information gathered as part of the consultation on 'Living and Aging Well in Halton', along with national best practice guidance was used to underpin the development of an overarching integrated 'Older People's Pathway'. This outlined the expected interventions, standards and aims to the approach for supporting older people across the whole system.

- It was evident that system partners understood the importance of including and involving people who use services, their families and carers in developing their strategic approach to managing the quality of the interface of health and social care.

Promoting a culture of inter-agency and multi-disciplinary working

- From interviews with system leaders and operational staff it was evident that leaders across respective agencies were working together to implement systems to support inter-agency and multi-disciplinary working.

  The framework for interagency working was supported by separate organisational strategies; however we did not find evidence of this being co-ordinated into a system wide approach. There were shared performance metrics between the local authority and the CCG which were scrutinised at the Executive Partnership Board. However these were not aligned with all system partners.
- We found a range of support services that encouraged staff to work across organisational boundaries. Examples included:

  ⇒ A new contract from the CCG that will see all GP practices aligned to individual care homes – every care home will now have a designated GP practice.

  ⇒ Social workers embedded within GP practices.

  ⇒ The continued development of the multi-disciplinary team (MDT) approach at primary care level offered a medical, nursing and a social care service as well as a multi-disciplinary prevention and wellbeing approach.

  ⇒ District nurses working together with local pharmacies to support effective medicines management and mitigate risk to safety to enable people to be maintained in their usual place of residence.

Learning and improvement across the system

- The CCG and the local authority are engaged with the STP and LDS and the Liverpool City Region Combined Authority which enabled them to transfer and apply learning from outside their local area.

- There was some evidence of learning being shared across agencies to improve quality and safety of care, for example, the CCG has worked with operational staff in hospices and hospitals to improve the quality of discharge information.
- We found evidence of learning at an organisational level regarding lessons learned however it was less apparent that this learning was being shared across organisations within the local area.

What impact is governance of the health and social care interface having on quality of care across the system?

We looked at the governance arrangements with the system, focusing on collaborative governance, information governance and effective risk sharing.

We found governance arrangements had been developed across the system to support partners to

collaboratively drive and support quality of care across the health and social care interface.

The overarching forum for system leaders to jointly plan how best to meet local health and care needs, and to commission services accordingly was the Health and Wellbeing Board (HWB). However there was little evidence of shared success criteria between the local authority and CCG commissioners and providers, underpinned by shared key performance metrics outside of the BCF

Overarching governance arrangements

- Governance arrangements had been developed across the system to support partners to collaboratively drive and support quality of care across the health and social care interface. Governance for the local authority and CCG's Section 75 partnership agreement was through a shared Executive Partnership Board (EPB) with an Operational Commissioning Committee (OCC) undertaking the detailed work of the agreement**.**

- The Health and Wellbeing Board was described as the overarching forum for system leaders to jointly to plan how best to meet local health and care needs, and to commission services accordingly. Partners were already engaged in system wide dialogue regarding the development of an accountable care system however these discussions had not yet manifested into detailed planning arrangements. Partners were committed to moving this work forward over the coming months

- Individual organisational governance arrangements were supported by well-developed committee structures in each of the system partner organisations. Strategic objectives were linked appropriately to organisational priorities. Organisational performance dashboards were shared and understood across partners and focussed on service quality and delivery.

- System partners acknowledged that pathways of care across organisational boundaries continued to challenge the system and required additional work regarding governance arrangements as well as future contracting and commissioning arrangements to ensure a truly collaborative and shared approach.

- There was a good process for agreeing Better Care Fund (BCF) allocations and responsibilities were agreed, shared and understood across the local authority and the CCG, and this was built on a pooled budget. However, the NHS trusts were not fully engaged

- There was not a collective governance framework that culminated in a series of agreed or shared performance metrics that were robustly monitored at the Health and Wellbeing Board. From the minutes of its meetings, and from our discussions with senior leaders, we found that the Health and Wellbeing Board had extensive membership and good rates of attendance. However the minutes indicated positive stakeholder engagement rather than a forum for strategic leadership and robust governance. There was a lack of challenge around performance for the system through the Health and Wellbeing Board.

- There was a history of joint working across health and social care, with some joint posts established, for example, the local authority's divisional manager is also the urgent care lead for the local authority and the CCG, and is an active member of the Mid Mersey A&E Delivery Board, representing both organisations. This appointment was well received at an operational level and the divisional manager was seen as visible and supportive across the CCG, local authority and local NHS Trusts. There was an opportunity to replicate these posts at a more strategic level to better support alignment and the integration of services as well as establish joint governance and performance management arrangements.

- In addition there was an agreement for a single executive lead for the development and delivery of older people's services supported by the chief nurse.

The governance of data collection systems were not always aligned to inform performance, which meant that information could not be effectively monitored across the system. For example, information from the discharge lounge at Warrington Hospital was not being used to improve the effectiveness of discharge lounge processes.

Information governance arrangements across the system

- Better Care Fund returns for 2016/17 indicated that the area was meeting the national conditions around data sharing. This included confirmation that they are using NHS numbers as the consistent identifier for health and care services. The local authority and the CCG are pursuing interoperable Application Programming Interfaces (APIs) – systems that can exchange and make use of information – with the necessary security and controls, ensuring appropriate information governance controls for information sharing, in line with national guidance. This approach supports people having clarity about how their data is used, who may have access to it, and how they can exercise their legal rights.

- The system has agreed to undertake work to improve information sharing and is transferring urgent care centres and community services onto 'EMIS Web' which will allow access to shared records with out of hospital services. This approach (due to be fully implemented in 2020) aims to promote seamless transfer of information across the system and reduce duplication of effort.

- All organisations within the system had robust policies regarding personal information and a person's right to confidentiality and privacy.

Risk sharing

- Work is required at a system level to articulate and mitigate wider system risks; this process was not yet fully developed across the STP and LDS or the emerging ACS

- We found no evidence (either during on site activities or through reviewing minutes from Health and Wellbeing Board meetings) of risk management arrangements across the system, however these were in place at an organisational level.

- All partners in the system were experiencing complex financial challenges. Partners were transparent and open with each other in sharing information about their own risks as to the impact this was having on decision making in respect of resource allocation and the setting of priorities.

- There was a shared understanding regarding risk mitigation in respect of the new approach to domiciliary care provision between the local authority and the preferred provider.

To what extent is the system working together to develop its health and social care workforce to meet the needs of its population?

We looked at how the system is working together to develop its health and social care workforce, including the strategic direction and efficient use of the workforce resource. In Halton we found system leaders acknowledged a number of workforce issues across the health and social care system. Workforce challenges in the NHS were most prevalent in the availability of medical staff in hospitals, general practice and urgent care. In adult social care the biggest challenge was in the recruitments and retention of domiciliary care staff. Robust actions had been taken by each organisation to address vacancies however this had not yet resulted in a system-wide workforce strategy that supported the system to determine joint investment in a future workforce.

Workforce planning and development

- With the exception of the acute trusts we met with system leaders responsible for workforce planning. All participants indicated that there were strong personal relationships across the system and a shared understanding that workforce issues were a risk to high quality, timely service delivery. Most partners had an organisational workforce strategy however; we found little evidence of a cross sector analysis of workforce challenges or joint plans to address them.
- Individual partners in the system had an organisational workforce strategy. However, there was not a joint workforce strategy for the Halton footprint that was shared and governed across the health and social care system.

- System leaders acknowledged a number of workforce issues across the health and social care system. Workforce challenges in the NHS were most prevalent in the availability of medical staff in hospitals, general practice and urgent care.

- Actions had been taken by each NHS acute trust to address hospital-based nursing vacancies; however this remained an ongoing challenge and there were rolling programmes in place to secure nursing staff and manage turnover.

- Within social care, analysis of Skills for Care data from 2013-14 to 2015-16 indicated that staff turnover and vacancies in Halton were below national and comparator group averages. During our visit we found there were no social worker vacancies, the greatest challenges related to the recruitment and retention of domiciliary care workers.

- The increased skill expectation of care and nursing staff in the independent care sector was having an impact on capacity, demand and the delivery of high quality care. These matters also had an impact on the ability of community services to respond to the changing pattern of demand and the desire to deliver older peoples' care closer to and in their own home.

- The local authority and in some areas the CCG, had started work to support care and nursing staff in the independent sector through the transformation of domiciliary care and the support to care homes projects. This involved initiatives such as apprenticeships, and training and development programs to support staff development and retention in these areas.

- We found that there was a collaborative agreement across the whole system, including Health Education England, to work with the developing Health Academy to help address staffing challenges within health and social care and to adopt a more collegiate and strategic approach to manage workforce across the local authority footprint.

- Work was also underway to develop the skills of the existing workforce to help manage gaps. Partners were looking at ways to increase the numbers of advanced nurse practitioners and nurse prescribers to support timely interventions and improved access in both primary and secondary care.

- We found little evidence of a cross sector analysis of need regarding the workforce and no joint strategic action plan to support the anticipated increased demand as winter approached.

- However, there were positive steps being taken at an organisational level to support the maximisation of the existing workforce through work-related wellness campaigns and immunisation projects that included staff in the independent sector who were involved in direct care.

Is commissioning of care across the health and social care interface, demonstrating a whole system approach based on the needs of the local population? How do leaders ensure effective partnership and joint working across the system to plan and deliver services?

We looked at the strategic approach to commissioning and how commissioners are providing a diverse and sustainable market in commissioning of health and social care services.

There was evidence that the local authority and the CCG worked positively together to develop the JSNA over a number of years. Commissioning strategies were underpinned by the JSNA and were regularly reviewed and evaluated.

There was a specific JSNA for older people and good evidence of partners meeting people's needs in terms of health and wellbeing, social inclusion, social prescribing and transport; however a joint

commissioning strategy for older people's service provision had not yet been fully developed.

There was acknowledgement, particularly by the local authority, that work was needed to strengthen and diversify the range and nature of support services particularly domiciliary and care home provision to meet the needs of older people.

Strategic approach to commissioning

- Commissioners in the local authority and the CCG had carried out a comprehensive needs assessment and had used this to determine commissioning priorities at the interface of health and social care.

- To secure improved outcomes for older people commissioners had initiated several large-scale, long-term commissioning initiatives that were in the early stages of development and implementation. For example the 'Healthy New Town' project that aimed to improve peoples' experience by providing housing with health and wellbeing services that were easily accessible and co-located. This initiative also aimed to address staffing shortages in health and social care.

- A JSNA for older people had been completed however a joint commissioning strategy for Older People had not yet been formalised at the time of our review.

- There was evidence of consultation and inclusion of older people in the assessment process.

- One of the issues raised by users was they often felt unprepared for discharge from hospital and that the discharge process was not always well managed, especially for those older people who lived alone.

- Partners had responded positively to improving older people's experiences in this regard; this was one of the main areas identified to shape future service commissioning

- The local authority acknowledged that patients being able to exercise a choice regarding which care home to move to was leading to delays, patients were given the full range of care homes in the borough and not just a list of those care homes with vacancies. This meant that if a patient chose a home without vacancies their transfer of care could be delayed. The rationale for this was that the local authority wanted to provide information on all care homes within the area to ensure people in the borough received their care in a place of their choice. However there was a choice policy in place at Warrington and Halton NHS FT intermediate care unit that would have mitigated this issue, by a service user choosing there long term home but waiting in the interim in another care home however, we did not see evidence this was being implemented

- There were joint commissioning initiatives for older people based on robust analysis and evidence-based commissioning principles to keep people well and when they experienced a crisis, focussed on recovery. These were not yet fully implemented and embedded at the time of our review but included:

- ⇒ The development of multi-agency guidance regarding the early recognition of frailty across health and social care sectors
- ⇒ Rapid assessment 'close to home' and at hospital including management of frailty and improved discharge processes
- ⇒ Review of capacity, demand and models in intermediate care provision
- ⇒ Outcome-based domiciliary care commissioning and contracting
- ⇒ Strengthening of the existing primary and secondary falls prevention work

- There was one A&E Delivery Board for covering both St Helens and Knowsley NHS Trust and Warrington and Halton NHS Foundation Trust. The A&E Delivery Board met regularly and supported system resilience planning across the system including capacity planning and out-of-hours planning, however joint winter plans were still being developed at the time of the review. Pooled budgets had been in place since 2013, for example the continuing healthcare budget. Other initiatives included the use of embedded Social Care in Practice (SCIP) workers who worked across the primary care and social care interface.

- The joint commissioning of new services and the implementation of some key initiatives was already underway, for example the development of a frailty pathway.

- Changes to domiciliary care provision proposed by the local authority were agreed and due for full implementation by November 2017.

Market shaping

Our analysis showed that, per population aged 65+, there are fewer residential and nursing care home beds in Halton compared to comparator areas and the England average. Furthermore, our analysis identified that the number of residential care home beds had decreased by 9% since April 2015, meanwhile nursing home beds had decreased by 13%. However the vacancy rates in care homes was below the England average and that of comparator areas.

- There was an acknowledgement, particularly by the local authority, that work was needed to strengthen and diversify the range and nature of support services *particularly domiciliary and care home provision* to meet the needs of older people. Partners had an understanding of the changing environment of the adult social care provision and a subsequent risk assessment has been used to inform the 'Transforming Domiciliary Care' project.

- Commissioners were using long term contracts and risk sharing to address the challenges in the market. For example, through the Transforming Domiciliary Care project a long term contract was offered to a sole provider. The contract had an associated risk mitigation process, allowing the provider to sub-contract to meet identified and anticipated increased need, if required.

- The local authority had agreed to expand its in-house service provision by recommissioning long-term care beds for the provision of intermediate care.

- LDS partners had worked together to agree the key characteristics of a high performing out-of-hospital system, undertaking a baseline assessment and identifying the areas for improvement. Implementation of the following would commence in September 2017:

  ⇒ Halton's GP Forward View and the local strategy for primary care. These outlined the plans to manage the increasing demand for local medical services and primary care through service redesign.

  ⇒ Work to strengthen the domiciliary care and care home sector as part of Halton's BCF plan.

  ⇒ A single contract for care home provision was developed by the local authority and the CCG as part a Section 75 agreement, following a consultation on the cost of care.

  ⇒ The transformation of domiciliary care and the re-procurement of domiciliary care which sought to strengthen the market and plan for future demand. This would be done through using long term contracts, more efficient care delivery, and greater utilisation of the third sector to support older people in their own homes.

  ⇒ Developing existing multi-disciplinary teams, wrapped around primary care and supporting better self-care through technology.

- Developing an ACS will go some way to managing competitive elements with the health and social care system, however at the time of our review this work was in its very early stages.

Do commissioners have the right range of support services in place to enable them to improve interface between health and social care?

- An assistive technology program (telemedicine) was well established in Halton with approximately 3,000 people currently using the service that included a 24-hour response service.

- Community wardens responded to calls within approximately 30 minutes and were actively involved in the falls prevention programme.

- There was evidence emerging locally that the falls reduction programme was having a positive impact in reducing the number of domestic admissions to hospital as a result of falls.

- There was a single team approach in the falls team with good communication and support between teams and single senior management oversight of operational provision of this valued service.

- Halton Direct Link services, supported by partners in the voluntary sector, provided two centres in Widnes and Runcorn for people to access or be signposted to services that supported health and wellbeing and avoid medical intervention. Support was also available for people to access an appropriate assessment of need. People also had access to social prescribing and productive activities to maintain the wider determinants of health such as housing and social isolation.

- In addition, a member of the wellbeing service team was based at each GP practice; people could be referred directly to wellbeing services at the point of GP contact. Feedback from service users was very positive about these services and they felt valued and included as a result. Feedback from GPs indicated that this service was successful at preventing older people becoming lonely, demotivated and suffering from related conditions such as depression and anxiety.

Contract oversight

- The local authority had systems and processes in place to review the impact and quality of service provision through close working with the CCG in respect of contract renewal. This was particularly evident in the recent work regarding the transformation of domiciliary care and care home provision in the borough.

- More widely, all service commissioners had systems in place to review contractual arrangements as part of a rolling programme. However we found that some quality monitoring arrangements relating to commissioning contracts would benefit from a more proactive approach, for example in primary care and the performance of the intermediate care services provided by Warrington and Halton Hospitals NHS FT.

How do system partners assure themselves that resources are being used to achieve sustainable high quality care and promoting peoples' independence?

We looked at resource governance and how systems assure themselves that resources are being used to achieve sustainable high quality care and promote peoples' independence.
We found that the assurance and governance process across the system would benefit from the addition of agreed performance metrics underpinned by a continuing challenge and scrutiny function from the HWB. Partners met regularly to share information, discuss key issues and adopt a problem solving approach. However not all partners felt fully involved in determining how resources were allocated, primarily the NHS trusts, and in particular with regards to the resource allocation for the Better Care Fund. We found performance dashboards in place to monitor resource capacity and predict demand. Performance metrics were shared and a problem solving approached adopted, particularly by the local authority and the CCG.

- The Health and Wellbeing Board had ultimate oversight of the work of the Operational Commissioning Committee, the forum undertaking the detailed work of the pooled budget agreement which included the BCF. Governance of this was through a shared Executive Partnership Board (EPB). However, not all partners felt fully engaged in this process, particularly the NHS Trusts.

- The assurance and governance process across the system would benefit from the addition of agreed performance metrics underpinned by a continuing challenge and scrutiny function from the HWB.

- The CCG and the local authority held monthly joint meetings of the Executive Board of the Council

and the Executive Management Team of the CCG, to share information and discuss key issues.

- There were a number of joint management team meetings that included the local authority, CCG and NHS Trusts that supported an open culture and problem solving approach.

- There were performance dashboards in place to monitor resource capacity and predict demand. Resource allocation and effective financial management was scrutinised through an embedded committee structure that called senior officers to account in their respective organisations.

- In respect of the BCF, joint consideration had been given and agreed by the local authority and the CCG as to where the investment of the fund would have the biggest impact on improving the care for older people and reducing DTOC.

- Work was planned and underway in respect of:
  - ⇒ Investment in re-ablement as the first approach on discharge from hospital, rather than a reliance long-term domiciliary care
  - ⇒ Investment in the transforming domiciliary care project
  - ⇒ The development of improved technology such as telecare
  - ⇒ The development of a social care Trusted Assessor model
  - ⇒ Improved information systems within the hospital to support discharge choices/ pathways
  - ⇒ Enhancing health in care homes, working with providers to develop an alternative commissioning and delivery model

- Expected outcomes were to:
  - ⇒ Meet adult social care needs in a timely way
  - ⇒ Reduce pressures on the NHS. There is an expectation that additional funding will reduce DTOC in accordance with national expectations
  - ⇒ Stabilise the social care provider market to support a wider range of support in the community

- Associated action plans had been developed to ensure that these initiatives would be implemented during 2017/18. A review of the outcomes and financial impact achieved was scheduled for completion at the end of 2017/18, and would form the basis of recommendations for further initiatives/developments for 2018/19 and 2019/20.

- The local authority worked with the CCG to complete the Urgent & Emergency Care Milestone Tracker that indicated positive progress in relation to the implementation of the high impact change model. However, the trusted assessor element of the model had yet to be implemented.

- We saw evidence of where resources were not being managed effectively. For example, some people being cared for in hospital were also being funded for a residential care home bed, when it

was apparent their needs had changed and they would require more intensive support ,for example a nursing home placement and consequently would not be eligible to return to their usual place of residence.

- Halton had one of the highest costs per patient with regards prescriptions in the country. To reduce the costs and optimise medication use in the system, the CCG medicine team were beginning to review cases where older people were prescribed large numbers of medicines in care homes. However this work needed a more system wide approach as the team were struggling to reach all GPs to identify cases for review.

Do services work together to keep people well and maintain them in their usual place of residence?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: maintaining the wellbeing of a person in usual place of residence

Are services in Halton Safe?

Strategies and initiatives have been developed and put in place to prevent avoidable harm.

- Each GP practice held monthly MDT meetings targeted at people with complex needs and those at risk of deterioration. These meetings were attended by a range of health and social care professionals to develop a person centred approach to case management.

- Systems were in place across the health and social care interface to safeguard people from avoidable harm, abuse or neglect. Halton's Safeguarding Adults Board was well established and was supported by its member agencies including the local authority, Halton CCG, North West Ambulance Service (NWAS), the local acute trusts, NHS England, Cheshire Probation Service, Halton Housing Trust and Cheshire Fire and Rescue.

- Providers were supported to identify people who were frail and with complex needs. A frailty pathway had been developed with input from all partners in the system. This included assessments being developed and rolled out across health and social care teams to facilitate the early identification of frailty, and timely access to support and interventions.

- Systems were in place to support the management of medicines. Pharmacy support was provided to reduce polypharmacy related risks, including falls prevention. The CCG medicines management team were working with the falls team to proactively address medication prescription and polypharmacy issues to support falls prevention for people living in care homes.

- Domiciliary care providers were working with their commissioners to assess risk to people using their services. Risk assessments were in place for each service user that could be reviewed on a regular basis. The domiciliary care provider proactively raised concerns to the local authority where there were mental capacity concerns that had not been communicated by the Acute Trust. In these instances a Mental Capacity Act assessment was subsequently completed, however we were told this could sometimes be delayed.

Are services in Halton Effective?

Halton had a high rate of attendance at A&E for older people. Joint initiatives had been developed across the health and social care system to maintain people in their usual place of residence. However these were not always fully coordinated and evaluated, meaning they might not always be used to their maximum benefit.

- Our analysis showed that Halton had a significantly higher rate of attendance at A&E of people aged 65+ than the England average and their comparator areas.[2] Analysis also showed a comparatively high number of hospital admissions from care homes, with a diagnosis associated with accidents and injury[3].

  A high number of falls in Halton had been identified as a challenge by the system, and a joint strategy involving public health, the CCG and the fire service had been put in place to prevent falls. There was multi-agency working to prevent falls including the falls team working with care homes to train staff, and the fire service conducting falls risk assessments in domestic premises. The system reported that the number of admissions to hospital as a result of falls has since reduced.
- The planned enhanced care home model, involving the CCG, local authority and GPs, will support care home staff to have the skills and confidence to make care decisions that avoid hospital admission. However this initiative will not be embedded to support the anticipated increase in service demand over this winter.

- An Older Peoples' Pathway had been jointly developed across the system with an emphasis on reducing the dependency culture for older people and supporting them to remain independent. The pathway had nine elements, including staying healthy, living well and rapid support to avoid admissions.

- We found that many older people had access to a range of services to help them remain healthy and socially included. Service user satisfaction rates remained high with over 90% of older people who responded to the local authority satisfaction survey saying the services were effective.

- Rapid and out of hours support in Halton included the Rapid Clinical Assessment team (RCAT) and

[2] Hospital Episode Statistics April 2015-March 2016.
[3] Hospital Episode Statistics October 2015- September 2016. Analysis based on attendances from postcodes containing a registered care home. Data could pertain to other addresses within the postcode. Postcodes containing more than one care home have been excluded from analysis.

Rapid Access Rehabilitation Service (RARS) services. Across stakeholders, the RCAT service was regarded as an effective and valued service; an unpublished exploratory study conducted locally identified that RCAT successfully avoided admissions for 85% of cases referred to it.

- However, the RCAT service was underutilised due to low referral numbers (196 in 2016/17). A recent (June 2017) report commissioned by the local authority identified the reasons for this as being gaps in GPs' knowledge of the service, inadequate communication between system partners, and a lack of shared understanding as to the capacity of the service and its availability out of hours. The recommendations made following the report were yet to be agreed and implemented by partners. The number of referrals to RCAT was being monitored as part of shared BCF Key Performance Indicators.

- In the RARs service there was historical evidence of a formal commissioning process and agreed performance criteria. However operational staff were unable to articulate this when asked

Are services in Halton Caring?

People and their carers are supported and involved in the planning and delivery of their care. There was good evidence of support services for carers that met their individual needs and preferences; however the assessment process for carers was duplicated.

- We observed a number of assessments carried out by different teams during the course of the review. We saw good examples of person centred assessments, including for people experiencing memory loss. Clinical, social and cultural information was included in assessments which provided all aspects of what was important in people's lives.

- Halton CCG had a high uptake of personal health budgets and direct payments. Cumulative activity through Q1 2017/18 showed their rate of personal health budgets for all adults was 27.7 per 50k, compared to the England average of 5.82 and the average across Cheshire and Merseyside of 7.44. Their number of direct payments for all adults was 11.18 per 50k, compared to the England average of 3.63 and Cheshire and Merseyside region average of 3.79. The Halton Disability Partnership delivered a service to support people through the process of accessing and using direct payments. Direct payments can empower people to make decisions about their future care and manage their health and wellbeing.

- Carers were well supported in Halton, with input from the Carer's Centre that reached approximately 5000 carers, including 528 carers supporting people with dementia. The centre had a carers support group specifically for people living with dementia which had 20 members. The centre considered the wishes and aspirations of carers and held a well-attended quarterly forum to seek feedback to ensure that they were meeting carers' needs.

- However, there was some duplication of assessments for service users between system partners and the local authority. There was an opportunity to streamline the assessment processes and reduce the number of times service users have to tell their story in order to receive support.

Are services in Halton Responsive?

People are assessed and receive care and treatment at the right place and the right time to maintain them in their usual place of residence. However, data showed that there were challenges in Halton in avoiding admission and readmission to A&E.

- Work was being undertaken to reduce A&E attendance by increasing the capacity within care homes to be more responsive to the needs of residents. The care home support team, and mental health care home liaison team supported care homes to prevent hospital admissions and improve the quality of care. There were plans to link each care home to a named GP, due to begin in September 2017 and be completed by December 2017.

- People in Halton could contact the local authority Contact Centre or attend the Direct Link services which were available to signpost and support people to make decisions about their care. Direct Link hosted health improvement and prevention programmes to keep people well, such as stop smoking groups and diet and nutritional advice.

- Direct Link could refer people to the local authority Contact Centre for pendant alert system services and blue badge applications, the Citizens Advice Bureau, and the Sure Start to Later Life service (offering information and activities for people over 55) . However, staff at Direct Link felt that by taking a greater role in referral process they could be more responsive to people's needs. Staff at the Direct Link centre had not received dementia training, meaning that there was a risk that people with dementia were not having their needs identified.

- Halton had a range of services designed to enable people to receive the right care in the right place at the right time to maintain them in their usual place of residence. This included:
  - ⇒ The 24-hour assistive technology service
  - ⇒ Community wardens working to a 30 minute response from referral time
  - ⇒ The Initial Assessment Team, RCAT and RARs services working to a same day response from referral target
  - ⇒ Community equipment provided within five days and emergency equipment available for teams as needed
  - ⇒ Strong and bespoke support for carers.

Do services work together to manage people effectively at a time of crisis?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: crisis management

Are services in Halton Safe?

Partners were working together to implement initiatives to assess risk and reduce avoidable harm, however there are still challenges in meeting the needs of older people at a time of crisis, particularly in relation to patients moving to intermediate care.

- There were systems and processes in place across the system to safeguard people from avoidable harm at a time of crisis. For example, NWAS had worked with the CCGs to reduce the number of A&E admissions from people who call the emergency services. NWAS deployed a 'falls care' process to incidents where an older person had fallen to give specific care and support to prevent a direct A&E admission.

- Our analysis of waiting times in A&E from 2014/15 to 2016/17 showed that both trusts were performing below the national expectation. In Whiston Hospital (St Helen and Knowsley Teaching Hospitals NHS Trust) an increasing percentage of people arriving at A&E had to wait longer than four hours year-on-year, with only 85% seen within four hours in 2016/17. At the two hospitals in Warrington and Halton Hospitals NHS Foundation Trust, 90% were seen within four hours in 2016/17.

- Risk assessments and escalation pathways were in place to mitigate avoidable harm for people who use services during a crisis. These included pressure area management and falls prevention. However, due to the extended waits for some patients to access intermediate care at Warrington and Halton Hospitals NHS FT we found evidence of avoidable harm to people.

- The CCG and local trusts had shared key performance indicators around quality, safety and experience of care, these look at recurrent trends for incidents and falls. Incidents were reported and discussed at the Quality Surveillance Group (QSG).

- Staff in A&E departments displayed an awareness of how to identify and manage safeguarding concerns, however further training in safeguarding awareness was identified as a need. Halton Adult Social Care was recognised in the system as providing high quality safeguarding training, and had been requested to deliver training to NHS staff.

- At Whiston Hospital GP streaming had been in place since June 2017 WHFT was due to have front door clinical screening provided by GPs in place by October 2017, this would allow the emergency departments to focus on caring for people with the highest needs, including older people.

Are services in Halton Effective?

We found evidence that the urgent care system was effectively managing the flow of people at a time of crisis, including through effective joint working in the emergency departments.

- There were good examples of effective system working at the Urgent Care Centres (UCCs) in Widnes and Runcorn. The UCCs were aligned in their approach, using a shared care pathway to deliver a consistently high standard of care across both sites.

- Systems were in place to support the effective collaboration and information sharing between professionals and organisations to meet the needs of the people who used services. Both UCCs had access to a record sharing system that included a summary care record, information about allergies, medications, and risk management.

- Diagnostic testing such as scans and blood tests could be carried out in the centres and the person's care and treatment plan was sent to their GP by 8am the following morning. Multi-disciplinary assessments were carried out by the appropriate professionals, as therapy staff were co-located at the centres. Referrals could be made to community services, district nurses, or when appropriate local safeguarding teams.

Are services in Halton Caring?

People and their carers are involved in their care and supported to make informed choices during a time of crisis. However people indicated that the discharge process could be more informative.

- In the discharge lounge people told us they had been given information about their care and treatment options and that the process had been explained in a way that they could fully understand. There was a wide range of information available in the departments for people to take away regarding the management of their condition and discharge options. However, there were also some people who indicated that the discharge process could be more informative.

- A survey carried out by the discharge teams at WHFT in 2016/17 was generally positive and people felt assessment and discharge was a smooth process, however, 10% of people and their carers who took part in the survey felt they weren't given enough time to prepare for the change in care arrangements.

Are services in Halton Responsive?

Services have been developed and planned in consultation with the local population. People are managed well through their admission and assessment in acute settings. However some people remain in acute care longer than necessary while waiting for intermediate and re-ablement services.

- Operational and management staff acknowledged that there was a challenge around delayed discharge due to a lack of care home placement and domiciliary care packages. During our site visit to Warrington hospital we saw examples of people who had been assessed as no longer requiring an acute bed remaining in hospital because an enablement /intermediate care bed was not available. There was evidence to suggest that one patient had suffered avoidable harm because of this.

- Data for 2016/17 showed an improvement in reaching the four hour treatment expectation at Warrington and Halton Hospitals NHS FT; however performance was still below the national expectation, and at St Helen and Knowsley Teaching Hospitals NHS Trust performance had been declining each year and in 2016/17 was below the expectation and the national average. The system attributes the improvement at Warrington and Halton Hospitals NHS FT to the RCAT and RARs services.

- At Q4 2016/17, 95.4% of the 718 available overnight beds at St Helens and Knowsley Hospital NHS Trust were occupied and throughout 2016/17 occupancy had remained above 90% at the trust. Although optimum occupancy rates for hospital beds may vary according to type of services offered, hospitals with average bed-occupancy levels above 85% are likely to face regular bed shortages, periodic bed crises and increased numbers of health care-acquired infections. At Warrington and Halton Hospitals NHS Foundation Trust, 86.9% of the 613 available overnight beds were occupied in Q4 2016/17 and occupancy had stayed close to the optimal 85% level throughout the year.

- We found positive examples of effective discharge planning when we sampled records in Whiston hospital and Warrington hospital A&E and discharge lounges. There was evidence of people progressing through the system with a multi-disciplinary focus on assessment and discharge planning.

- There was a challenge around the sharing of relevant service user information in a timely way across organisations with different IT systems. This was identified as causing delays to the process, duplication of effort, and impacting effective decision making.

- Halton operated a borough based urgent care system review using daily information on capacity and demand in hospitals, intermediate care, and care home and domiciliary care provision. This information supported operational teams to identify gaps and direct existing resources (finance and staffing) accordingly. This also fed into longer term trend analysis used for the commissioning of additional capacity and alternative forms of care as well as for seasonal planning.

Do services work together to effectively return people to their usual place of residence, or a new place that meets their needs?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: step down, return to usual place of residence and/ or admission to a new place of residence

Are services in Halton Safe?

There was a shared view of risk management across staff, however there were sometimes difficulties with joined up working between health and social care when people are returned to their usual place of residence, or a new setting.

- Our analysis of emergency readmissions within 30 days of discharge during 2015/16 showed that Halton was in line with the England and comparator averages. However, the rate of emergency readmissions from care homes was significantly higher in Halton than the England average (28% in Q1 2016/2017 compared to 20%) and was also higher than the comparator group average (22%).

- A lack of communication between hospital social work teams and domiciliary care agencies during the discharge process was sometimes leading to people being discharged to their usual place of residence without all aspects of packages of care in place. The system in place for the domiciliary care provider to contact the social work team to address any issues was not always effective.

- There was an agreed view on risk across professions within the intermediate care team; that people should be facilitated to take ownership over their risk management plans. From a number of years of health and social care services working together a shared understanding of risk management had developed, this was well embedded and GPs trusted the system and used it to inform decisions as to whether a hospital re-admission was necessary.

Are services in Halton Effective?

There were a number of discharge pathways and plans in place involving partners across the system to effectively enable people to return to their usual place of residence. However these were not always able to be carried out effectively due to a lack of social care availability and poor information flow.

- We observed people experiencing delayed discharges on the review: one person waiting for a care home placement, one person waiting for intermediate care and another waiting for a domiciliary package of care. We saw the negative impact of delayed discharge; one person developed a pressure ulcer and another experienced an increase in clinical symptoms.

- Both our analysis and the analysis conducted by the Department of Health indicated that Halton

had comparatively longer length of stay in acute hospitals for older people. Across Halton's comparators, 90% of people aged 65+ who were admitted as an emergency were discharged within 19 days, however in Halton this figure was 23 days.

- At the time of our review the length of stay at the intermediate care unit at Warrington hospital was more than 50 days. The reasons cited by senior leaders and operational managers for these delays were the challenges in the care home and domiciliary care market including volume and capacity and quality issues.

- Analysis of Adult Social Care Outcome Framework (ASCOF) reablement measures for 2015/16 showed that Halton had a significantly lower percentage of people aged 65+ still at home 91 days after discharge from hospital into a reablement service (63.3%) compared to the England average (82.7%) and comparator areas (81%). Analysis of the longer term trend between 2011/12 to 2015/16 showed that the proportion had been consistently lower in Halton relative to the national and comparator averages and had decreased over that period. The rationale for this of the Local Authority was to respect people's choice if they wanted to return to their usual place of residence, sometimes against professional advice. This resulted in a higher percentage of people being transferred to a more suitable care environment.

- The quality of discharge summaries was raised as a concern across professional groups. Poor quality discharge summaries sometimes impacted on providers' ability to meet the needs of people when they return to their usual place of residence or a new setting. This was a particular issue with regard to quality of information around medications. It was acknowledged at a senior level that there was a lack of understanding about the importance of the quality of discharge information and actions were in place to help address the issue. These included the introduction of compulsory fields on electronic discharge forms.

- Our analysis showed there were fewer care home beds available in Halton compared to similar areas and recent care home closures had contributed to this. The local authority had worked with an external consultancy firm to assess the reasons for closures and develop early warning indicators before services closed. This had been fed into the care homes transformation programme and the local authority was also in the processes of purchasing a care home at risk of closure to secure these placements.

- Although both the domiciliary care and care home transformation plans appeared robust they were not in place at the time of the review. At the time of the review was that there were no new domiciliary care placements available and people had to stay in hospital until capacity became available. This meant that people were having extended length of stays in intermediate care. We also saw examples of people waiting in acute hospital beds to go into intermediate care.

- It was acknowledged across the system that there was a shortage of care home placements for people living with dementia. This was being addressed through the care home transformation programme, however this was not due to fully implement until 2018. It was not possible to assess if either of these programmes would be effective in dealing with the increased demand over winter.

Are services in Halton Caring?

People using serves, their families and carers felt included and involved in care planning. However the co –ordination of care and content of needs assessment was not always consistent across services

- Feedback from people in the Halton Borough Council satisfaction survey who had received a service (approximately 4,500) was positive overall with 58% of people responding:
  - ⇒ 96% of people said that they felt that staff treated them with respect and dignity all of the time.
  - ⇒ 100% of people outlined that they fully understood the information given to them about their care.
  - ⇒ .
  - ⇒ 96% of the people said they were either likely/extremely likely to recommend the service to a friend.
  - ⇒ 100% of people were either satisfied/very satisfied with the care they received.

- We reviewed eight assessments and discharge plans at Whiston, Warrington and Halton hospitals and found they varied in content and quality. There was evidence of people progressing through the system with a MDT approach to discharge planning. However in records reviewed at Halton hospital we found no evidence of involvement from people, their family or carers in terms of discharge planning and preferred place for discharge.

- In our review of case notes we saw examples of repeated assessments; in one case a person had received five assessments by different professionals in two weeks. The person had some cognitive impairment and had become distressed at the number of questions they were being asked and the number of people visiting them. This had also led to duplication of effort across professionals. The reoccurrence of such situations may be reduced by the planned implementation of the trusted assessor component of the high impact change model; however this had not been implemented at the time of our review.

- Case note review and dip sampling showed that people who used services and their relatives were involved in the development of care plans and discharge arrangements. We also saw evidence that GPs had discussion post admission with families about their choices and future planning, for example around further hospital admissions.

- However, involvement of people who use services, their families and carers was not consistent across Halton, and in some records we saw no evidence of their involvement in terms of discharge planning and preferred place of discharge. This was more significant in records reviewed from Warrington and Halton hospitals.

Are services in Halton Responsive?

Partners are working together to enable people to be discharged at the right time and to the right place, however, there are significant challenges with delayed transfers of care that had a negative impact on people.

- The capacity challenges in the care home, nursing home and domiciliary care market was widely recognised at operational and management levels at both hospitals as a key contributor to delayed transfers of care.

- The length of stay at the Warrington and Halton Hospitals NHS FT intermediate care unit (HICU/ B1) was at an average of 48 days for 2016/17, on the day we visited this had risen to 67 days. Staff dealing with discharges did not routinely attend the length of stay weekly meetings at Warrington hospital in person and any delayed transfers of care would be reported by phone.

- When reviewing six sets of case notes, the most common reasons for delayed discharge were people waiting for care packages, either domiciliary care provision or a care home placement.

- Senior leaders in the local authority and CCG had instigated the plans to transform provision in both domiciliary and care home settings, however these plans were untested and therefore the impact could not be measured as to see how they would increase capacity in the system and address the increased pressures during winter

- Analysis of DTOC figures from April 2015 to April 2017 showed that the rate of delays had been increasing within Halton and after October 2016 had remained higher than both national and comparator area averages. Although recent DTOC figures were improving (figures for June 2017 indicate that the average daily rate of delayed transfers of care in Halton had dropped to 8.8 delayed days per 100,000 population, below the England figure of 13.8 and below Halton's comparator average of 10.80), there were a number of challenges in the timely provision of appropriate rehabilitation services and intermediate care to support this reduction. Patients with complex needs were experiencing some considerable delays.

- Our analysis of delayed transfers of care showed that one of the main reasons reported for delayed discharges was 'patient or family choice', accounting for 35% of delays in the area. We were informed at the Warrington and Halton NHS FT intermediate care unit that people awaiting discharge to a care home were provided with information about all homes within the area, even those that did not have availability. This could result in delays if people and their families chose to wait for a bed in their preferred home. There was a choice policy in place at Warrington and Halton NHS FT intermediate care unit, we did not see evidence this was being implemented. The local authority acknowledged that people choice was leading to delays; however they wanted to provide the information to enable people to choose the right provision for them.

- Halton has comparatively longer lengths of stay in hospital for older people than the England average and that of its comparators. Analysis produced by the Department of Health showed that

across Halton's comparators, 90% of people aged 65+ who were admitted as an emergency were discharged within 19 days, however in Halton this figure was 23 days[4]. Additionally, our analysis showed that during 2015/16 33% of people aged 65+ who were admitted stayed in hospital for over a week, compared to the national average of 32% and comparator average of 30%.

- We held discussion with members of staff who dealt with discharges from the two acute hospitals and the intermediate care units. Staff from Whiston hospital had a good overview of how many delayed transfers of care they were managing that week. However staff covering Warrington and Halton were less clear because of a lack of robust managerial oversight.

- Continuing Healthcare (CHC) was provided through a joint local authority and CCG budget which had been established for a number of years. Staff did not recognise CHC as being a primary cause of delays. However, NHS CHC figures for all adults (NHS England) for Q1 2017/18 showed that for Halton CCG 25% of referrals for standard CHC were completed within 28 days, lower than the England average of 57% and the Cheshire and Merseyside regional average of 73%.

- The same data (NHS CHC figures for all adults for Q1 2017/18) showed that Halton CCG had a standard NHS CHC referral conversion rate (% of newly eligible cases of total referrals completed) of 43%. This was high compared to the England and Cheshire and Merseyside regional averages of 25%. Their assessment conversion rate (% newly eligible cases of total cases assessed) was also higher. This indicates that Halton's processes for identifying people eligible for CHC are working well and a lower proportion of people and their families entered the CHC process to be then denied CHC funding.

[4] Department of Health analysis of Hospital Episode Statistics - March 2016 – February 2017

Maturity of the system

What is the maturity of the system to secure improvement for the people of Halton?

- Relationships were strong with a high level of mutual trust and a culture of openness and transparency. There was a shared understanding of system challenges and a willingness to work together to achieve a solution, coupled with a strong commitment to serve the people of Halton well.
- Partners in the Halton system had a longstanding history of working together effectively for the benefit of the people living in the borough.
- There were some excellent examples of shared preventative approaches and local agreements that supported local people in having timely access to services and support that met their needs in a person centred way.
- However, there was still work required in relation to developing a wider system vision for the STP and ACS footprint and the development of a common framework for prioritizing actions, accountabilities and governance arrangements.
- Although managed well at a local level, the system had work to do to develop a strategic approach to workforce planning and development.
- In addition, the allocation of resources within a financially challenging environment and managing system wide performance would benefit from a more robust approach to risk sharing and shared success criteria.
- Work was underway to allow access to shared records with out of hospital services. This approach (due to be fully implemented in 2020) aims to promote seamless transfer of information across the system and reduce duplication of effort.
- This approach to records and information sharing should be part of a wider IT strategy that supports compatibility across partner IT systems to ensure that all parties have access to a full range of a person's record.
- Strengthening these key elements of system wide working would support the area to understand its future priorities and direction of travel more comprehensively and support improved outcomes for local people in a timely and effective way.

Areas for improvement

- The Health and Wellbeing Board would benefit from increased vigour in calling system leaders to account to ensure that agreed plans and service improvements are delivered at pace.
- A cohesive interface and robust alignment between the local authority's and CCGs vision for the borough, the Local Delivery System, the STP and planned ACS should be developed. This alignment should be underpinned by shared success criteria, key performance metrics and formal joint governance arrangements so that the all partners have a voice and appropriate recognition in wider system planning.
- While the local authority and the CCG work effectively together as commissioners in the borough, commissioning activity would benefit from increased care provider engagement including local NHS trusts and the GP Federations.
- The implementation of local strategies and plans to reduce avoidable admissions to hospital and improve delayed transfers of care should continue at pace.
- Plans to meet winter pressures should be aligned and coordinated at a system level to ensure that actions between key partners, staff, and people are effective and communications with the public to deter hospital attendance are clear, helpful and consistent.
- Further oversight and monitoring of commissioned services, particularly the intermediate care service provided at Warrington and Halton NHS FT should be put in place by both the service provider and the service commissioner so that poor performance is actively managed and patient experience improved.
- Data collection in different assessment processes across the system should be reviewed to avoid duplication this was particularly evident in assessment of people living with dementia and in the carer's assessment process.
- Now that strategic plans have been developed, strategic leaders should focus on delivery at the front line to improve outcomes for people in Halton.

CARE QUALITY COMMISSION
HALTON LOCAL SYSTEM REVIEW
(AUGUST 2017)

ACTION PLAN

Background

Following the publication of the Care Quality Commission (CQC) Local Review of Health & Social Care Services in Halton report on 12th October 2017 (link: http://www.cqc.org.uk/sites/default/files/20171012_local_system_review_halton.pdf), this Action Plan has been developed in response to the issues highlighted within the report.

The issues highlighted within the report have been reviewed and themed under the following headings:-

- Strategic Vision and Governance;
- Delayed Transfers of Care (including user experience);
- Key Actions for Winter 17/18
- Workforce;
- Market Capacity and Capability;
- Commissioning; and
- Patient Flow.

This Action Plan has been developed by the CQC Review Working Group, chaired by Sue Wallace-Bonner, the Director of Adult Social Services, Halton Borough Council and with representation from:-

- NHS Halton Clinical Commissioning Group (CCG)
    - Michelle Creed, Chief Nurse
- Halton Borough Council
    - Damian Nolan, Divisional Manager for Intermediate and Urgent Care
- Warrington & Halton Hospitals NHS Foundation Trust;
    - Lucy Cunliffe, Transformation and Delivery Manager
    - Neil Holland, Associate Director of Nursing
    - Jan Ross, Acting Chief Operating Officer
    - Jenny Farley, Deputy Director of Operations
- St Helens & Knowsley Teaching Hospitals NHS Trust;
    - Sue Redfern, Director of Nursing, Midwifery and Governance

    - Ann Rosbotham-Williams, Assistant Director of Governance
- Northwest Boroughs Healthcare NHS Foundation Trust; and
    - Lindsey Maloney, Director of Operations
- Bridgewater Community Healthcare NHS Foundation Trust
    - Jacqui Tudor, Clinical Services Manager
    - Caroline Williams, Interim Director of Operations
    - Ian Senior, Assistant Director of Operations
    - Joanne Barnfield, Clinical Manager

The Group has been supported in its development by Hannah Miller, Senior Associate from the Social Care Institute for Excellence.

1. Strategic Vision & Governance

Action No.	Action Required	Responsible Officer	By When		Progress Made to Date
			Start	Finish	
1.1	One Halton Accountable Care Strategic Vision to be signed off by Halton's Health & Wellbeing Board (HWBB).	Leigh Thompson	Ongoing	17.1.18	The Strategic vision has already been signed off by the NHS Halton CCG and Halton Borough Council Executive Officers and will be formally presented to the HWBB on 17.1.18. Copy of Strategic Vision below:-  One Halton Draft Strategic Vision v6 (2
1.2	Establish Accountable Care System Programme Board.	Leigh Thompson	Completed	Completed	The Programme Board has been established and a Chair appointed (David Colin Thome). The first meeting of the Programme Board is scheduled for 23rd November. NB. As part of the ongoing development of the ACS, work will take place on the development of interagency/joint working and associated joint posts, associated governance arrangements and performance metrics.
1.3	Ensure that there is a cohesive interface between and across Halton's Accountable Care System and the Cheshire and Merseyside STP.	David Parr	Completed	Completed	David Parr is the Executive for Halton Accountable Care System (ACS) within the Cheshire and Merseyside STP.
1.4	Establish Alliance LDS Joint Committee.	Dave Sweeney	Completed	Completed	The Committee was established. It has been agreed that the Chair will be on a 6 month rotational basis. Initial chair of the Committee is Dave Sweeney. Three areas have been identified for initial focus as follows: • Elective Care; • Mental Health; and • Urgent Care.

1.5	Review role of Halton's HWBB to ensure that there is enhanced challenge across the Health and Social Care system.	Eileen O'Meara	9.11.17	17.1.18	Proposal to be presented to the HWBB in January 2018 will include suggestions on:- • Revised Membership (to include GP Federations) • Review of Terms of Reference • Format of Future Meetings – to include the sharing of learning across the local system (see Action 4.5). • Performance Dashboard which will focus on the local system performance (to included Delayed Transfers of Care and the performance against the national standard for A&E) and highlight system risks • Development sessions for the HWBB
1.6	CQC Local System Review Action Plan to be monitored, on an ongoing basis, by the HWBB.	Sue Wallace-Bonner	17.1.18	Ongoing	Action Plan to be presented to the next meeting of the HWBB on 17.1.18 and thereafter on a quarterly basis. Action Plan to also be monitored at the monthly joint Halton Borough Council/CCG Management Team meeting. System review of progress to be completed by February 2018
1.7	Develop Winter Plan for the Halton System. • Ensure Winter Plan communicated to Operational Staff.	Damian Nolan Damian Nolan	Completed Ongoing	Completed 30.11.17	The Mid Mersey A&E Delivery Board has submitted the systems Winter Plan for 2017/18, in line with NHS England's timeframes. The Plan covers the Halton, Warrington, St Helens & Knowsley areas. Winter Plan being operationalised via the development/review of the Escalation Management System (EMS) Action Cards. Session planned with staff from across the local system on 16.11.17 to review Action Cards and test resilience of the system over winter. The Action Cards cover across health and social care organisations and will be cascaded within these by nominated leads.

2. Delayed Transfers of Care (inc. user experience)

Action No.	Action Required	Responsible Officer	By When		Progress Made to Date
			Start	Finish	
2.1	Ongoing improvement to be made in the level of Delayed Transfers of Care (DTOCs).	System leaders and HWBB	Ongoing	Ongoing	Delayed Transfers of Care and the associated actions to reduce these will be monitored at a strategic level via the Health and Wellbeing Board. There is a monthly report to the Chief Officers Management Team (HBC) including progress against the identified actions. Taking a collaborative approach, as a minimum, DTOCs are discussed weekly with the respective Trusts, with daily reports produced and considered at an operational level. In addition to monitoring at the Health and Wellbeing Board, monitoring of DTOCs, by senior leaders across the Mid Mersey area, takes places via the A&E Delivery Board. Current level of DTOC as at August is 514 (Target 425). This is due to : • Patient or family choice; • Awaiting residential/nursing home placements/ awaiting further non-acute NHS care (including intermediate care); and • Arranging domiciliary care packages. Below are some of the key actions in relation to these with further detail included in the sections identified.
2.2	Ensure that the Home of Choice Policy within the Acute Trusts is appropriately applied	Jan Ross/ Amanda Farrell	1.04.17	31.3.18	Both Trusts have a home of choice policy based on the Cheshire and Merseyside Home of Choice Policy and enforces this where choice is available. Work is ongoing to ensure this is used effectively and is being monitored through the contractual route by the lead commissioners. Both Trusts continue to work with staff teams to ensure this

					approach is embedded within Discharge Planning.
2.3	Improve the length of time that patients are waiting for Intermediate Care Beds.	Damian Nolan	30.10.17	31.1.18	In addition to the work being undertaken as outlined below (see Action 6.1), the work taking place in respect of the Intermediate Care Review (see Action 6.4) will address the issues associated with the length patients are waiting. Target LOS is 28 days.
2.4	Improve the length of time patients are waiting for a CHC assessment.	Anna Marie Jones	Ongoing	31.3.18	There are no delays in respect to patients waiting for CHC assessments. Delays have been occurring in relation to the completion of a decision support tool (DST) within the 28 day timescale. A trajectory for improvement has been agreed with NHS England and will reach 80% within the financial year. This is monitored as part of the CHC improvement plan by NHS England.
2.5	Implement Trusted Assessors Model in Halton	Helen Moir	Ongoing	January 2018	As part of the Care Home Development Board work a number of care homes have agreed the employment of a shared Trusted Assessor to undertake a single assessment for care home placements. A Job Description has been completed and recruitment is underway.
2.6	Improve capacity and demand management within Domiciliary Care Provision.	Damian Nolan	1.9.17	31.3.18	The work taking place in respect of Domiciliary Care, as outlined in Actions 5.1, 5.2 demonstrate how current and future capacity and demand issues will be addressed and therefore contribute to the improvement of DTOCs.
2.7	Some evidence of delays having a detrimental effect on individuals	Jan Ross	1.6.17	31.3.18	**Warrington and Halton NHS Foundation Trust** have implemented red to green to identify delays in patient's journeys; these have been implemented across all medical wards and are discussed twice a day. Any issues are escalated to senior operational teams for help to unblock. Any patient who is medically fit and has a LoS of 10 days + over, are discussed at the weekly escalation meeting, attended by community, social and trust staff to look at discharge delays and see what can be put in place to ensure a safe and

					proactive discharge. All patients with a LoS of over 10 days are discussed in a weekly MDT, where appropriate additional therapy support is provided and all patients are monitored through Nursing assessments for any signs of deterioration in their condition due to a delayed discharge.
		Diane Stafford	Ongoing	Ongoing	**St Helens and Knowsley Teaching Hospitals NHS Trust** continue to monitor and assess patients who are experiencing delays to care, including delivery of maintenance therapy to ensure patients retain optimal function prior to discharge.
2.8	Improve the quality of discharge summaries provided, particularly in respect of medication	Jan Ross	1.6.17	31.3.18	**Warrington and Halton Hospitals NHS Foundation Trust** have created a "medically fit for discharge" area on the patient administration system – Lorenzo. The Medically Fit for Discharge' tab will populate with 'live' up to date discharge information. The discharge teams are then able to interrogate the numbers and use this to identify delays in discharge processes. This feeds the patient flow meetings and the Trust has also established task and finish groups for implementing improvements to the Trusts e-discharge processes. This is chaired by the Trusts Acting Medical Director Alex Crowe. All patients are given advice on discharge. The Medical Director is working closely with the divisions now that improvements in compliance with numbers of discharge summaries sent have improved. The quality of the summary is the focus and these will be audited on a bi monthly basis.
		Diane Stafford	1.11.17	31.12.17	**St Helens and Knowsley Teaching Hospitals NHS Trust** are undertaking an audit to confirm compliance with discharge checklists, including information for patients about take home medications and to identify areas for improvement. In addition, an audit will be completed on a sample of discharge summaries sent to GPs to review the quality of information

					provided regarding medications and to identify areas for improvement.
2.9	Improve the information available to patients within the Discharge Lounges of the Acute Trusts	Neil Holland Bongi Gbadebo	1.10.17 Ongoing	31.3.18 31.12.17	**Warrington and Halton Hospitals NHS Foundation Trust** is in the process of reviewing all materials provided to patients regarding discharge as part of the safe and proactive discharge CQUINN. This will include proactive management of TTOS and transport management as necessary. **St Helens and Knowsley Teaching Hospitals NHS Trust** are reviewing the information available in Transfer Lounge, seeking the views of patients/carers on the quality and relevance of information available and will develop appropriate information to meet the identified needs of patients, including information leaflet about the purpose and function of the Transfer Lounge.
2.10	Implement Halton's IM&T Strategy to ensure that appropriate agencies are able to access the full range of patient data, as required, in order to expedite discharges from Hospital etc.	Emma Alcock	As per Strategy	As per Strategy	Strategy attached here. NHS Halton CCG IMT Strategy Final.pdf A number of actions form part of the strategy including the implementation of the following: • EMIS Web into Halton Urgent Care Centres and HBC Adult Community Services; • Full Electronic Patient Record (EPR) system within St Helen's and Knowsley Hospital Trust; • Warrington Shared Care Record Portal; • EMIS Viewers into HBC Social Care Services; and • End of Life Palliative Care Co-ordination System.

3. Key Actions for Winter 2017/18

<table>
<tr><th rowspan="2">Action No.</th><th rowspan="2">Action Required</th><th rowspan="2">Responsible Officer</th><th colspan="2">By When</th><th rowspan="2">Progress to date</th></tr>
<tr><th>Start</th><th>Finish</th></tr>
<tr><td>3.1</td><td>To continue to meet the required targets in relation to DTOC</td><td>Sue Wallace-Bonner/ Michelle Creed</td><td>Ongoing</td><td>Ongoing</td><td>A number of system changes are underway whilst these will make structural changes in the medium to long term additional actions are required to mitigate the impact of these changes during the winter whilst also managing seasonal pressures.

Halton has seen some improvements in the number of delayed days over the summer months, August has seen an increase in the number of delayed days:

The main reasons are patient or family choice and waiting further NHS care. Halton are still having difficulties with residential/nursing and domiciliary care capacity.

<table><tr><td></td><td>July</td><td>August</td></tr><tr><td>NHS</td><td>256</td><td>390</td></tr><tr><td>SC</td><td>69</td><td>70</td></tr><tr><td>Both</td><td>0</td><td>54</td></tr></table>
Weekly/monthly monitoring will continue, with monthly reports to Chief Officers Management Team (HBC). The monitoring of DTOCs will also take place at a strategic level as outlined in section 2.1 of the Action Plan.</td></tr>
<tr><td>3.2</td><td>Implement additional capacity for this winter</td><td>Sue Wallace-Bonner</td><td>Completed</td><td>Completed</td><td>9 additional block purchase beds commenced November 2017. Additional beds available for spot purchase identified daily. MDT support to improve support in care homes in place.</td></tr>
</table>

					Lead domiciliary care agency has recruited 23 people in 5 weeks, recruitment continues with an average of 10 interviews being completed per week. This will continue for the next four months. Agency also working with staffing agencies to supply capacity.
3.3	Identify opportunities for additional capacity over the winter period while in transition	Sue Wallace-Bonner/ Leigh Thompson	2.11.17	17.11.17	A meeting has been arranged for the 9th November- CCG and LA to discuss options for: • Additional health support for nursing homes • Feasibility to open a short-term unit • Feasibility of block purchasing additional care home beds for long- term placements
3.4	Improve communications across the system	Sue Wallace-Bonner/ Leigh Thompson	1.11.17	30.11.17	Reissue information to teams regarding the Halton discharge to assess pathway. Marketing campaign in respect of staying well in the winter and accessing appropriate health services commenced November 2017. System wide flu vaccination programme in place and inclusive of all health, social care and voluntary sector staff.
3.5	Continue to sustain the current care home capacity	Sue Wallace-Bonner	Ongoing	Ongoing	Continue to work across all care homes in Halton to prevent reductions in quality, which require suspension of placements. Led by HBC Quality Assurance Team, a group of health and social care professionals work proactively with homes identified as at risk of suspension of placements. Continue to work with providers to prevent closure of beds/homes. Monthly meetings are undertaken with all home care providers to ascertain their current sustainability and identify appropriate supports to ensure this is maintained.

					HBC have purchased a residential home and are in negotiations to purchase a nursing home with a provider who has declared their intention to cease operating the home.

4. Workforce

Action No.	Action Required	Responsible Officer	By When		Progress Made to Date
			Start	Finish	
4.1	Develop system wide workforce strategy.	Leigh Thompson	Ongoing	TBC	Halton workforce strategy to be developed across health and social care as part of the Accountable Care System.
4.2	Develop Halton Social Care Workforce Strategy.	Sue Wallace-Bonner	9.11.17	April 2018	Initial meeting has been arranged. Desk top review of existing strategies commenced. HBC ASC undertaking corporate collaboration with Liverpool City Region re: Apprenticeship providers.
4.4	Organise Dementia Training for staff at the Halton Direct Links and ensure training for staff is provided on an ongoing basis to allow new staff to receive appropriate training, as and when required.	Damian Nolan	9.11.17	30.11.17	Dementia Action Alliance to facilitate the training.
4.5	Additional Safeguarding training to be provided to A&E staff, as necessary and on an ongoing basis.	Rob Cooper – STH&K/ Jan Ross - WHH	9.11.17	31.3.18	HSAB developing a pilot programme of training to offer out on a multi-agency footprint. Also developing promotional learning materials in 7-minute briefings. To be delivered at team meetings and other appropriate forums within the Trusts.

5. Market Capacity & Capability

Action No.	Action Required	Responsible Officer	By When		Progress Made to Date
			Start	Finish	
5.1	Implement Transforming Domiciliary Care (TDC) Programme which aims to deliver modern and sustainable provision of domiciliary care for Halton's population.	Damian Nolan	Ongoing	1.4.19	In line with project timescales, phase 1 of the TDC programme has been implemented i.e. Successful implementation of the new Domiciliary Care contract from 1.11.17. External support re: outcomes-based commissioning through Adams Consulting Partners Ltd. New Domiciliary Care model in place, in advance of winter 2017. Key aspects of the model to mitigate immediate capacity issues are as follows: • Recruitment underway. 23 new recruits commencing. Average of 10 interviews per week. Recruitment drive to continue until March 2018. • Prime provider is offering rates of pay in excess of the living wage, enhancements for weekend working, pay travelling and training time. • Data analysis of existing utilisation of planned care provision is being undertaken. This is targeting reviews by social work teams and is releasing domiciliary care capacity. • Equipment that supports the management of manual handling by a single carer rather than two carers is being procured and staff being trained in its use. This will increase capacity. • Reduction in the number of providers is enabling a more focussed identification of issues with care provision.
5.2	Implement Reablement First Approach.	Helen Moir	Ongoing	January 2018	A review of the current capacity model has released an additional 10% with a further 30% to be realised over the next couple of months.

					Recruitment commenced November 2017 with a plan to increase the current capacity of the Service by 50%. Tunstall are currently working in partnership with HBC to review, develop and implement new technology and systems transformation across telehealthcare based on best practice. This preventative approach has been shown to deliver better outcomes at lower costs.
5.3	Produce an updated Halton Market Position Statement (MPS).	Damian Nolan	Ongoing	31.3.18	Review of current MPS commenced. This work will focus on: • Determining the short, medium and long-term requirements for care provision across health and social care. • Co-producing the strategy with current providers, voluntary sector, people who use services and the local population.
5.4	Address issues of Care Home Market Capacity & Sustainability.	Sue Wallace-Bonner	Ongoing	April 2018	The overall aim, as outlined with Halton's Better Care Fund Plan, is to sustain the level of Care Home beds within the Borough. This has resulted in the completion of HBC's purchase of a 23 bedded residential care home and discussions ongoing in respect to the purchase of a 44 bedded nursing home.
5.5	Develop plan to address the high level of admission/readmission rates to hospital from care homes.	Sarah Vickers	Completed	Completed	The Enhanced Care Provision to Older People's Care Homes in Halton Service (GP Alignment to Care Homes) was implemented on 1st September. NB. Addressing admission and readmissions and links through to prevention initiatives is a key aspect of this service and will be monitored via quarterly monitoring as outlined in the specification. The Care Home Development Group will monitor on a monthly basis. Copy of the Enhanced Care Provision to Older People's

					Care Homes in Halton Service Specification below is based on the best practice from national Vanguards:-  Enhanced Care Provision in Older Pec
5.6	Review system of finding nursing home care placements where patient's discharge needs have substantially changed and therefore individuals cannot return to their original care home.	Damian Nolan	Completed	Completed	A review of the processes, in conjunction with the Discharge Teams, in place at both the Acute Trusts has taken place and identified enhanced escalation where issues are likely to occur.
5.7	Ensure effective Medication practice in place in Care Homes.	Lucy Reid/ Katherine O'Loughlin	Ongoing	**Timelines Audit programme:** ongoing **Roll out of medicines policy to services:** by 31.3.18 **Pilot training** : start November 2017 **Roll out of full training programme:** from 1.4.18	There is already a programme of audit of medicines management processes in local care homes – this will continue to be developed and delivered along with targeted support where incidents or issues are highlighted. This is led by the NHS Halton CCG Medicines Management team. A new overarching Medication Policy for the Borough Council's internal services has been completed and it is proposed that the principles within this will need to be adopted by all commissioned Care Homes by March 2018. The Medicines Management Team of NHS Halton CCG led the development of the policy due to the technical knowledge required to appropriately advise services of safe and effective practice. Work is progressing on the development of an associated training programme which will be delivered by the CCG medicines management team to care homes within the Borough. The training will start to be piloted end of 2017 with a view to rolling it out wider from April 2018.

6. Commissioning

Action No.	Action Required	Responsible Officer	By When		Progress Made to Date
			Start	Finish	
6.1	Develop Joint Commissioning Strategy for Older People.	Sue Wallace-Bonner	Completed	Completed	Following completion of the Joint Strategic Needs Assessment for Older People, work was completed on a gap analysis, the information from which was used to develop an overarching integrated Older People's Pathway to support Older People living and ageing well in Halton which is based on national good practice. This Pathway has been agreed across the Local System and Halton's Older People's Delivery Board, the membership of which is designed to be reflective of the local Adult Health and Social Care economy whose role is to ensure that the Pathway continues to be fit for purpose.
6.2	Ensure that the monitoring of Primary Care within Halton is robust and fit for purpose.	Leigh Thompson	Completed	Completed	As a delegated commissioner of General Medical Services the Primary Care Commissioning Committee (a subcommittee of the Governing Body) oversees the contracts, quality & performance of all GP practices. A Quarterly report is received by the committee outlining achievement against key performance and quality indicators. During 2017 the CCG Primary Care Team and GP Lead commenced Contract, Quality & Transformation visits to all practices. These visits have an agreed list of criteria for discussion which includes the local GP Quality Dashboard. For the range of additional contracts or enhanced services, which are over and above the national core contract, performance and quality are monitored as per the specification.

					There is a clear process in place for practices and the Primary Care Team to escalate any ad-hoc issues that may arise.
6.3	Ensure that robust mechanisms are in place to monitor the provision in the Halton Intermediate Care Unit (B1).	Damian Nolan	Completed	Completed	A new service specification has been implemented. Improved monitoring is in place. Weekly monitoring is being completed by the commissioner of this service. Regular reports are being made through to the Operational Commissioning Committee on a monthly basis. Following the CQC Review, a review of processes has taken place at the Unit including discharge planning and the involvement of carers/families and of the managerial oversight of the Unit, has been undertaken by the Commissioner and Associate Director of Nursing from Warrington & Halton Hospitals NHS Foundation Trust. A new Matron is in place and the provision within the Unit is being monitored via the Length of Stay mechanisms within the wider Trust.
6.4	Complete system review of Intermediate Care (IC) Provision within Halton.	Damian Nolan	30.10.17	31.1.18	Working group established. This review will address all aspects of provision including discharge planning processes and the promotion of services across the system to ensure a better understanding of what IC services are able to provide and workforce issues. REVIEW OF INTERMEDIATE CARE
6.5	Ensure that there are robust mechanisms in place for the sharing of learning across the local system.	Michelle Creed	Completed	Completed	NHS England Cheshire & Merseyside Quality Surveillance Group (QSG) receives monthly reports to highlight any areas of concern that may affect the quality, safety or patient

					experience of users of services. Deep dive focussed sessions are undertaken as required. CQC Local Area Review has been presented to the system partners (NHSE, CCG, LA, NHSI, CQC, HEE, Deanery, Healthwatch, PHE). Below outlines examples of processes in place. • Serious incident learning event 25.10.17 on End of Life resulting from serious incident management. Root cause analysis is being undertaken and resultant action plan being developed. • Primary Care Safeguarding Leads learning event facilitated by Katherine Appleton, the LADO, on allegations against a healthcare and non-healthcare professional 26.9.17 • SAB Learning events on 01.09.17 and 08.09.17. These events were open to all HBC staff and staff from partner organisations to enable learning with regard two recent safeguarding reviews. The aim was to share the findings and learning around the Safeguarding Adults Review (SAR) and the Multi-Agency Review (MAR). The aim was to ensure that partners had a greater understanding of: o Safeguarding Adult Reviews and Multi-Agency Review and how and why they are undertaken o Managing risks o Understanding joint working o The learning and development points from a carers perspective o What the intended improvements in processes and practices are from these reviews However these will be formally reported through to HWBB

					on an ongoing basis to allow for appropriate challenge etc. to take place (see Action 1.5).
6.6	Complete gap analysis against the current Service Delivery Model for Halton's Urgent Care Centres (UCCs) and the newly published Urgent Treatment Centres (UTCs) Standards and develop recommendations for progressing the UTC development in Halton	Damian Nolan	Ongoing	31.12.17	Attendances at the UCC's continue to increase. In July 2017 6,859 patients attended the centres and the proportion of UCC attendances to A&E attendances for NHS Halton CCG registered patients was 2.24:1. Recognising the need to build on the success of the UCCs the gap analysis, as outlined opposite, has commenced and initial work will be presented to the UCC Development & Monitoring Group on 22.11.17.
6.7	Undertake review of the Rapid Clinical Assessment Team (RCAT)	Damian Nolan	Ongoing	30.11.17	Building on the work undertaken by the Liverpool School of Tropical Medicine, discussions to take place at the next Clinical Advisory Group on 8.11.17 regarding the future of RCAT and to agree an associated commissioning model. Revised Service Specification has already been drafted in advance of the meeting on the 8.11.17.

7. Patient Flow

Action No.	Action Required	Responsible Officer	By When		Progress Made to Date
			Start	Finish	
7.1	Address the length of A&E Waiting Times at both Acute Trusts		Ongoing	Ongoing	The performance of both Trusts in respect of the A&E standard is monitored through NHSi, NHSE, contract monitoring by the lead commissioners with strategic oversight through the A&E Delivery Board.
		Jan Ross	Ongoing	Ongoing	**Warrington and Halton NHS Foundation Trust** actively manages its 4 hour target and has been achieving the NHSI trajectory. The trust has a patient flow board with 9 key work streams aimed at delivering 95% performance against the four hour standard. GP streaming has commenced in October 2017. All key actions related to four hour performance are monitored internally.
		Rob Cooper	Ongoing	Ongoing	**St Helens and Knowsley Teaching Hospitals NHS Trust** – in addressing the length of A&E waiting times, the Trust has weekly meeting of Executive-led Transformation Group; live dashboard with real-time tracking of all patients; Mon-Fri in-reach frailty consultant into ED; GP streaming in Emergency Department has been in place since June 2017. Associated estates work is underway for co-located urgent care centre and recruitment commenced for Emergency Department Advanced Clinical Practitioners.
7.2	Improve communication channels between the Hospital Discharge Teams and Domiciliary Care Providers	Damian Nolan	Completed	Completed	Communication channels have improved with the introduction of a single Domiciliary Care provider in Halton. Improvements in the speed of discharges will be seen with the implementation of the Reablement First Approach (see Action 3.2)

7.3	Address longer length of stay for emergency admissions in both acute trusts	Neil Holland	1.6.17	31.3.18	**Warrington and Halton NHS Foundation Trust** have implemented red to green to identify delays in patient's journeys; these have been implemented across all medical wards and are discussed twice a day. Any issues are escalated to senior operational teams for help to unblock. The Trust is also working in conjunction with partners on discharge planning on day of admission, to ensure all relevant partners/agencies are involved in the transfer of care at discharge from the point of admission onwards. Any patient who is medically fit and has a LOS of 10 days + over, are discussed at the weekly escalation meeting, attended by community, social and trust staff to look at discharge delays and see what can be put in place to ensure a safe and proactive discharge. The Trust is also in the process of implementing MCAP (Making Care Appropriate for Patients) Patient Flow Decision Support Tool this year. The tool identifies patients that are clinically suitable for non-admission or discharge based on an objective analysis of the individual patient care service requirements, using evidence based clinical criteria.
		Rob Cooper	Sept 2017	Ongoing	**St Helens and Knowsley Teaching Hospitals NHS Trust** have clinically-led board rounds on inpatient wards 7/7; daily red/green principles in place with escalation to Matron for any daily delays. Daily Acute Medical Unit huddle with ED team is currently removing up to 3 patients from the bed list removing the need for an overnight stay. Task and finish group set up, discharge swim lanes agreed to improve access for all staff at ward level to the range of discharge options. IT support to enable next steps to roll out; identification of early morning discharges to support flow at ward level is in place, with on-going monitoring to improve performance; live Discharge Tracking List maintained to track and manage

					patients with complex discharge needs, escalating when blockages occur with weekday live inputs/updates from ward teams and IDT in place. Therapy inputs to be added by end of November; DTL meetings held twice weekly, resolving internal blocks and identifying external blocks for escalation to LA and CCG partners; monthly system-wide executive led multi-agency discharge event (MADE).
7.4	Improve managerial oversight of the Halton Intermediate Care Unit (B1).	Damian Nolan	Completed	Completed	See Action 6.3
7.5	Improve and closely monitor the average length of stay at the Halton Intermediate Care Unit (B1).	Damian Nolan	Completed	Completed	As at the end of September 2017, average length of stay had reduced to 37 days. Target is 28 days. The average length of stay is monitored as part of the regular reports being made through to the Operational Commissioning Committee on a monthly basis.
7.6	Improve the Assessment/Discharge Plans in both Acute Trusts	Neil Holland Diane Stafford	1.4.17 1.11.17	1.4.18 31.12.17	**Warrington and Halton Hospitals NHS Foundation Trust** is supporting discharge planning much earlier in the patient's journey, with a focus on the over 65 age group. They are working closely with partners to ensure good communication with the newly implemented check list; this will be audited monthly. **St Helens and Knowsley Teaching Hospitals NHS Trust** has commenced an audit to confirm compliance with admission/discharge checklists and identify areas for improvement.
7.7	Lower % 65+ still at home 91 days after discharge into Reablement versus comparators and decreasing	Sue Wallace-Bonner	30.10.17	April 2018	Halton do have a lower proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services compared to comparator authorities. This does not equate to service users being admitted back into hospital. 2016/17 data shows the following:

					• 61% at home • 23.5% in intermediate care services (step down or increased need) • 6% in long term residential care setting • 7% deceased • 2.5% in hospital HBC have requested support from NW ADASS Sector Led Improvement Board with regards to how we report on this in the future.

REPORT TO:	Health and Wellbeing Board
DATE:	17th January 2018
REPORTING OFFICER:	Director of Public Health
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Care Quality Commission- Local System Review Action Plan (Health and Wellbeing Board actions)
WARD(S)	Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 The purpose of this report is to provide members of the board with an update on progress against actions from the CQC action plan relating to the Health and Wellbeing Board.

2.0 RECOMMENDATION: That the Board

1) note the contents of this report and associated documents;

2) agree the proposed approach and revised Terms of Reference; and

3) agree that update reports be brought to future meetings of the Board.

3.0 SUPPORTING INFORMATION

3.1 During summer 2017, CQC were commissioned by the Secretaries of State for Health and Communities and Local Government to undertake a programme of targeted system reviews in 12 Local Authority areas; Halton was selected as the first area for one of these LSRs.

3.2 The LSRs are aimed at looking at how people move between health and social care, including delayed transfers of care, with a particular focus on people over 65 years old and includes an assessment of commissioning across the interface of health and social care and of the governance systems and processes in place in respect of the management of resources.

3.3 Following the publication of the review on 12th October 2017 an action plan, with a number of themes, was developed in response to issues highlighted in the report. Under the theme of *Strategic Vision and Governance* the following action was developed for the Health and Wellbeing Board:

Review role of Halton's HWBB to ensure that there is enhanced challenge across the Health and Social Care system.

In order to respond to this action, a number of areas for development were identified to be presented to the Board. These are as follows:

Revised Membership (to include GP Federations)

The Health and Social Care Act 2012 provides direction on the core membership of Health and Wellbeing Boards and in 2015 there was further instruction that they should include providers and partners working on the wider determinants. This fitted with the current model within the borough. Since that time the Board has appointed a pharmacy representative and now in line with CQC recommendations we propose GP Federations are added. The revised membership list can be reviewed as part of the wider Terms of Reference in Appendix 1.

Review Terms of Reference

The Terms of Reference for the Board have been reviewed to ensure they meet the duties and responsibilities for Health and Wellbeing Boards as outlined within the Health and Social Care Act 2012. A full copy of the revised Terms of Reference is included in Appendix 1.

Format of Future Meetings – to include Board development.

At present the Health and Wellbeing Board meets on a quarterly basis. If agreeable with members of the board it is proposed that there is an annual development session. The format of this will be agreed in advance of the meeting so that all partners can prepare.

Performance Dashboard which will focus on the local system performance (to included Delayed Transfers of Care and the performance against the national standard for A&E) and highlight system risks

It is proposed that the Board has an integrated dashboard to cover key indicators and narrative for Health and Wellbeing. This is attached for consideration in Appendix 2.

3.4 Assuming all of these actions are agreed this should provide assurance to the Health and Wellbeing Board and its constituent members that the action for the Board, outlined within the CQC action plan has been addressed. This will be reported back to the co-ordinating officer.

4.0 POLICY IMPLICATIONS

4.1 None associated with this report.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 None associated with this report.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

None identified

6.2 Employment, Learning & Skills in Halton

None identified

6.3 A Healthy Halton

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

6.4 A Safer Halton

None identified

6.5 Halton's Urban Renewal

None identified

7.0 RISK ANALYSIS

7.1 None associated with this report.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None associated with this report.

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

None under the meaning of the Act

Appendix 1

TERMS OF REFERENCE FOR HALTON'S HEALTH AND WELL-BEING BOARD

Aims of the Health and Well-Being Board

1. Health and wellbeing boards were established under the Health and Social Care Act 2012 to act as a forum in which key leaders from the local health and care system could work together to improve the health and wellbeing of their local population.
   Principally this includes:

   - guiding and overseeing the Joint Strategic Needs Assessment;
   - overseeing the implementation and monitoring of the Joint Health and Well-being strategy based upon the findings of the JSNA
   - promoting joint commissioning and integrated provision between health, public health and social care.

2. The Health and Wellbeing Board will provide a key forum for public accountability of the NHS, Adult Social Care, Children's Services, Public Health and other commissioned services relating to the wider determinants of health in Halton.

Suggested Terms of Reference based on the above:

Principle Responsibilities:

- To be responsible for guiding and overseeing the implementation of the ambitions outlined in the health white papers, health strategies for England and local health strategies

- To promote sound joint commissioning, partnership arrangements and integrated provision between health, public health, social care, the voluntary and third sector.

- To assess the needs of the local population and support the statutory Joint Strategic Needs Assessment.

- To identify and monitor the reduction of health inequalities

- To develop and monitor relevant activity and performance

- To ensure effective relationships between the HWBB and other strategic boards operating in Halton.
- Halton Health and Wellbeing Board will have oversight of local safeguarding boards.

- To contribute to the developments of Health and Well-being Services in Halton which may arise as a result of changes in Government Policy and relevant legislation.

Membership

- Elected Member (Chair)
- Executive Board Portfolio Holder for Health & Wellbeing
- Executive Board Portfolio Holder for Children and Young Peoples Services (Chair of Children's Trust)
- Other Local Portfolio holders for other strategic priorities that sit under Halton's HWBB
- Chief Executive, Halton Borough Council
- VCA Representative
- Health Watch Representative
- Director of Adult Social Care
- Operational Director Children's Services
- Director of Public Health
- Chair of Safeguarding Children's Board
- Chair, NHS Halton Clinical Commissioning Group
- Chief Officer, NHS Halton Clinical Commissioning Group
- GP representatives (GP Federations)
- Chief Executive or representative from NHS England
- Operational Director, Integrated Commissioning, NHS Halton Clinical Commissioning Group
- North West Boroughs Partnership NHS Foundation Trust
- Bridgewater Community Healthcare NHS Trust
- Warrington & Halton Hospitals NHS Foundation Trust
- St Helens and Knowsley Hospitals NHS Trust

- Registered Social Landlords
- Chair(s) of the Safer Halton Partnership Board
- Chair of the Employment, Learning & Skills Special Strategic Partnership Sub Group
- Chair of the Children's Special Strategic Partnership Sub Group
- Cheshire Constabulary
- Cheshire Fire and Rescue Service
- North West Ambulance Service
- Pharmacy Representative

In the event of a representative not being able to attend the Board, a substitute of that organisation should be made available.

Conflict Resolution

- To build consensus, members need to be aware of, and understand, the different values, outlook, skills and experience that each member brings to meetings.
- Given the range of people involved in the Board, differences of opinion will unfortunately be inevitable and this diversity is welcomed as it leads to reasoned and challenged debate within the Partnership which helps in achieving its goals. The aim must be for differences of opinion to be dealt with in a positive and constructive manner and to avoid situations where decisions escalate into formal confrontations and breakdown of trust and conflict, as ultimately this will discredit the Board.
- The operating principles and policies of The Board, aim to show how to build consensus and deal with conflict in a positive way by stressing the key principles of diplomacy, negotiation, mediation and arbitration that all members must adopt in Board meetings
- In situations where differences of opinion are seriously escalating at Board meetings and jeopardising the work of the board, the members concerned need, with the assistance of an impartial third party, to go to mediation. Mediation should be jointly called by both parties concerned, or may be requested by other members of the meeting where conflict arose.
- Nothing in this document should be interpreted as changing the statutory or other responsibilities of partners, or their own accountabilities. It does not prevent them pursuing their own individual action if they so wish.

Meetings

Meetings of the Health and Well-being Board will take place quarterly. The chair may call an extraordinary meeting at any time. The agenda and associated papers will be sent out a minimum of one week (five clear working days) in advance of the meeting. Minutes of the board will be formally minuted.

Chair

The Chair will be an Elected Member of Halton Borough Council.

Quorum

The meeting will be quorate provided that at least fifty per cent of all members are present. This should include the Chair or Vice Chair and at least one officer of the CCG and one officer of the Local Authority. Where a Board is not quorate, business may proceed but decisions will need to be ratified.

Decisions

Where a decision is required, that decision will be made by agreement among a majority of members present. Where a decision needs to be ratified by one of the statutory agencies, the ratification process will be in accordance with the agreed process within that particular agency.

Minutes

Minutes of the proceedings of each meeting of the Board will be drawn up, circulated and agreed as a correct record at the subsequent meeting, once any required amendments have been incorporated.

Review

The membership and terms of reference of this partnership will be reviewed regularly (normally annually) to ensure that they remain relevant and up-to-date.

ADULT SOCIAL CARE

ADULT SOCIAL CARE METRICS

Ref	Description	16/17 Actual	NW	England
ASC 01	Permanent Admissions to residential and nursing care homes per 100,000 population 65+ (Lower is better) ***Better Care Fund performance metric***	515.3	769	610.7
ASC 05	Proportion of Older People (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (ASCOF 2B) ***Better Care Fund performance metric***	62.12%	81.8	82.5
ASC 06	Percentage of items of equipment and adaptations delivered within 7 working days	93%	NA	NA
ASC 22	The Proportion of People who use services who say that those services have made them feel safe and secure – Adult Social Care Survey (ASCOF 4B)	69.8	70.7	70.1
ASC 27	Do care and support services help to have a better quality of life? (ASC survey Q 2b) ***Better Care Fund performance metric***	79.4	85.8	86.4
ASC 28	Social Care-related Quality of life (ASCOF 1A). (This figure is based on combined responses of several questions to give an average value. A higher value shows good performance)	19.4	19	19.1
ASC 29	The Proportion of people who use services who have control over their daily life (ASCOF 1B)	80.6	77.4	77.7
ASC 30	Overall satisfaction of people who use services with their care and support (ASCOF 3A)	71.6	64.9	64.7

NHS
Halton
Clinical Commissioning Group

CORPORATE PERFORMANCE REPORT

October 2017

EXECUTIVE SUMMARY

Introduction
This report provides the governing body with information on the key strategic and operational issues and developments related to the CCG's statutory requirements. Detailed reports can be seen at each relevant committee with corresponding actions, risks and mitigations. Achievement of 'recovery milestones' for access standards remains a priority for 2017/18. Standards relating to A&E and ambulance waits, referral to treatment, 62-day cancer waits (including securing adequate diagnostic capacity) along with mental health access standards account for four of the nine National 'must dos' which every local system is expected to achieve for the financial year.

Key issues

Constitutional Standards
The CCG is missing the constitutional standards for cancer treatment in 62 days, 8 minute response times and 4 hour A&E waits.

Cancer
Halton has a relatively high prevalence of cancer compared to the national average, with above average rates of smoking and obesity and average for below take up of national screening programmes. Despite the high prevalence the numbers of those diagnosed in hospital as an emergency admission is no worse than the national picture and those who are referred by their GP are seen and treated quicker than the national average . Halton does struggle in achieving the constitutional standard of treatment within 62 days but performs in the top quarter of CCG's.
The CCG meets monthly with the local acute providers to discuss every patient who did not meet the standard and improvements are planned at Warrington Hospital where issues around escalating patients who missed appointments has been raised.

Ambulance Response Times
Although the national standard of 75% was missed in August, NWAS reported the best performance since September 2016.
From October this standard will be replaced following the National Ambulance Response review, this is therefore the last time this metric will be reported. Nationally this measure has been removed as a measurement of CCG performance.

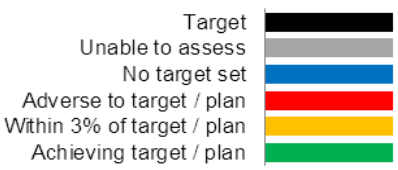
4-Hour A&E waits
The NHS constitution states that 95% of patients are treated in 4 hours, this was achieved in August but is at 94.7% YTD, this is much better than the national average and exceeds the NHS mandate to providers which stated that a target of 90% would be used for 2017/18. The majority of Halton patients use the Urgent Care Centres rather than A&E departments and 99.5% are seen in 4-hours with an average waiting time for treatment of around an hour.

Primary care
The Quality and Contracting visit has been developed and visits have commenced with practices. These visits are intended to be a conversation with practices and will look at three areas of best practice and three areas for improvement and is an opportunity for practices to raise issues with the CCG

Mental health
The CCG continues to see improvements in recovery rates for people accessing the psychological therapy service at North West Boroughs but access rates are still below target. North West Boroughs has implemented an action plan to provide more group therapy and the CCG is working with North West Boroughs and other local providers to improve the data collection for people accessing IAPT services from other providers such as KOOTH which are not currently included in the national figures.

WHAT'S IN THIS REPORT

KEY TO CHART



Achieving target
Adverse variance to target
No target set

CONSTITUTIONAL STANDARDS

AT A GLANCE

NHS Halton CCG is committed to ensuring that performance against constitutional measures and outcomes are consistently and rigorously maintained. It should be noted that not all of the indicators are reflected in the Corporate Performance Report.

Cancer
As expected, following warnings from Warrington & Halton Hospitals NHS Foundation Trust, 62-day cancer performance was particularly poor in August. 10 patients did not begin their treatment within 62-days, unfortunately due to the timing of meetings the reasons behind these breaches will not be discussed until the 19th October, however the delays occurred at the diagnostic stage as time from referral to first appointment and time from diagnosis to treatment remains low.

Mental Health
The CCG is performing well against the waiting time standards for mental health, both for those with anxiety and depression and those with psychosis, however the number of people accessing psychological therapies is still below national expectations. The CCG is working hard with its local mental health service providers to develop new ways of providing the service, including greater use of group therapies and ensuring the use of voluntary sector provision is captured

Urgent & Emergency Care - Ambulance Response Times
Ambulance response times continue to be below the national standard although improvements have been witnessed and the most urgent ambulances (Red 1) are now reaching their destination within 8 minutes more often than they have for 12 months. There have been difficulties in recent weeks in Health Care Professionals (HCP) trying to arrange ambulances via the dedicated HCP line, this has led to GP's using the 999 emergency line to arrange for urgent ambulance journeys. this has led to greater demand on the 999 service and may impact on October's reported performance.
The difficulties experienced by HCP's are due to a technical issue on this dedicated line which NWAS and BT are attempting to resolve.

Referral To Treatment
The percentage of patients being treated within 18 weeks has begun to improve following reductions over the previous months. The national standard of 92% continues to be achieved

CANCER TWO WEEK WAITS

94.1% YTD Target 93.0%

CANCER 62 DAY TREATMENT

78.5% YTD Target 85.0%

LESS THAN 4-HOUR A&E WAITS

94.7% YTD Target 90.0%

RED 1 AMBULANCE RESPONSE: 8 MINUTES

61.1% YTD Target 75.0%

REFERRAL TO TREATMENT

93.1% YTD Target 92.0%

DELAYED TRANSFERS OF CARE

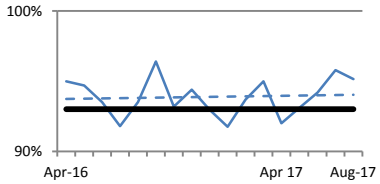
514 AUG 17 Target 439

CONSTITUTIONAL STANDARDS

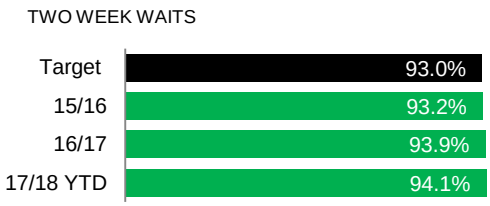
CANCER

KPI	2017/18 PERFORMANCE	ACTIONS

TWO WEEK WAITS
The % patients seen within two weeks for an urgent GP referral for suspected cancer

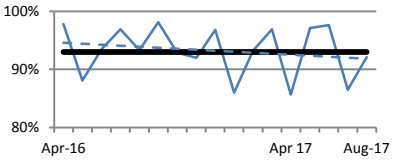


95.2% **Aug-17**



Overall two week wait appointment performance remains above standard. patient choice & patient cancellations remain the biggest reasons for delay.

TWO WEEK WAIT - BREAST
Two week wait standard for patients referred with breast symptoms not covered by two week wait for breast cancer

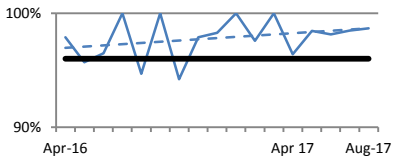


92.1% **Aug-17**

Due to very small numbers there is a large degree of volatility in performance reporting.

There were 3 patient breaches of 2 week waits for referrals for breast symptoms where cancer was not initially suspected. all breaches relate to patient cancellations. The longest wait to be seen was 17 days.

31 DAY TREATMENT
The % of patients receiving their first definitive treatment within one month of diagnosis

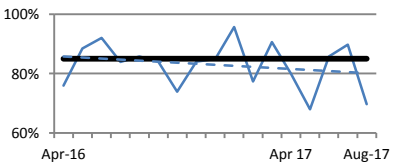


98.7% **Aug-17**

The local treating trusts perform very well with respect to treating patients within one month of a cancer diagnosis with almost 99% of patients treated within 31 days in August.

The CCG has no concerns regarding this element.

62 DAY TREATMENT
The % of patients receiving their first definitive treatment within two months of GP referral for suspected cancer



69.7% **Aug-17**

The CCG had 10 patients breach the overall 62-day treatment standard. these delays occurred in the diagnostic stage of the pathway as overall initial appointments in 2 weeks and treatment following diagnosis perform well.

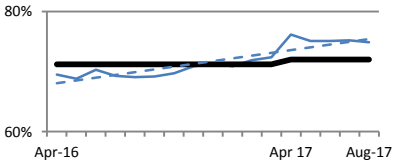
The CCG attends the patient breach meetings with both local providers (5 breaches each) and will expect to see the trusts taking action to eliminate these delays as far as possible

CONSTITUTIONAL STANDARDS

MENTAL HEALTH

KPI	2017/18 PERFORMANCE	ACTIONS

DEMENTIA DIAGNOSIS
Diagnosis rate for people with dementia, expressed as a percentage of estimated prevalence (aged 65+)

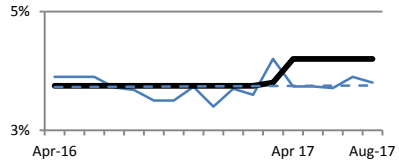


74.9% **Aug 2017**

DEMENTIA DIAGNOSIS

The target for dementia diagnosis has increased from 67% to 72% and will rise again to 75% by the end of 2017/18. The CCG is well placed to achieve this target.
The CCG is also working to improve the number of people who have a care plan review, there is currently a wide range of performance at practice level, from 50% to 92%

IAPT ACCESS
People who receive psychological therapies as a percentage of people who have depression and/or anxiety disorders (rolling 3 month)

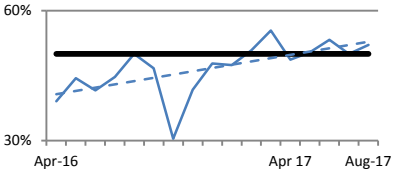


3.8% **Aug 2017**

IAPT ACCESS

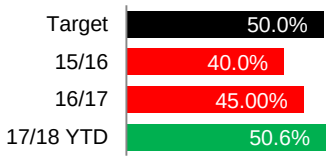
NW Boroughs have developed an action plan to support a higher access rate target, this will involve other partners in delivery of stage 2 IAPT services and the move towards greater use of group therapy. There is not expected to be any movement in achieved performance until 2018

IAPT RECOVERY
The proportion of people who complete treatment who are moving to recovery.



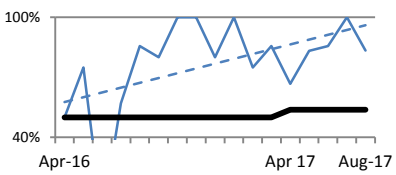
52.1% **Aug 2017**

IAPT RECOVERY



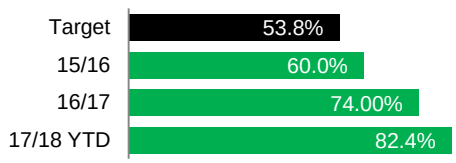
The work currently being undertaken with NW Boroughs should have the effect of increasing the number of people receiving stage 2 IAPT services being included. A greater number of stage 2 services should make achieving the IAPT recovery measure more achievable.

PSYCHOSIS 2WW
The percentage of people experiencing a first episode of psychosis with a NICE approved care package within two weeks of referral



83.3% **Aug 2017**

PSYCHOSIS 2 WEEK WAIT



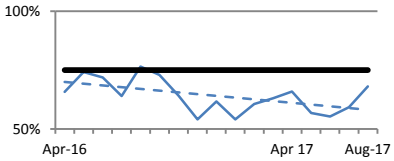
The CCG performs well with respect to people receiving treatment promptly after a first episode of psychosis, although numbers are only small, two out of three people treated in two weeks. The CCG performs in line with both regional and national averages.

CONSTITUTIONAL STANDARDS

URGENT & EMERGENCY CARE

KPI	2017/18 PERFORMANCE	ACTIONS

8 MINUTE AMBULANCE
Percentage of category A (Red 1) calls resulting in an emergency response arriving within 8 minutes

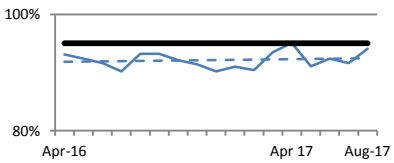


68.1% **Aug 2017**

AMBULANCE 8 MINUTE RESPONSE

Although the national standard of 75% was missed in August, NWAS reported the best performance since September 2016. From October this standard will be replaced following the national Ambulance Response review. The CCG are working with NWAS to report this in a timely manner. NWAS have not reported any concerns regarding the extensive roadworks for the new bridge

19 MINUTE AMBULANCE
Percentage of category A (Red 1&2) calls resulting in an emergency response within 19 minutes

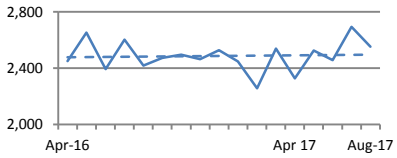


94.1% **Aug 2017**

AMBULANCE 19 MINUTE RESPONSE

Alongside the improvement seen in 8 minute response times NWAS have also reported improvements in the wider 19 minute standard. Although still missing the national standard NWAS are within 0.9%. The CCG has been made aware of increases in emergency calls being made by Health care professionals (HCP) due to the HCP dedicated phone line not functioning correctly. This has been identified as a technical issue with the network and is being addressed by NWAS

TYPE 1 A&E ATTENDANCES
The number of Halton patients attending a type 1 AED (Acute hospital site)

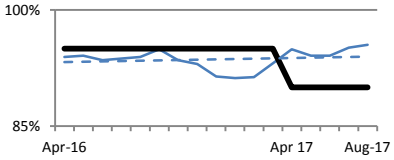


2552 **Aug 2017**

TYPE 1 AED ATTENDANCES

Following below average attendances at the beginning of the financial year the CCG has begun to see type 1 attendances exceeding last years activity. YTD performance has consequently dropped from 3% below 16/17YTD to just 1.5% below 16/17 YTD. The CCG is working with others to provide GP streaming at A&E and developing the Urgent Treatment Centre offer, this will reduce demand on A&E

4-HOUR A&E WAITS
The percentage of patients who spent less than four hours in A&E



95.5% **Aug 2017**

A&E 4-HOUR WAITS

The Governments mandate to NHSE has been reduced to 90% for the start of 17/18, which the CCG exceeds. The reduction in patients attending Type 1 AED (whose average wait is in excess of three hours) and the increase in patients attending UCC's (average wait 57 minutes) is as a result of the CCG's strategy and greater use of the UCC will improve this performance further.

KEY ACTIVITY

AT A GLANCE

NHS Halton CCG monitors performance against key activity metrics continuously. Significant variations to plan are raised through contract review meetings . It should be noted that not all activity levels being monitored are reflected in the Corporate Performance Report.

Overview
A decrease has been seen in planned care but this has not been to the level required by the plan, placing pressure on the budget. An increase has also been see in unplanned care with the most significant increases in A&E and non-elective admissions.

A&E activity
Type 1 A&E activity began the year significantly lower than 16/17, however the number of attendances in recent months has been higher than 16/17. Despite increases in attendances at the Urgent Care Centres, this increase has meant that from reporting 3% under plan A&E activity is now at plan. GP streaming at Whiston is currently still being recorded as an A&E attendance, GP streaming at Warrigton is due to come online in November

GP referrals
NHSE permitted the CCG to resubmit plans for GP referrals due to the impact of the correction of Lorenzo at Warrington Hospital being less than anticipated. This corrected plan now shows GP referrals at plan and in-line with 16/17 activity. The RMS is not having a significant impact on the number of referrals

Non elective admissions
Non-elective activity is both above plan and above 16/17 levels. A&E conversion to admission rates are increasing at Whiston hospital signifying that those attending are appropriate, this also correlates with information from A&E departments that arriving patients have greater acuity. The CCG is looking at a number of schemes to reduce the impact of non-elective admissions including high intensity users and patients with very short admission stays (less than 1 hour)

Elective activity
Elective and Daycase activity are both slightly below 16/17 levels in August, however they are both significantly above plan, whilst some impact has been seen in the MSK QIPP programme other areas have seen increases or the impact of activity reduction schemes has not yet materialised. The CCG is working hard to prioritise which schemes can be implemented for an in-year impact.

Delayed Transfers of Care
There has been a large increase in delayed transfers of care and Halton exceeded the target is was set for August. the large majority of delays are attributed to patient choice or awaiting further non-acute NHS care. Most delays are at the main acute providers, however there were 4 patients delayed with North West Boroughs.

GP REFERRALS

12973 YTD Target 12642

FIRST OUTPATIENTS

19137 YTD Target 19952

URGENT CARE CENTRE ATTENDANCES

21187 YTD Target -

NON-ELECTIVE ADMISSIONS

7436 YTD Target 7279

A&E TYPE 1 ATTENDANCES

10003 YTD Target 10097

ELECTIVE DAYCASE ADMISSIONS

6969 Target 6601

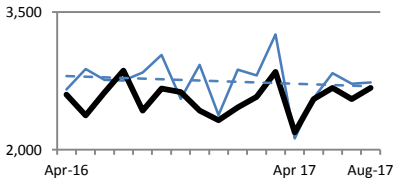
KEY ACTIVITY

KEY ACTIVITY

KPI	2017/18 PERFORMANCE	ACTIONS

GP REFERRALS

GP written referrals for a first outpatient appointment in G&A specialties



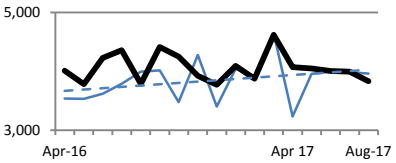
2733 **Aug 2017**

GP REFERRALS

The CCG has had its resubmitted plans accepted by NHSE. Although slightly above plan, the CCG is lower than the number of referrals submitted in the same month last year.

FIRST OUTPATIENTS

All first outpatient activity G&A specialties



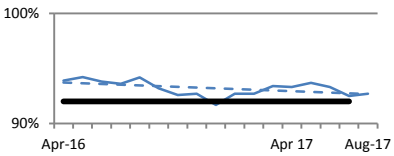
3963 **Aug 2017**

FIRST OUTPATIENTS

First outpatient activity is very similar to 16/17 levels and above plan. Delays in the implementation of QIPP schemes has meant limited success in the reduction in activity, although significant reductions have been witness in MSK. The CCG is considering a number of schemes to reduce out-patient levels, not all of which will impact in 2017/18

REFERRAL TO TREATMENT

The percentage of patients waiting at the period end, who have been waiting less than 18 weeks from referral to treatment



92.7% **Aug 2017**

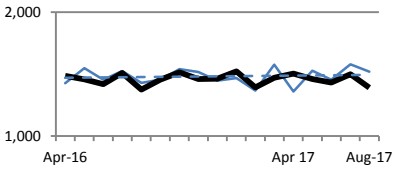
REFERRAL TO TREATMENT - 18 WEEKS

The Referral to Treatment standard continues to be achieved, with most waiting list clearance times around 3 months.

The CCG has no immediate concerns regarding RTT, however the long term downward trend shows there is little room for manoeuvre.

NON-ELECTIVE ADMISSIONS

Total non-elective FFCEs in general and acute specialties



1518 **Aug 2017**

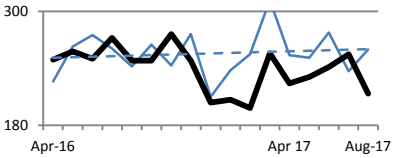
NON-ELECTIVE ADMISSIONS

Non-elective admissions are significantly above plan and last years level. with more patients admitted as an emergency. The increase was most marked at Whiston with July having 5% more non-elective admissions that the previous highest total and almost 20% more than July 16. This is despite GP streaming being in place at Whiston during this period.

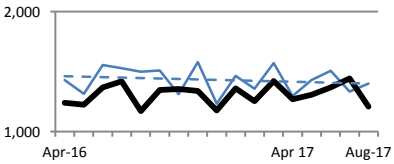
KEY ACTIVITY

KEY ACTIVITY

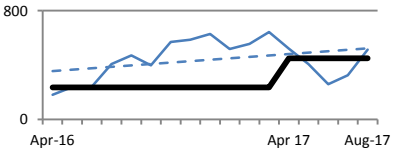
KPI	2017/18 PERFORMANCE	ACTIONS
ELECTIVE ADMISSIONS Total ordinary elective admissions in general and acute specialties	**260** Aug 2017	Significant amounts of activity was taken out provider contracts for 2017/18 . Around £3 million each year for 17/18 and 18/19., however QIPP schemes to achieve this reduction have been delayed in their implementation and the is only been limited impact on ordinary elective admissions
DAYCASE ADMISSIONS A Patient admitted electively during the course of a day who does not require the use of a bed overnight and who returns home as scheduled.	**1402** Aug 2017	Although there has been some reduction seen in Daycase elective activity it has not been to the level taken out of provider contracts. The CCG is currently in the process of prioritising QIPP schemes which can have an impact in year, however a number may not be in place until 2018/19
DELAYED TRANSFERS The number of delayed days from acute or non-acute (including community and mental health) care	**514** Aug 2017	Halton has seen a marked increase in delayed transfers of care in August, with 514 days attributed to delays, These are almost entirely patient choice delays or patients waiting for further NHS non-acute care. 170 days were at Warrington, 249 at St Helens and 74 at North West Boroughs.
CONTINUING HEALTH CARE Individuals eligible for NHS CHC (Standard NHS CHC and Fast Track) at quarter end per 50,000 GP patient list size - all types	**79.2** Q1 2017/18	The number of people assessed as eligible in Halton is higher than both England and regional averages. There are three elements to this. 1) The % of referrals assessed as eligible is higher than average at 43% against an average of 31% 2) The number coming off CHC in the quarter is very low at 7 per 50,000 against an average of 26. 3) The number assessed for NHS funded nursing care is less than half the average. The CCG is putting a plan in place to improve reviewing rates for people on CHC



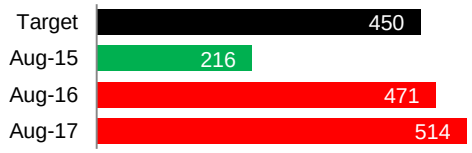
ORDINARY ELECTIVE ADMISSIONS



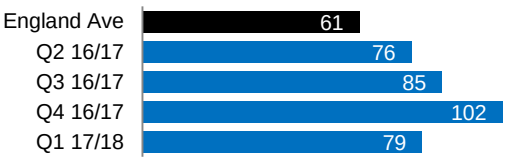
DAY CASE ELECTIVE ADMISSIONS



DELAYED TRANSFERS OF CARE



CONTINUING HEALTH CARE (Per 50,000)



QUALITY & SAFETY

AT A GLANCE

Ensuring that people have a positive experience of care.

Warrington and Halton Hospital has reported a further 14 Mixed Sex Accommodation breaches bringing a YTD total to 27. The CCG are working with the Trust to understand the detail behind this and ensure privacy and dignity is maintained at all times whilst appropriate solutions are determined.

Serious Incidents (SI)

A further Serious Incident has been reported relating to a Halton CCG patient Within North West Boroughs Healthcare, which is a total of 4 YTD. Concern has been raised within the Quality Surveillance Group regarding the quality of investigation reports and thematic learning within a provider and the CCG are a key partner in the task and Finish Group seeking assurance. Whilst this may appear positive Trusts are encouraged to report SI's to enable an open transparent culture with a focus on learning. The Quality Team have this area as a priority with a planned review of process, protocol and effective thematic learning as key areas. Four may appear low in terms of work load however we have the Lead Commissioner role for Bridgewater so whilst SI's may not relate to Halton patients the same process applies for others. The SI panel is in development to ensure wider clinical engagement and review. A revised SI policy and panel protocol is in development and will be taken to the CCG Quality Committee for ratification.

Mortality

The CCG uses the Summary hospital Level Mortality indicator as the measure for mortality within our Provider organisations as recommended nationally. Both providers are currently above plan with Warrington & Halton Hospital scoring 1.10; and St Helens & Knowsley Hospital just over plan at 1.03. Mortality is an area of work progressing across Cheshire and Merseyside CCG's and Providers being led by NHSE. The CCG are central to these discussions and this will be monitored via the Clinical Quality and Performance Group meetings (CQPG).

Health Care Acquired Infections

MRSA

There have been 2 cases of MRSA reported against a zero tolerance .

C Difficile

There has been 25 cases of C Difficile reported year to date which is 39% over plan as the tolerance applied is 36 whole year. This work is part of a multipronged approach including AMR as most cases have been identified within the community. An appeals panel is in place to evidence those cases where there have been no lapses in care so that we have an accurate picture and this is also being reviewed as part of the Mid-Mersey HCAI network meeting.

E-coli bacteraemia

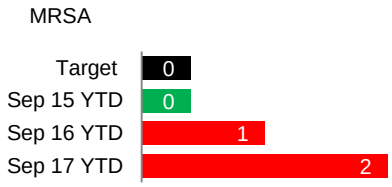
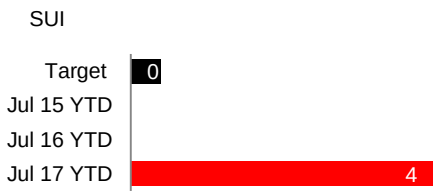
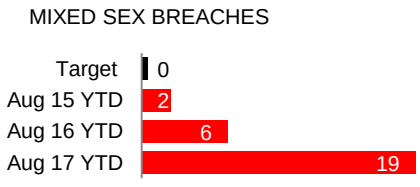
As part of the quality Premium the CCG has a target of reducing the number of E-coli bacteraemia by 50% by 2020. This is a challenging target however work is in train to address this. A crude audit has been conducted by St Helens and Knowsley Hospitals to elicit initial areas for development which include appropriate screening and appropriate antibiotic therapy. This work is ongoing within the network and the CCG Quality team with support from Medicines Management; and Infection, Prevention and Control have a work plan to address this.

MRSA

C-Diff

QUALITY & SAFETY

PATIENT SAFETY QUALITY MEASURES

KPI	2017/18 PERFORMANCE	ACTIONS
MRSA All reported MRSA bacteraemia cases are attributed to a CCG	**2** Sep 17 YTD 	There have been 2 cases of MRSA reported against a zero tolerance
C-DIFF All reported C-DIFF bacteraemia cases are attributed to a CCG	**25** Sep 17 YTD 	An appeals panel is in place to evidence those cases where there have been no lapses in care so that we have an accurate picture and this is also being reviewed as part of the Mid-Mersey HCAI network meeting.
SUI The number of Serious Untoward Incidents affecting Halton registered patients	**4** Jul 17 YTD 	The Quality Team have this area as a priority with a planned review of process, protocol and effective thematic learning as key areas. The SI panel is in development to ensure wider clinical engagement and review. A revised SI policy and panel protocol is in development and will be taken to the CCG Quality Committee for ratification.
MIXED SEX BREACHES The total occurrences of unjustified mixing in relation to sleeping accommodation.	**19** Aug 17 YTD 	Warrington and Halton Hospital has reported further Mixed Sex Accommodation breaches . The CCG are working with the Trust to understand the detail behind these and ensure privacy and dignity is maintained at all times whilst appropriate solutions are determined. It is understood these breaches relate to patients in critical care beds who are fit enough to be moved to a ward but whose move is delayed

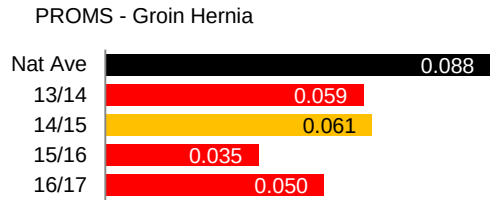
QUALITY & SAFETY

CLINICAL EFFECTIVENESS QUALITY MEASURES

KPI	2017/18 PERFORMANCE	ACTIONS

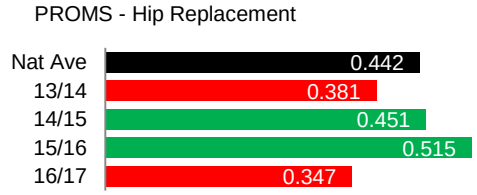
PROMS - Groin Hernia
Adjusted average health gain (EQ5D, EQ VAS)

0.050 **16/17**



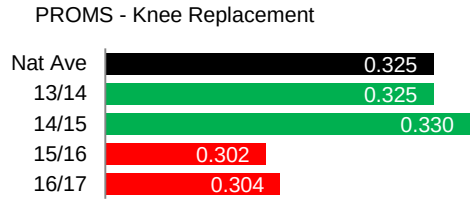
PROMS - Hip Replacement
Adjusted average health gain (EQ5D, EQ VAS)

0.347 **16/17**



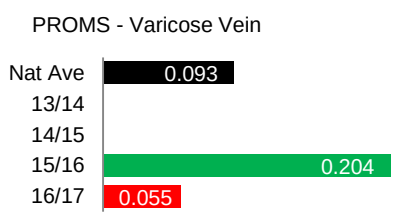
PROMS - Knee Replacement
Adjusted average health gain (EQ5D, EQ VAS)

0.304 **16/17**



PROMS - Varicose Vein
Adjusted average health gain (EQ5D, EQ VAS)

0.055 **16/17**



QUALITY & SAFETY

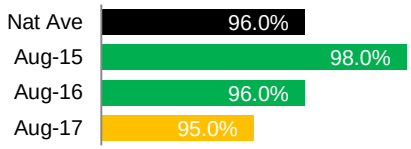
PATIENT EXPERIENCE QUALITY MEASURES

KPI	2017/18 PERFORMANCE	ACTIONS

Friends & Family - Inpatient stays - STHK

95.0% **Aug-17**

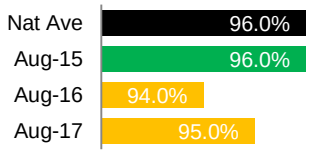
Friends & Family - Inpatient Stays: STHK



Friends & Family - Inpatient stays - WHHFT

95.0% **Aug-17**

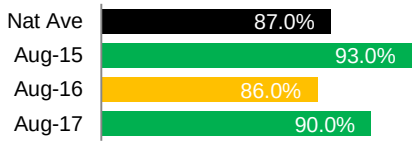
Friends & Family - Inpatient Stays: WHHFT



Friends & Family - A&E - STHK

90.0% **Aug-17**

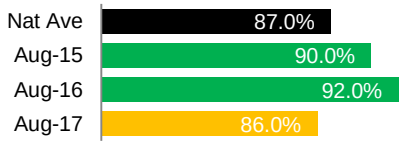
Friends & Family A&E: STHK



Friends & Family - A&E - WHHFT

86.0% **Aug-17**

Friends & Family A&E: WHHFT



QUALITY PREMIUM

AT A GLANCE

Outline
The 17/18 Quality Premium for Halton CCG is worth in the region of £690,000.
The award is calculated by performance against a series of quality metrics, some of which are nationally mandated and others have a degree of local input with respect to the choice of metric and the level of ambition.
The metrics for which an award can be made are detailed in the following pages, with the level of award detailed against each.

In addition to the metrics for which a quality premium award can be made there are national metrics which can reduce the value of any award. These are detailed on the right.

For 2017/18 there are a number of metrics for which baseline data has still not been made available nationally or has been supressed. Therefore no judgement has yet been made on the likelihood of receiving this portion of the quality premium.

Of the metrics from which an award can be Made the CCG is currently forecasting the following.

Achieve	3	£104,974
Not Achieve	5	£253,526
No Judgement	3	£331,500

The CCG is currently forecasting achieve financial plan, although it is acknowledged that this will be difficult, should the financial plan be achieved the CCG is forecast to achieve £53,675 in Quality Premium. If the financial plan is not achieved the quality premium award will be reduced to £0

QP ADJ - this is the adjustment to be made to any quality premium award due to the failure to meet the selected constitutional standards

Constitutional standard adjustments

REFERRAL TO TREATMENT

93.1% – Target 92.0% / QP adj 0.0%

LESS THAN 4-HOUR A&E WAITS

94.7% – Target 90.0% / QP Adj 0.0%

CANCER 62 DAY TREATMENT

78.5% ↓ Target 85.0% / QP Adj -33.3%

Financial gateway adjustments

ADVERSE VARIANCE TO PLAN

NO – Target NO / QP adj 0%

QUALIFIED AUDIT REPORT

NO – Target NO / QP adj 0%

Quality gateway adjustments

CQC ENFORCEMENT

NO – Target NO / QP adj 0%

BREACHES OF PROVIDER LICENCE

NO – Target NO / QP adj 0%

NHSE ASSESSMENT - INADEQUATE CCG RESPONSE

NO – Target NO / QP adj 0%

Total Quality Premium Adjustments

TOTAL ADJUSTMENTS

-33% – Target 0.0%

Total Quality Premium Award

TOTAL QUALITY PREMIUM AWARD

£70,017 – Target £690,000 / 16/17 £0

QUALITY PREMIUM

PERFORMANCE METRICS

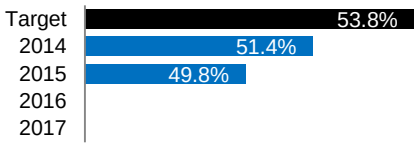
KPI	2017/18 PERFORMANCE	ACTIONS

EARLY STAGE DIAGNOSIS
Cases of cancer diagnosed at stage 1 or 2 as a % of all new cases of cancer

Value £110,500
Forecast n/a

49.8% **2015**

EARLY STAGE CANCER DIAGNOSIS



The National Cancer Intelligence Network (NCIN) have not yet updated any early stage diagnosis figures since 2015 although they are expected to publish figures quarterly. This has been raised with them and we are awaiting a response.

The Target for the quality premium award is 60% or a 4% improvement on 2016 actuals, so the current target may yet change

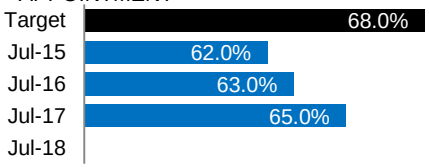
---

GP Access and Experience
Overall experience of making a GP appointment assessed through Q18 of the GP patient survey (those answering 'very good' or 'fairly good' as a % of the total

Value £110,500
Forecast n/a

65.0% **Jul-17**

EXPERIENCE OF MAKING AN APPOINTMENT



The target for the quality premium is for 3% improvement on the July 17 figure or achieve 85%.

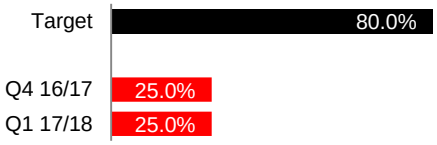
It is anticipated that the expansion of online consultations and improved telephone access via call queuing will improve patient experience when making an appointment.

Continuing Healthcare
Full NHS CHC assessments are completed within 28 days

Value £55,250
Forecast £0

25% **Q4 16/17**

FULL CHC ASSESSMENT <28 DAYS



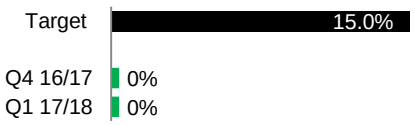
The CCG has recognised that CHC assessments are not being completed within the 28 timescales. A CHC improvement plan has been implemented and reported to NHS England. Activity is monitored monthly through CHC audit and improvements are required to meet statutory obligations. Q2 data analysis demonstrates improvement.

Continuing Healthcare
Full NHS CHC assessments take place in an acute setting

Value £55,250
Forecast £55,250

0% **Q4 16/17**

FULL CHC ASSESSMENT IN ACUTE SETTING <15%



The CCG monitors this monthly and has no concerns regarding performance.

QUALITY PREMIUM

PERFORMANCE METRICS

KPI	2017/18 PERFORMANCE	ACTIONS
Mental Health OOA stays A reduction in the number of inappropriate adult OAPs for non-specialist adult acute care. Total number of bed days to have reduced by 33% of the baseline number as at 1st April 2017 Value £110,500 Forecast n/a	**n/a** **Jul-18** MH OOA PLACEMENTS Target Apr-17 Jul-18	NHS Digital has suppressed this data for a large number of CCG's due to the small numbers involved. The CCG is currently working to find an alternative route to obtain this information to calculate both the baseline and the associated target
Bloodstream Infections PART A) reducing gram negative blood stream infections across the whole health economy – I) reduction in e-coli infections Value £38,675 Forecast £0	**108** **Sep 16-Aug 17** E-COLI: Bloodstream infections Target 81 Sep 14 - Aug 15 95 Sep 15 - Aug 16 90 Sep 16-Aug 17 108	
Bloodstream Infections PART A) reducing gram negative blood stream infections across the whole health economy – ii) collection of core data Value £11,050 Forecast £0	**No** **2017** E-COLI: Primary Care data collection Target Yes 2016 No 2017 No	Public Health England have published a requirement for a core data set to be collected in Primary Care regarding all E-Coli BSI, occurring in Q2-Q4 2017/18. The CCG has a copy of the required data fields and is in communication with Public Health as to how this data should be collected and submitted
Bloodstream Infections reducing inappropriate antibiotic prescribing for UTI's in primary care – I) reduction in trimethoprim:Nitrofuantoin prescribing ratio Value £24,862 Forecast £24,862	**1.117** **12 month to Jul 17** E-COLI: Bloodstream infections Target 1.511 2015/16 1.679 12 month to Apr 17 1.208 12 month to Jul 17 1.117	The Quality Premium is for a 10% reduction in the Trimethoprim:Nitrofuantoin prescribing ratio based on CCG baseline (June 15-May 16)

QUALITY PREMIUM

PERFORMANCE METRICS

KPI	2017/18 PERFORMANCE	ACTIONS

Bloodstream Infections
PART B) reducing inappropriate antibiotic prescribing for UTI's in primary care – ii) reduction in trimethoprim prescribing in patients aged 70 or over

Value £24,862
Forecast £24,862

2878 **2016**

Inappropriate antibiotic prescribing for UTI's

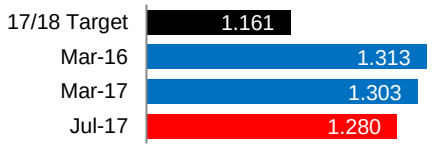
The CCG is on track to achieve this portion of the Quality Premium

Bloodstream Infections
PART C) sustained reduction of inappropriate antibiotic prescribing in Primary Care

Value £11,050
Forecast £0

1.280 **Jul-17**

Antibiotic Items per (STAR-PU)



Items per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR-PU) must be equal to or below England 2013/14 mean performance of 1.161 Similar tests will apply for 2018/19

Dementia care plan review
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months.

Value £97,500
Forecast £0

64.9% **Aug-17**

Dementia Care Plan Reviews

The CCG collects data on a monthly basis from General Practice and has allocated resources to improve the number of recorded dementia care plan assessments, both by identifying where underperformance exists and addressing this and by identifying poor recording practice

PRIMARY CARE

AT A GLANCE

The primary care dashboard would normally be presented the primary care commissioning committee, due to be updated in November, and to the practices via the Quality, contract and transformation visits. We are intending to share this information and more to support the practice visits that commenced in September. In order to support the CCGs statutory duty to improve the quality of its general practice services, and more lately to support the delegated commissioning of services, a local quality dashboard has been developed. The dashboard includes a range of indicators under the Patient Experience, Patient Safety and Clinical Effectiveness quality areas, whilst also including activity data.

Patient Satisfaction
Above average patient satisfaction continues in both 'making an appointment' and 'would recommend their GP' by patients from Hough Green, Oaks Place, Brookvale and Heath Road practices.
Bowel Screening Data illustrates that uptake across practices ranges from 45% (Heath Road Medical Centre) to 63% (Upton Rocks), with a CCG average of 53%. This shows an increase from 51% Quarter 3 2014/15 (the last data available.)
Flu Uptake in patients aged over 65 years illustrates that only Brookvale and Grove House met the national target of 75%. Practice uptake ranged from 63% (Newtown) to 75% (Brookvale.) Uptake is generally lower for the Widnes practices with four practices under 70% (Bevan Group Practice, The Beeches, Newtown Surgery and Upton Rocks.)
Vaccinations
Only three practices (Brookvale, Murdishaw and Bevan Group Practice) achieving the 95% national target for Pre School Booster uptake (range 84% to 98%.)
Coronary Heart Disease: Prevalence rates vary from 2.21% at Upton Rocks to 4.73% at Castlefields, Grove House and Tower House Practices. All but three practices (Heath Road, The Beeches and Newtown) meet the 93% maximum payment threshold for BP in the last 12 months ≤ 150/90. Exception reporting for this indicator ranges from 0.72% at Hough Green to 10.93% at Weaver Vale.

COPD prevalence: Ranges from 1.35% (Upton Rocks) to 5.14% Murdishaw. All practices exceeded the maximum payment threshold of 75% for record of FEV1 in the last 12 months. Exception reporting of this indicator ranges from 1.35% at Upton Rocks 40.49% at Peel House Medical Plaza, 41.13% at Hough Green and 49.3% at Tower House.
Diabetes Prevalence: Ranges from 4.24% at Oaks Place Surgery to 7.67% at Castlefields and Murdishaw. All but three practices (The Beeches, Heath Road and Murdishaw) exceeded the maximum payment threshold of 75% for IFCC is 59mmol/mol in last 12 months. Exception reporting for this indicator ranges from 1.77% at Heath Road through to 31.41% at Peel House Medical Plaza.
Atrial Fibrillation Prevalence: Ranges from 1.01% at Oaks Place to 3.12% at Appleton Village Surgery. All practice achieved the 70% maximum payment threshold for patients treated with an anticoagulation drug if a CHADS2-VASc score of 2 or more. Exception reporting ranges from 0% at Upton Rocks and Heath Road through to 22.86% at Weavervale.
Quality & Contracting visit programme
The Quality and Contracting visit has been developed and visits have commenced with practices. These visits are intended to be a conversation with practices and include a practice nominated GP Lead and Practice Manager along with the CCG GP Primary Care Lead and Primary Care team and will look at three areas of best practice and three areas for improvement.
The content of the visits includes; Quality & Outcome Framework indicators with wide variation such as COPD, Diabetes, Heart Disease as well as cervical cytology; An opportunity for practices to raise issues with the CCG; A quality dashboard is shared with practices to allow consideration prior to the visit.

PRACTICE POPULATION

130,860 Sep17 ↑ May 16 130,147

PATIENTS PER WHOLE TIME EQUIVALENT GP

1,716

'GOOD' OVERALL EXPERIENCE GP

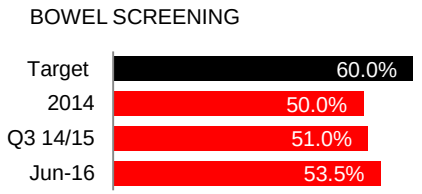
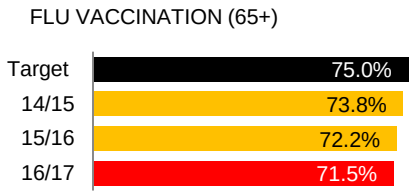
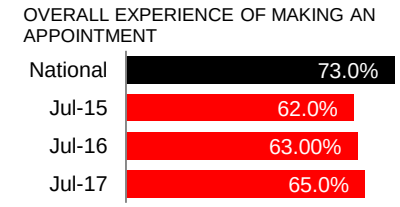
85% July 17 National 85% Jul-16 85%

'GOOD' EXPERIENCE MAKING AN APPOINTMENT

65% July 17 ↑ National 73% Jul-16 63%

PRIMARY CARE

SCREENING, PATIENT EXPERIENCE

KPI	2017/18 PERFORMANCE	ACTIONS
BOWEL SCREENING Proportion (%) of eligible 60-74 year old population screened for bowel cancer in last 2.5 years	**53.5%** **Jun-16** 	The Halton health improvement team continue to work with the practices to improve screening uptake. Whilst still behind target it is encouraging to see an increase since 2014
FLU VACCINATION Proportion (%) of stated population who received vaccination	**71.5%** **16/17** 	The Flu group continue to oversee performance and areas for improvement. It is anticipated that the Care Home Alignment scheme will improve flu vaccination rates amongst the over 65's
OVERALL EXPERIENCE OF GP The % of patients responding to the GP patient survey reporting 'very good' or 'fairly good' when asked to rate their Overall experience of GP surgery	**85%** **Jul-17** 	It is positive to note that performance is in line with the national average. It is anticipated that transformation work, in line with the GP forward View will improve patient experience
OVERALL EXPERIENCE OF MAKING APPOINTMENT The % of patients responding to the GP patient survey reporting 'very good' or 'fairly good' when asked to rate their Overall experience making an appointment	**65%** **Jul-17** 	Although below the national average, improvement over the last two years has been noted. It is anticipated that the expansion of online consultations and improved telephone access via call queuing will improve patient experience when making an appointment.

PRIMARY CARE

QOF

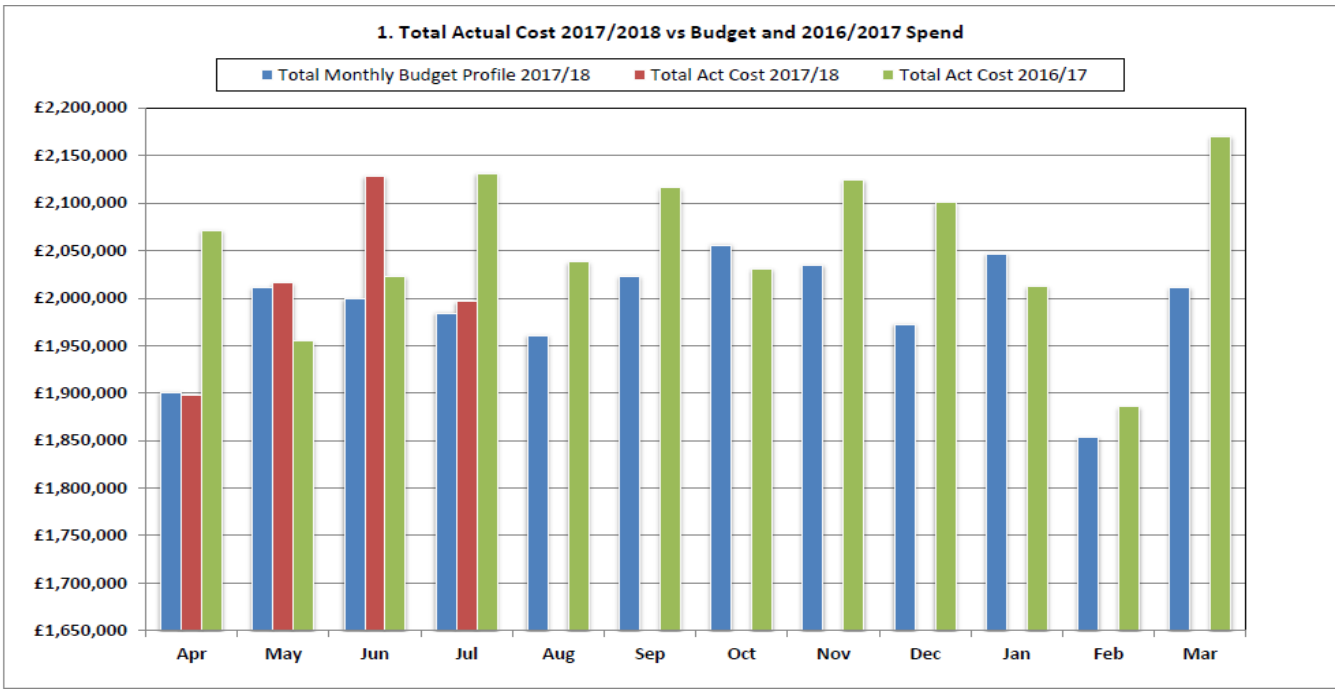
KPI	2017/18 PERFORMANCE	ACTIONS
CORONARY HEART DISEASE CHD002The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less QoF Achievement threshold 53-93%	**82.4% 16/17** CORONARY HEART DISEASE: BP last 12 months <=150/90 	All but three practices (Heath Road, The Beeches and Newtown) meet the 93% maximum payment threshold. Exception reporting ranges from 0.7% at Hough Green to 10.9% at Weavervale Prevalence rates vary from 2.2% at Upton Rocks to 4.7% at Castlefields, Grove House and Tower House
CHRONIC OBSTRUCTIVE PULMANORY DISEASE COPD004 The percentage of patients with COPD with a record of FEV1 in the preceding 12 months QoF Achievement Threshold 40-75%	**78.1% 16/17** COPD: FEV1 in last 12 months 	All practices exceeded the maximum payment threshold of 75%. There are large variations in exception reporting ranging from 1.3% at Upton Rocks to 49.3% at Tower House The content of the Quality and Contracting visiting programme will include the wide variation in exception reporting
DIABETES DM007: The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 12 months. QoF Achievement Threshold 35-75%	**68% 16/17** DIABETES: last IFCC is 59 mmol/mol in last 12 months 	All but three practices (The Beeches, Heath Road and Murdishaw) exceeded the maximum payment threshold of 75%. There are large variations in exception reporting, from 1.7% at Heath Road to 31.4% at Peel House. The Quality and contracting visiting programme will look at the reasons behind these variations
ATRIAL FIBRILATION **AF007:** In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy. QoF Achievement Threshold 40-70%	**78% 16/17** ATRIAL FIBRILATION 	All practices achieved the maximum payment threshold. large variations in exception reporting were apparent, with 0% at Upton Rocks to 22.9% at Weavervale. The large variations will be investigated through the Quality & Contracting visiting programme.

MEDICINES MANAGEMENT

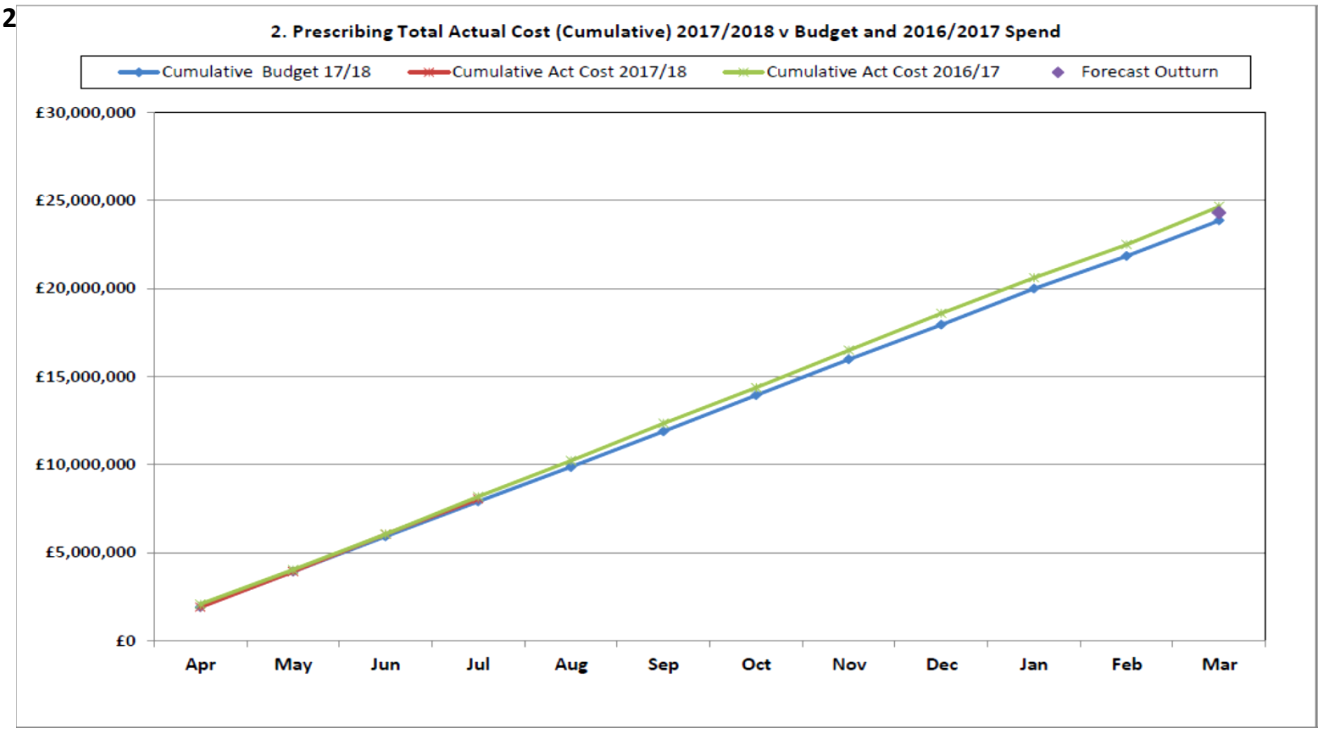
AT A GLANCE

Prescribing Budget Performance Dashboard July 2017 Position
The 2017/18 prescribing budget £23,850,271 (excluding QIPP)

1. Total actual prescribing cost by month in 17/18 against the same period in 16/17 and the monthly budget profile.



2



Halton CCG projected year-end over/underspend against budget (incl local adjustments):

MEDICINES MANAGEMENT

Cost Pressures on Prescribing Budget 17/18

Community Pharmacy Margin - 'Category M'
From time to time the Department of Health consults with the Pharmaceutical Services Negotiating Committee on adjustments to the fees and/or margin that we as commissioners pay to pharmacies to reflect any under/over delivery of the agreed amounts in prior years. Recent discussions have resulted in a reduction in Category M (generic drugs) prices estimated to amount to £15m per month (nationally), to take effect from 1 August 2017. These changes could not have been anticipated in operational plans and therefore result in a windfall benefit of about £120m nationally which would normally accrue to CCGs through reduced medicines expenditure.

We have been notified by NHSE that the benefit that would otherwise flow to CCGs will be now be retained centrally and as such CCG finances will not benefit immediately from the price reductions. It is their intention that the benefit of the price reduction retained centrally should be available for investment by CCGs either in 2017/18 or in subsequent years subject to specific criteria.

The details of how this will work have only just been issued to CCGs and we are still clarifying the exact process but we anticipate that this money will be clawed back from CCGs each month and as such will have an impact on the overall forecast outturn. The impact for Halton is difficult to quantify but is estimated to be approximately £185,924 for Q2 and Q3 2017/18 i.e. from August to December 2017.

Medicines Supply Issues
There are a number of issues affecting the medicine supply chain and on occasion this will result in a concessionary price being applied nationally to specific products as 'No Cheaper Stock Obtainable' (NCSO). This in turn has a significant impact on prices we pay for commonly used drugs and as such becomes a cost pressure on our prescribing budget. These concessionary prices are difficult to predict and the impact has to be assessed on a month by month basis to ascertain the true picture.

There have been a number of NCSO concessions applied in recent months with some significant price increases as a result. According to prescribing data up to July 2017 the cost pressure for Halton is approximately £127K however it is estimated that this could increase significantly over the coming months and we will have to monitor closely. The category M savings retained centrally do not include drugs subject to NCSO status but the cost pressure will remain.

Pregabalin
As of July 2017 Pregabalin came off patent and the price reduced from 1st August 2017. Halton is the second highest CCG for prescribing of this drug and as such savings were predicted to be significant however all strengths of this drug are now subject to NCSO status which fluctuates every month and this has had an impact on the savings achieved.

We will know more re: the impact of switching over to generic when August and September data is available but given the category M savings to be clawed back and the NCSO cost pressures it is unlikely we will see the full benefit of the savings as originally predicted.

This will continue to be a priority QIPP area for the CCG due to the very high volume of prescribing that still remains. Halton are also second highest prescriber in terms of volume and as such monitoring has been changed to reflect this.

RIGHTCARE

A BRIEF INTRODUCTION TO RIGHTCARE

Background
NHS RightCare is a national NHS England supported programme committed to delivering the best care to patients, making the NHS's money go as far as possible and improving patient outcomes.
Ensuring people access the right care, in the right place at the right time means the NHS can treat more people effectively, now and in the future. NHS RightCare work is core to ensuring the best possible care is delivered everywhere.

NHS RightCare advises local health economies to:

→ Make the best use of resources – by tackling overuse and underuse of resources.

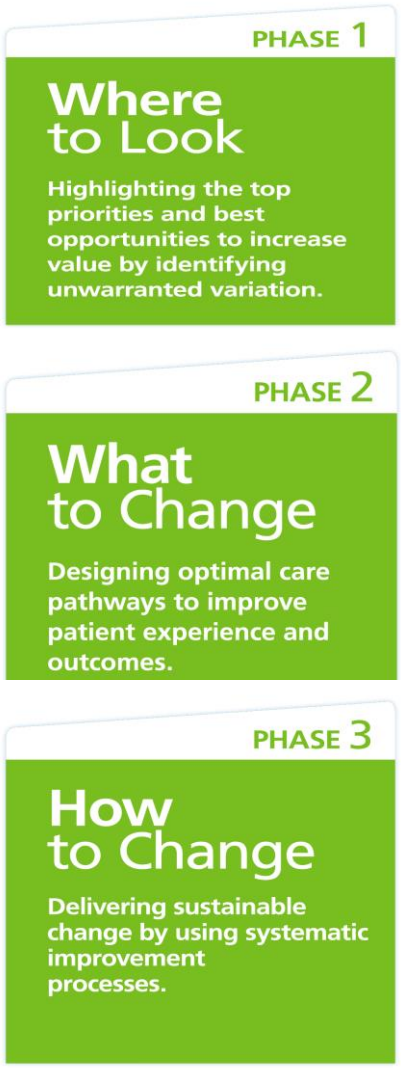
→ Understand performance by identifying variation between demographically similar populations to enable the adoption and implementation of optimal care pathways more efficiently and effectively.

→ Talk together about the same things – about population healthcare rather than organisations, and encouraging joint decision-making.

→ Focus on areas of greatest opportunity by identifying priority programmes which offer the best opportunities to improve healthcare for people and ensuring taxpayer money goes as far as possible.

→ Use tried and tested evidence based processes to make sustainable improvement to reduce unwarranted variation.

The 3 phases of RightCare



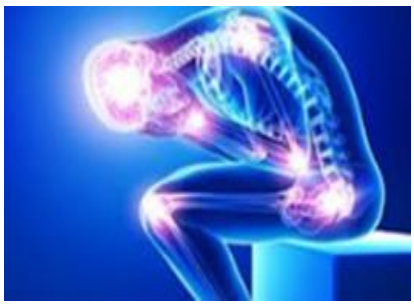
Summary of Key Financial Improvement Opportunities

		NHS Halton Priority Programme Areas						
		Neurology £k	Respiratory £k	Muskelo-skeletal £k	Gastro-Intestinal £k	Sub Total £k	% of Grand Total	**Grand Total £k**
Total		**1,595**	**1,243**	**935**	**1,539**	**5,312**	**50%**	**10,532**
Admitted Patient Care	**Sub Total**	**845**	**608**	**762**	**1,075**	**3,290**	**53%**	**6,182**
	Non Elective	845	531	522	341	2,239		**4,026**
	Elective & Day Case	-	77	240	734	1,051		**2,156**
Prescribing		**750**	**635**	**173**	**464**	**2,022**	**46%**	**4,350**

RIGHTCARE

RIGHTCARE EMERGING OPPORTUNITIES

The following areas have been chosen as the most promising areas to undertake a change programme, and have been developed into priority programmes , and submitted to NHSE as the emerging opportunities for NHS Halton.

PROGRAMME AREA	NARRATIVE	PROJECTS
Neurology 	NHS Halton is identified, through the RightCare programme, as an outlier in the level of expenditure on management of patient with neurological conditions, through acute hospital services and primary care prescribing. This review covers a number of neurological conditions but the management of pain is the highest element.	→ Spinal Surgery → Alliance multi-disciplinary Pain Management Programme → Engage with Vanguard → Embed Parkinson's Nurse → Pregabalin optimisation
Respiratory 	The aim of the Respiratory programme is to transform the management of COPD in the borough along the entire pathway; from diagnosis through to end of life. This will be delivered through the provision of Patient centred care which supports patients with COPD to become more independent, taking more responsibility for their own care	→ COPD Service Review → Community Respiratory Service Procurement → PointsPlus/GRASP tools → MyCOPD app → Inhaler Formulary and guidance
Musculoskeletal 	This programme has been informed by the growing evidence around outcome based commissioning and also the growing number of case study sites for outcome based commissioning within MSK services across the country with a number adopting the use of prime provider contracting processes to ensure the whole patient pathway is being considered.	→ Service re-design → Implementation of MSK Cats Community Tri-age Service → MoM pathway review → Demand Management → Medicines Optimisation
Gastro-Intestinal 	Gastro-intestinal has been identified as a key area for improvement by NHS RightCare. A paper went to the Service Development Committee (SDC) in Aug 2016 where high levels of activity and variation across towns and practices were discussed, and a mandate for further investigation was given.	→ Alcohol joint working with the LA → MoM pathway review - Scopes → Faecal Calprotectin test availability → Lifestyle education sessions → PPI Formulary and guidance

PUBLIC HEALTH

AT A GLANCE

Key Developments

IGR screening in Practices via Halton's Health Trainers has been very successful with all patients showing a reduction in their Hba1c and this contributes to decreased diabetes and improved CVD figures. However, this programme is at risk as all CCGs are now obliged to use the National Diabetes Prevention Programme which does not have the same successful outcomes.

A very well attended Training Conference and Workshop Eat, Sleep, Play, Repeat was delivered by a range of experts for frontline staff in June. This covered helping children become active, safe sleep, how to prepare your child for school, developing your babies speech and communication skills.

A Health Literacy Workshop was run for frontline staff and the voluntary sector. This included learning about the work completed on this area in Stoke and building plans on how we can use this in Halton. This was augmented via a workshop on Self Care between NHS Halton CCG, the voluntary sector and Public Health to take forward a new programme of work in this area. Cheshire and Merseyside DsPH came together with DCSs and CCGs to prioritise a key area for children that we can all work on. It was agreed we will concentrate on Self Harm and develop the Adverse Child Experiences model as this has proved to be very successful in Wales.

Exception narrative

Child Weight

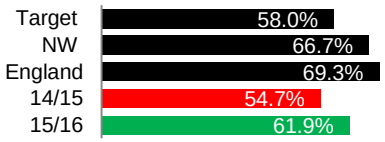
For the first time in 3 years the obesity trend for 10 11 year olds is worse than the England average. A number of new programmes are addressing this issue in addition to established programmes: Junior Park Run in Victoria Park on Sundays is proving popular with families and children - linked to this is the Couch to 2 km activity so parents can run with their children. Active Halton additional activities for children in areas with low uptake (Windmill Hill and Hale). Free swimming for under 8s, expansion of Game Changer. Programmes are in place for under 5s; including revamped parenting classes from the midwives, a family approach to weight management for women 28 weeks pregnant which links into the 6-8 week health check for baby so mum and baby stay a healthy weight.

Smoking

Currently working with partners to refresh the Halton tobacco control strategy. The strategy will focus upon young people recruited as smokers, motivating and assisting every smoker to quit and protecting families and communities. Halton CCG received £75,000 of funding from NHS England for use in 2016/17 to reduce maternal smoking rates. An action plan has been developed outlining joint proposals for the use of this funding. A recent pilot of promoting stress management techniques and use of a quit buddy has significantly increased the number of pregnant women who quit smoking and will be continued. Focus on reducing smoking rates in certain social groups for example routine and manual workers, those with a mental health condition, pregnant women, those with long term health conditions and those with drug and alcohol addictions

PUBLIC HEALTH

CHILDREN

KPI	2017/18 PERFORMANCE	ACTIONS
Child development - School Readiness Percentage (%) of children achieving a good level of development at the end of reception	**61.9% 15/16** CHILD DEVELOPMENT 	
Child weight - Reception (4-5 year olds) obesity Prevalence (%) of obesity amongst reception children	**12.2% 15/16** CHILD WEIGHT - Reception 	Multidisciplinary antenatal Parenting programme including a universal session on infant feeding. Infant feeding team, including home visits and support groups for breastfeeding mothers, BFI stage 3. Community session on introduction to solid foods. Height and weight measurements at the 2 year integrated review, with a pathway for children and families who are overweight. Active play sessions and work through children's centres. Referral of all children who are identified as obese in NCMP into dietetic services (family futures). Health promotion through NCMP and schools, using change for life materials, and local portion size leaflets. Healthy schools work, including fit for life – for schools, for the community and for the early years, and Healthitude. Healthy Early years healthy settings awards and healthy food awards.
Child weight - Year 6 (10-11 year olds) obesity Prevalence (%) of obesity amongst year 6 children	**22.8% 15/16** CHILD WEIGHT - Year 6 	For the first time in 3 years the obesity trend for 10 11 year olds is worse than the England average. A number of new programmes are addressing this issue in addition to established programmes: Junior Park Run in Victoria Park on Sundays is proving popular with families and children - linked to this is the Couch to 2 km activity so parents can run with their children. Active Halton additional activities for children in areas with low uptake (Windmill Hill and Hale). Free swimming for under 8s, expansion of Game Changer. Programmes are in place for under 5s; including revamped parenting classes from the midwives, a family approach to weight management for women 28 weeks pregnant which links into the 6-8 week health check for baby so mum and baby stay a healthy weight.
Infant mortality Rate of deaths in infants aged under 1 year per 1,000 live births	**3.0 2013/15** INFANT MORTALITY 	

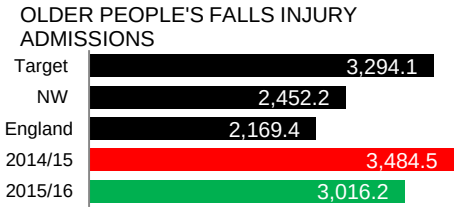
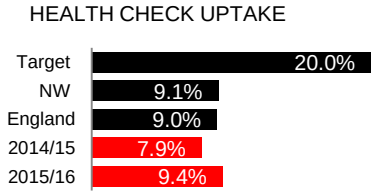
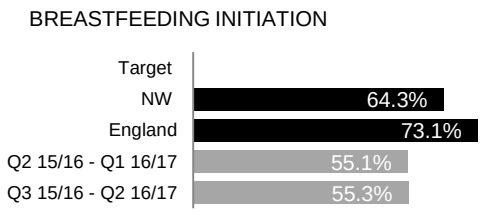
PUBLIC HEALTH

SMOKING & ALCOHOL

KPI	2017/18 PERFORMANCE	ACTIONS
Alcohol - Admission episodes for alcohol-related conditions Directly Standardised Rate per 100,000 population	**841.9** **15/16** ADMISSIONS FOR ALCOHOL RELATED CONDITIONS 	Developing a coordinated alcohol awareness campaign plan. Delivery of alcohol education within local school settings and the community alcohol partnership. 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 so that those who need support can access treatment. 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 and promoting more responsible approaches to the sale of alcohol and a diverse night-time economy.
Alcohol - Under-18 alcohol-specific admissions Directly Standardised Rate per 100,000 population	**48.6** **12/13 - 14/15** UNDER 18 ALCOHOL SPECIFC ADMISSIONS 	
Smoking - Current smokers Proportion (%) of adult population currently smoking	**20.1%** **2015** CURRENT SMOKERS 	Currently working with partners to refresh the Halton tobacco control strategy. The strategy will focus upon young people recruited as smokers, motivating and assisting every smoker to quit and protecting families and communities. Halton CCG received £75,000 of funding from NHS England for use in 2016/17 to reduce maternal smoking rates. An action plan has been developed outlining joint proposals for the use of this funding. A recent pilot of promoting stress management techniques and use of a quit buddy has significantly increased the number of pregnant women who quit smoking and will be continued. Focus on reducing smoking rates in certain social groups for example routine and manual workers, those with a mental health condition, pregnant women, those with long term health conditions and those with drug and alcohol addictions
Smoking - Smoking at time of delivery Proportion (%) of women with known smoking status recorded, who were smoking at the time of delivery (rolling year)	**16.0%** **Q4 15/16 - Q3 16/17** SMOKING AT TIME OF DELIVERY 	

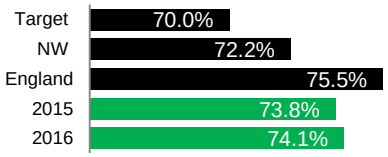
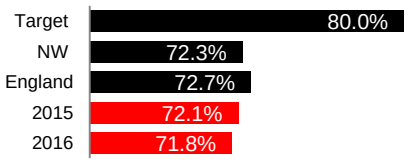
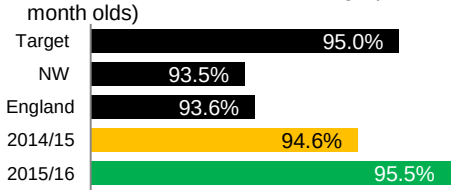
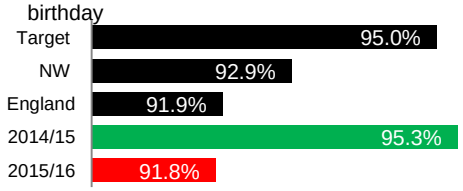
PUBLIC HEALTH

PUBLIC HEALTH METRICS

KPI	2017/18 PERFORMANCE	ACTIONS
Falls - Older people's falls injury admissions Directly Standardised Rate of admissions due to injuries from falls amongst those aged 65+, per 100,000 population	**3016.2** 15/16 	
Health Checks - Health Check Uptake Percentage of invited people who received an NHS health check in the financial year	**9.4%** 15/16 	
Breastfeeding- Breastfeeding Initiation Percentage (%) of all mothers who breastfed their babies in the first 48 hours after delivery	**55.3%** Q3 15/16 - Q2 16/17 	Number of maternities did not meet validation criteria for Q4 2015/16 or Q1 2016/17, so England comparison should be treated with caution

PUBLIC HEALTH

PUBLIC HEALTH METRICS

KPI	2017/18 PERFORMANCE	ACTIONS
Cancer Screening - Breast screening coverage Proportion (%) of eligible 50-70 year old women screened for breast cancer in the last 3 years	**74.1%** 2016 BREAST SCREENING COVERAGE 	Little localised campaign work to increase uptake - through location is being considered. It is the remit of the screening unit to find appropriate location, and as we have a mobile unit, choice of location could impact upon uptake.
Cancer Screening- Cervical screening uptake Proportion (%) of eligible 25-64 year old women population screened in the last 3.5/5.5 years	**71.8%** 2016 CERVICAL SCREENING COVERAGE 	We have not had a cervical screening campaign, other than general national campaigns for a while and we must focus particularly on first time screening groups to encourage early programme participation, and on the older age group to ensure participation before they are out of the scope of recall.
Immunisations - DTaP/IPV/Hib vaccination coverage (12 month olds) Proportion (%) of stated population who received vaccination	**95.5%** 2015/16 DTaP/IPV/Hib vaccination coverage (12 month olds) 	
Immunisations - Mumps, Measles & Rubella (MMR) by 2nd birthday Proportion (%) of stated population who received vaccination	**91.8%** 2015/16 Mumps, Measles & Rubella (MMR) by 2nd birthday 	Working with NHSE SCRIMS team to look at action plans to pick up the steady fall across all ims programmes. We will be facilitating practice plans, working with individual practices and ensuring data accuracy is as good as it can be.

REPORT TO: Health and Wellbeing Board

DATE: 17 January 2018

REPORTING OFFICER: Director of Public Health.

PORTFOLIO: Health and Wellbeing

SUBJECT: Pharmaceutical Needs Assessment

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To provide members of the Board with the final version of the Pharmaceutical Needs Assessment (PNA) and briefing on the results of the statutory 60-day consultation.

2.0 **RECOMMENDATION: That the Board**

1. **Approve the PNA for publication.**

2. **Delegate the Steering Group to deal with production of supplementary statements needed throughout the lifetime of the PNA.**

3. **Support the continuation of Healthy Living Pharmacies.**

4. **Support the use of New Medicine Reviews and Medcine Management Reviews by pharmacists in Halton.**

5. **Support pharmacists in their stewardship role on prescribing of antibiotics.**

3.0 **SUPPORTING INFORMATION**

3.1 The pharmaceutical needs assessment is a statutory document that states the pharmacy needs of the local population. This includes dispensing services as well as public health and other services that pharmacies may provide. It is used as the framework for making decisions when granting new contracts and approving changes to existing contracts as well as for commissioning pharmacy services. First detailed in the NHS Act 2006 where PCTs were divested with the responsibility for producing the PNA, since 1 April 2013 this responsibility now sits with Health & Wellbeing Boards (HWB).

3.2 **Background to the PNA**

National guidance states that the PNA should detail the current

pharmaceutical service provision available in the area and where there may need to be changes to this in the future because of changes to the health needs or geographical location of the local population. The guidance, in line with regulations, includes both minimum content of a PNA and the process that must be followed.

The PNA is designed to be a statement of fact, both the current position and where there are 'known firm plans' in place to review or amend provision based on need, evidence of effective practice and identified gaps in provision. Also to assess where there are 'known firm plans' for new developments or population changes which may impact on the needs of pharmaceutical services. It is designed to assess the need for pharmaceutical services and adequacy of provision of pharmaceutical services, not to assess general health needs. The latter is the role of the Joint Strategic Needs Assessment (JSNA). Preparation of the PNA has taken account of the needs identified in the JSNA, where they are relevant to pharmaceutical services.

3.3 **Statutory 60-day consultation**

The Regulations set out that HWBs must consult the bodies set out in Regulation 8 at least once during the process of developing the PNA.

Regulation 8(1) states that the HWB must consult the following list as a minimum during the development of the PNA:

(a) Local Pharmaceutical Committee(s) for its area;
(b) Local Medical Committee(s) for its area;
(c) all pharmacy contractors and any dispensing doctors for its area;
(d) any LPS chemist in its area with whom the NHS England has made arrangements for the provision of any local pharmaceutical services;
(e) Local Healthwatch organisation for its area, and any other patient, consumer or community group in its area which in the opinion of HWB has an interest in the provision of pharmaceutical services in its area;
(f) NHS trusts or NHS foundation trusts in its area;
(g) NHS England
(h) neighbouring HWBs.

3.4 **60-day consultation process**

A standard letter was sent to all organisations detailed in Section 3.3. Additionally the invitation to participate in the consultation was sent out to a wider range of stakeholders via various partnerships.

The consultation opened Wednesday 8 August 2017 and ended at close of normal business hours on Wednesday 11 October 2017.

One response was received.

The consultation formed a set of questions to which respondents could agree or disagree with space in each question to make comments. The survey was available online or could be filled in by downloading the questionnaire in a word document format.

3.5 **60-day consultation results**

The response indicated that they agreed that:

- The purpose of the PNA had been sufficiently explained
- The scope of the PNA was clear
- The local context and implications of the PNA had been clearly explained
- All commissioned services were reflected in the PNA with a reasonable description of each
- The pharmaceutical needs of the local population were accurately reflected in the PNA
- They agreed with the findings and future needs
- There were no omisions within the PNA

The Steering Group met on 17 October 2017. They agreed that the PNA was now ready to be presented to the Health and Wellbeing Board as the final version.

3.6 **Proposed next steps**

- The PNA must be published no later than 1 April 2018
- The Health & Wellbeing Board are asked to approve the attached version of the PNA as the publication version
- The PNA is uploaded onto Halton Borough Council's website as part of the Public Health pages detailing the JSNA
- This is communicated to key stakeholders and the public
- The Steering Group will meet periodically and as needed to produce supplementary statements during the lifetime of the PNA. These are needed if and when there are minor amends which do not substantially alter provision of pharmaceutical services. An example of this would be if a pharmacy changed their opening hours or in response to successful consolidations and mergers application

4.0 **POLICY IMPLICATIONS**

4.1 The health needs identified in the JSNA have been used to develop the PNA.

The PNA provides a robust and detailed assessment of the need for pharmaceutical services across Halton borough. As such it should continue to be used in the decisions around 'market entry' as well as local commissioning decisions of both Halton Clinical Commissioning Group and Halton Borough Council Public Health. Local groups and partnerships should also take the findings of the PNA into account when making decisions around the need for pharmaceutical services.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 Any legal challenges to decisions based on information in the PNA may open the HWB up to Judicial Review. This can have significant financial implications. It is therefore vital that the HWB continues to follow national guidance in the implementation of the Regulations.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**
Improving the Health of Children and Young People is a key priority in Halton and this should be reflected in the PNA, detailing service provision that is appropriate to this age group.

6.2 **Employment, Learning & Skills in Halton**
Not applicable

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

6.4 **A Safer Halton**
Not applicable

6.5 **Halton's Urban Renewal**
The environment in which we live and the physical infrastructure of our communities has a direct impact on our health and wellbeing. Pharmacies provide a vital primary health care service to residents across the borough, are located within the heart of communities and offer open access to trained health professionals for advice on a wide range of issues.

7.0 RISK ANALYSIS

7.1 Failure to comply with the regulatory duties fully may lead to a legal challenge, for example, where a party believes that they have been disadvantaged following the refusal by NHS England over their application to open new premises based on information contained in the PNA.

7.2 The risk of challenge to the HWB who produced that PNA is significant and Boards should add the PNA to the risk register.

7.3 A sound process, using national guidance and with support from local expertise, should be established to ensure this risk does not materialise.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 The PNA seeks to provide intelligence on which to base decisions about service provision that are based on levels of need across the borough. This includes analysis of a range of vulnerable groups and the need for targeted as well as universal services to meet the range of needs identified.

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

There are none within the meaning of the Act.

Halton Health and Well Being Board

Pharmaceutical Needs Assessment

2018-2021

Foreword

Halton's Health and Wellbeing Board has responsibility for the on-going review, development and publication of the Pharmaceutical Needs Assessment.

This is a statutory document, by virtue of the National Health Services (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. Its content has to be taken into account by those responsible for the approval of pharmacy contract applications (at NHS England) as well as those commissioning all other health services for our local population. From a primary care perspective this includes clinical commissioning groups and local authorities looking to commission and develop local services from pharmacy contractors, General Practice, dental and optometry.

As such we are very happy to present our second formal Pharmaceutical Needs Assessment 2018-2021 which outlines the pharmaceutical services available to our population. This document provides information around current services being commissioned and proposals for future changes and developments.

This document will assist us as a local authority, and Halton Clinical Commissioning Group, when reviewing our commissioning strategies upon which we base our decisions. It is recognised that our community pharmacy colleagues have a key role to play in helping us develop and deliver the best possible Pharmaceutical Services for our population.

We commend this report to you and we look forward to your continuing involvement as this document is annually reviewed and updated.

Leader, Halton Borough Council

Chair, Halton Health and Wellbeing Board

Director of Public Health, Halton Borough Council

Sponsor, Pharmaceutical Needs Assessment

Version Control

Main Authors: Sharon McAteer and Jennifer Oultram

Editor: Sharon McAteer along with members of the PNA* Steering Group

Issue Date: 1 April 2018

Review Date: Annual review with Supplementary Statements as necessary with a formal review by April 2021

Version	Summary of Changes	Date of Issue
2011 PNA	First formally approved PNA for Halton & St Helens PCT	1st February 2011
2015 PNA	Published Halton Health and Well Being Board's first PNA	1 April 2015
2018 PNA	Draft 1 presented to the PNA steering group	January 2017
	Draft 2 presented to the PNA steering group	July 2017
	Final draft presented to the PNA steering group	November 2017
	Completed version to Halton Health and Well Being Board	January 2018
	Published Halton Health and Well Being Board's second PNA	1 April 2018

***PNA = Pharmaceutical Needs Assessment**

PNA Steering Group Members

Ifeoma Onyia	**Consultant in Public Health (chair), Halton Borough Council**
Sharon McAteer	**Public Health Development Manager (deputy chair), Halton Borough Council**
Jennifer Oultram	**Public Health Intelligence Officer, Halton Borough Council**
Bertha Brown	**Chief Officer, Local Pharmaceutical Committee (Knowsley, Halton and St Helens)**
Stuart Ellis	**Local Pharmaceutical Committee (Knowsley, Halton and St Helens)**
Jackie Jasper & Emma Knox	**Contracts Managers, NHS England**
Lucy Reid	**Medicines Management, Halton CCG**
Irene Bramwell	**Healthwatch**
Sally Yeoman	**Chief Officer, Halton and St Helens Council for Voluntary Services**
Cllr Marie Wright	**Elected member, Portfolio Holder Health & Wellbeing, Halton Borough Council**

Further acknowledgements

- Lynne Woods and Mickey Leck for their administration skills throughout the PNA process
- Cheshire & Merseyside colleagues for support throughout development of PNA together with NHS England for arranging the sub-regional steering group
- Pharmacies for providing information on the services they provide
- Alison Williams, Business Support Officer, Halton, St Helens & Knowsley LPC for support the steering group and the pharmacies in achieving 100% compliance within the deadline date
- HBC Customer Intelligence Unit for managing the statutory consultation
- Richard Jones, Public Health, Liverpool City Council for setting up and administering the public survey on behalf of Halton, Liverpool, St Helens, Warrington and Wirral
- Halton networks for distributing the public survey to their members and Halton public for taking the time to complete the questionnaire
- David Nolan, Matt Hennessey and other staff at Public Health England for providing hospital admissions ward level analysis and support in obtaining driving and walking times maps
- Simon Bell, Tisha Baynton, Ifeoma Onyia, Elspeth Anwar, Louise Wilson, Anne Moyers, Kenneth Bowen, Sarah Griffiths-Johnson, Halton Borough Council and Lucy Reid, Halton CCG for providing input to section 7
- Gareth Rustage, Medicines Management Technician at Halton CCG, for supporting the updating of the prescribing data

Table of Contents

Table of Figures

Table of Maps

Table of Tables

Executive Summary

The Pharmaceutical Needs Assessment (PNA) aims to identify the pharmaceutical needs of people living in Halton.

The main objectives for this project were to:
1. Describe the scale and consequences of the main health issues in Halton
2. Describe the existing pharmacy services in relation to needs, policy and evidence-based practice
3. Make recommendations to commissioners based on findings of the PNA
4. Provide information for NHS England (NHSE) contracts committee when deciding pharmacy applications

Background

In April 2008 the White Paper, *Pharmacy in England: Building on Strengths – Delivering the Future* was published. This sets out the Government's programme for a 21st century pharmaceutical service and identifying ways in which pharmacists and their teams could contribute to improving patient care through delivering personalised pharmaceutical services in the coming years.

Following consultation in autumn 2008, two clauses were included in the Health Act 2009:

- To require Primary Care Trusts to develop and publish pharmaceutical needs assessments (PNAs) by 1st February 2011; and
- Then to use PNAs as the basis for determining market entry to NHS pharmaceutical services provision

Pharmacy in England: Building on Strengths – Delivering the Future – Regulations under the Health Act 2009: Pharmaceutical Needs Assessments –Information for Primary Care Trusts was published to assist PCTs in the development of their first and subsequent PNAs produced under the new statutory duty set out in the NHS (Pharmaceutical Services) Regulations 2005, as amended. In developing their PNA, Regulation [3G] outlines a series of matters that PCTs must have regard to, these are summarised as:

-

- The Joint Strategic Needs Assessment (JSNA)
- The needs of different patient groups
- The demography of the PCT area
- The benefits from having a reasonable choice in obtaining services
- The different needs of the localities
- The effect of pharmaceutical services provided under arrangements with neighbouring PCTs
- The effect of dispensing services or other NHS services provided in or outside its area
- Likely future needs

Section 128A of NHS Act 2006, as amended by Health Act 2009 and Health and Social Care Act 2012

From 1st April 2013, every Health and Wellbeing Board (HWB) in England has a statutory responsibility to publish and keep up to date a statement of the needs for pharmaceutical services of the population in its area, referred to as a pharmaceutical needs assessment (PNA). This is of particular relevance for local authorities and commissioning bodies. Guidance outlines the steps required to produce relevant, helpful and legally robust PNAs.

This PNA for Halton builds on the needs identified in the Joint Strategic Needs Assessment (JSNA) and the Health & Wellbeing Board's Joint Health and Wellbeing Strategy (JHWBS).

Process undertaken to develop the PNA

Key principles of the PNA are:

- It is an iterative process involving patients, the public and key stake holders
- It is a developing, live document to be reviewed annually
- It continues to focus on identifying health needs which can be supported by pharmaceutical services and makes recommendations for the commissioning of those services
- It is done through a multidisciplinary PNA Steering Group

Development of the Halton PNA has been initiated and overseen by the Public Health Evidence & Intelligence Team operating through a multi-professional steering group. The steering group consists of representatives from the following:

- Public Health Evidence and Intelligence
- Halton Clinical Commissioning Group (CCG)
- Local Pharmaceutical Committee
- NHS England
- Healthwatch
- Halton & St Helens Council for Voluntary Services
- Halton Borough Council elected member, Portfolio holder for Health and Wellbeing

The process of developing this PNA has drawn heavily on the NHS Employers guidance.[i][ii]

In order to identify the specific roles pharmacies do/could play in addressing the Joint Health and Wellbeing Strategy (JHWBS) and other local priorities, current pharmacy provision has been mapped against need using measures such as prevalence of disease and hospital admission rates. A literature review was also undertaken to determine potential roles of pharmacies in supporting local priorities as well as the use of Royal Pharmaceutical Society good practice guidance and NICE[iii] guidance.

Patient and Public Involvement

During June 2017 we asked the people of Halton for their experiences of using pharmacy services and their views on how services might be improved. We wanted to know this because:

- We want to make sure that pharmacies provide services people need and use
- We want to know what services we can improve in Halton
- We want to let pharmacies know what patients think of the services they provide
- We want to work with patients and pharmacies to improve services

i. NHS Employers (2009) *Developing Pharmaceutical Needs Assessments: A practical guide*
ii. NHS Employers (2009) *Pharmaceutical Needs Assessments (PNAs) as part of world class commissioning Guidance for primary care trusts*
iii. NICE stands for National Institute for Health & Clinical Evidence. They produce best practice guidance based on evidence of effectiveness and cost effectiveness.

216 people filled in the questionnaire, more than double that of the previous PNA. Feedback from this has been incorporated thoughout the report.

60-day consultation

A formal 60-day consultation is required for the development of the PNA. This began 9am Wednesday 9 7 August 2017 and closed 5pm Wednesday 11 October 2017. It was distributed widely to local pharmacies, neighbouring HWBs, acute trusts, local strategic partnerships, Local Pharmaceutical Committee (LPC), Local Medical Committee (LMC), all GP practices and to community & voluntary sector groups throughout the borough. Comments have been collated and a consultation response included in the PNA. Each comment was assessed by the steering group and amendments required as a result of them made to the final PNA.

Developments which may precipitate the need for changes to pharmacy services

Any conclusions gained from this PNA need to take account of the fact that future developments, such as but not limited to, changes in population, changes in sources/numbers of prescriptions may take place. This could influence the demand for pharmaceutical services. Hence this PNA is a 'dynamic' document.

Workload and demand in pharmacy is driven by two factors:

- Population growth and changing structure, which in Halton is predicted to be around 2% by 2024 (2015 Office of National Statistics mid-year population estimates). This is lower than the North West region which is projected to grow by 3.5% and nationally, which is projected to grow by 6.6%
- The change in population is not evenly distributed between the age groups; the 65+ population is estimated to see an increase of 25% over the 10 year period (6,100 more persons in age band). However, the 0-14 population is estimated to stay at a similar level between 2015 and 2024, and the 15-64 population will decrease by 3%. As a heavy user of health and social care, this 'ageing' of the population is especially important
- Nationally for 2015,[1] 1,083.7 million prescription items were dispensed overall, a 1.8% increase (19.1 million items) on the previous year and a 50.5% increase (363.4 million items) on 2005. The average number of prescription items per head of the population in 2015 was 19.8, compared to 19.6 items in the previous year and 14.2 in 2005
- In 2015, the total net ingredient cost of prescriptions dispensed rose to £9.3 billion. In 2005 the total cost was £7.9 billion. The average cost per head of the population has risen to £169.14, the highest it has been during the past 11 years. In 2005 the average cost per head was £156.83. The average net ingredient cost per prescription item increased from £8.32 in 2014 to £8.55 in 2015. In 2005 this figure was £11.02

The combined effects of population change and prescribing growth have a compounding effect on the pharmacy workload. This is especially pertinent as the pharmacies operating across Halton currently dispense more prescription items than the average for England and this has grown each year (based on assumption that Halton pattern would have been similar to Halton and St Helens PCT pattern). It is anticipated that growth in the future will continue at a similar rate. Prescription volumes and service provision needs to be monitored to identify where demand is likely to exceed supply. Planned developments, e.g. any major new housing developments, must also be monitored to ensure we are able to respond to the needs of our population for pharmacy services.

Key Findings

Taking into account information gathered for this PNA

The provision of pharmacy services within Halton in terms of location, opening hours and services provided is considered adequate, to meet the needs of the population.

As such this PNA has not identified a current need for new NHS pharmaceutical service providers in Halton.

The PNA has also identified actions to optimise the potential of the pharmacy contract for our population, these are:

Focus on **advanced services** specifically:

- Support active providers to increase their provision of advanced services by conducting more Medicines Use Reviews (MURs) up to their contracted limit and to increase uptake of New Medicines Service (NMS)

Develop **local services** commissioning:

- Continuously audit current activity at a local level to ensure that if gaps in provision develop a plan to address these gaps is developed
- Ensure that our commissioning intentions in relation to local services are reflected in the activity that we see from our community pharmacies
- Identify pharmacies that are successfully delivering multiple enhanced services and work with them to share best practice with other providers

This needs assessment provides a base from which commissioning plans for pharmacy can be developed which combine our local priorities with national strategy for community pharmacy services. The PNA will be used as a basis for 'control of entry regulations' so that NHS England is clear and transparent about where services may or may not be needed in the future. Therefore the PNA needs to be explicit about its gaps in service. It will be used in the development of local service provision alongside specific health strategies and plans.

However, there may be aspirations to develop local services but these need to be developed in a cost effective way and in light of current financial constraints.

PNA Conclusions

Access to pharmacies

- ***Overall access in terms of location, opening hours and services is considered to be adequate to meet the needs of the population of Halton***
- ***The PNA has not identified a current need for new NHS pharmaceutical service providers in Halton***

There is no simple way to determine this. As such a number of factors have been taken in to account including:

- Compared to the national average, Halton has a higher pharmacy: population ratio than the national average

- However, there is wide variation in the pharmacy–to-population ratio across wards, even taking town centre locations in to account. Any decisions regarding new pharmacies need to take the population-to-pharmacy ratio in to account. Conversely, any closures need to be carefully monitored to determine the impact this will have on access, especially, in those wards where the population-to-pharmacy ratio is already low
- There is a great deal of satisfaction with pharmacy services. Overall, members of the public find them accessible, friendly and helpful
- Members of the public commented that it is not always easy to access pharmacy services in the evening, i.e. after 6pm, and weekends
- The patient survey revealed that patients would like the option of getting hospital discharge and outpatient prescriptions filled at their local pharmacy
- Any decision to extend existing locally commissioned services or introduce new ones should initially be done by discussion with existing providers

Tobacco Control

- There is adequate provision for smoking cessation services across the borough. Pharmacies are a key component of this provision, with easy access, and this should be maintained

Healthy Weight

- Local weight management services give opportunities to receive practical instruction in healthy eating and physical activity as well as behaviour change support. It would not be possible for pharmacies to provide these practical sessions but there may be a role for them in terms of the ongoing behavioural support, with adequate training
- Promotion of healthy lifestyles forms part of the essential services within the community pharmacy contract through the 6 campaigns. Tackling obesity would be a key local issue for consideration
- Some pharmacies already weigh and measure patient's height and calculate BMI, offering information on how to eat more healthily and reduce their weight. This provides opportunities to share good practice in this area

Alcohol

- Pharmacies do not currently provide services to reduce alcohol consumption. Evidence of effectiveness for pharmacies role in conducting screening for unsafe levels of alcohol consumption and offering brief interventions is limited. What little there is indicates that, at this point in time, alcohol brief interventions should not be commissioned from community pharmacy. However, we need to keep abreast of new research and respond if this position needs to change
- Under the essential services contract pharmacies should support six health education campaigns per year. Community pharmacies are well placed to take part on local and national campaigns around alcohol misuse. As a local JHWBS priority this should be considered

Planned care

- There is generally adequate access to both NMS and MURs across the borough
- Monitoring the targeting of MURs in line with nationally defined target groups is carried out quarterly as part of the contractual data submission. Consideration of which other patients would most benefit from an MUR or NMS is also important

Unplanned/urgent care

- There is currently adequate access to the Minor Ailment Scheme, Care at the Chemist (CATC), including 100-hour evening and weekend provision. The formulary has been extended to include teething, colic, ear wax and nappy rash and the protocols in use are also due for review which will be done via a rolling programme.
- Cross-border collaboration between boroughs (Liverpool, St Helens and Knowsley) has ensured both access and choice
- Ways of improving awareness of CATC amongst key target groups continues to be investigated
- Influenza vaccination for at risk adults is now widely available through pharmacies across the borough and this has greatly increased accessibility. The primary provider of influenza vaccination remains General Practice

Managing and identifying long term conditions, including NHS Health Checks

- There is some evidence from the literature that pharmacies can play an important role in helping patients to manage long-term conditions, particularly cardiovascular disease. Pharmacies are able to offer checks for high blood pressure and blood sugar, signposting affected individuals into primary care for definitive management
- Under the essential services contract pharmacies should support six health education campaigns per year. This is led by NHS England and the content of the campaigns is open to local influence subject to consultation

Cancers

- There are currently no plans to commission services for the prevention of cancers in pharmacies. Specialist equipment and procedures mean it is not feasible for them to provide cancer screening services
- As part of the essential services contract, the use of the six health education campaigns should include at least one on cancers as a local HWB priority

Sexual Health: Emergency Hormonal Contraception (EHC)

- There is adequate provision of EHC in all areas with high levels of deprivation. There is less provision from community pharmacies in Riverside ward but there is community sexual health service provision at the Health Care Resource Centre and the Widnes Walk-in centre. There is c-card provision to pharmacies providing EHC

Mental Health

- Pharmacies are well placed to detect the early signs of mental health problems and could refer people in to the single point of access to mental health services and to participate in awareness raising campaigns
- Under the essential services contract pharmacies should support six health education campaigns per year. Community pharmacies are well placed to take part in local and

national campaigns around mental health. As a local JHWBS priority this should be considered

Substance misuse

- Provision of needle & syringe exchange is through the community drugs service. This provision is adequate. However, there is an ambition to recommence the pharmacy provision of this service
- There is adequate provision of supervised administration services provided by community pharmacies across the borough

Older people

- Influenza vaccination for at risk adults is now widely available through pharmacies across the borough and this has greatly increased accessibility. The primary provider of influenza vaccination remains General Practice

Antimicrobial Resistance

- Pharmacies have a key role to play in raising awareness of the importance of using antibiotics appropriately. As part of the essential services contract, the use of the six health education campaigns should include at least one on antibiotic use

Palliative Care

- This service provides convenient access and can only be provided by community pharmacy
- This service is primarily designed to provide access to infrequent and unpredictably required specialist drugs
- Given the changes that have taken place recently provision is adequate as it stands at the moment but the CCG will continue to review this on an ongoing basis

MAIN DOCUMENT

Key Findings

A Pharmaceutical Needs Assessment (PNA) forms part of the commissioning function for pharmacy services. It relates the current provision of pharmaceutical services to the characteristics of the local population and Health & Wellbeing Board priorities for improving health and wellbeing and reducing health inequalities in Halton.

The PNA addresses the following broad questions:

- What is the provision of pharmacy service to our population and is this adequate?
- How is the pharmacy contract utilised for the benefit of the population of Halton?
- How can community pharmacy through its nationally commissioned or locally commissioned services support us to deliver our priorities for health and wellbeing for the population of Halton?

The provision of pharmacy services within Halton in terms of location, opening hours and services provided is considered adequate, to meet the needs of the population.

As such this PNA has not identified a current need for new NHS pharmaceutical service providers in Halton.

This assessment is based on the following observations:

- Halton has an average of 26.9 pharmacies per 100,000 population. This compares to 21.5 per 100,000 for England as a whole and 26.0 per 100,000 across Cheshire & Merseyside
- It is possible to compare prescribing volume by converting total items prescribed in to a monthly prescribing rate per 1,000 population. In 2015/16 Halton CCG had a higher prescribing rate than England but was slightly lower than Cheshire & Merseyside and the North of England average
- The widespread availability of premises with consultation facilities in Halton means that our population has adequate access to such facilities
- There is adequate access to pharmacy services throughout the week, into the evening and at weekends across Halton. This takes into account needs in both Widnes and Runcorn. Where any specific service gaps develop these will be addressed initially through dialogue with existing contractors. Our existing network provides a comprehensive essential pharmaceutical service to our population
- There is adequate provision of locally commissioned services across our population. We will continue to work with our existing contractors to ensure that this provision continues to match the needs of our population and that any inequalities in activity which arise are addressed
- Feedback and information provided by patients, the public and other stakeholders consulted during the development of the PNA showed people feel the community pharmacies offer a valuable service, are convenient and staff are friendly and helpful

Developments which may precipitate the need for changes to pharmacy services

Any conclusions gained from this PNA need to take account of the fact that future developments, such as but not limited to, changes in population, changes in sources/numbers of prescriptions, may take place. This could influence the demand for pharmaceutical services. Hence this PNA is a 'dynamic' document.

Workload and demand in pharmacy is driven by two factors, changes to the population changes and to prescribing volume:

- Population growth and changing structure, which in Halton is predicted to be around 2% by 2024 (2015 Office for National Statistics mid-year population estimates). This is lower than the North West region which is projected to grow by 3.5% and nationally, which is projected to grow by 6.6%
- The change in population is not evenly distributed between the age groups; the 65+ population is estimated to see an increase of 25% over the 10 year period (6,100 more persons in age band). However, the 0-14 population is estimated to stay at a similar level between 2015 and 2024, and the 15-64 population will decrease by 3%. As a heavy user of health and social care, this 'ageing' of the population is especially important
- Nationally for 2015[2], 1,083.7 million prescription items were dispensed overall, a 1.8% increase (19.1 million items) on the previous year and a 50.5% increase (363.4 million items) on 2005. The average number of prescription items per head of the population in 2015 is 19.8, compared to 19.6 items in the previous year and 14.2 in 2005
- In 2015, the total net ingredient cost of prescriptions dispensed rose to £9.3 billion. In 2005 the total cost was £7.9 billion. The average cost per head of the population has risen to £169.14, which is the highest it has been during the past 11 years. In 2005 the average cost per head was £156.83. The average net ingredient cost per prescription item has increased from £8.32 in 2014 to £8.55 in 2015. In 2005 this figure was £11.02

The combined effects of population change and prescribing growth have a compounding effect on the workload of pharmacy. Halton pharmacies currently dispense more prescription items than the average for England. It is expected that growth in the future will continue as at a similar rate. Prescription volumes and service provision needs to be monitored to identify where demand is likely to exceed supply. Planned developments with our partners must also be monitored to ensure we continue to be able to respond to the needs of our population for pharmacy services.

Optimising pharmacy services

Table 1 summarises the services provided by community pharmacies across Halton.

Table 1: Summary assessment of services including gaps in provision

Service	Community Pharmacy only?	Current provision adequate	Other providers
Pharmacy essential service including dispensing	Yes	Yes	No
Pharmacy advanced services	Yes (except Influenza Vaccinations)	Yes	GPs (Influenza Vaccinations)
Minor Ailments -Care at the Chemist	Yes	Yes	
Stop smoking	No	Yes	GP and specialist service
Supervised administration of methadone (or similar medication)	Yes	Yes	Links to substance misuse services provided by CRI
Needle and syringe provision	No	Yes	CRI
Emergency Hormonal Contraceptives	No	Yes	GP, walk-in centres, community sexual health
On Demand Availability of Palliative Care Medicines	Yes	Yes	GP out of hours service

The PNA has also identified actions to optimise the potential of the pharmacy contract for our population, these are:

Focus on **advanced services** specifically:

- Support active providers to increase their provision of advanced services by conducting more Medicines Use Reviews (MURs) up to their contracted limit and to increase uptake of New Medicines Service (NMS).

Develop **local services** commissioning:

- Continuously audit current activity to ensure that if gaps in provision develop a plan to address these gaps is put in place
- Ensure that our commissioning intentions in relation to local services are reflected in the activity that we see from our community pharmacies
- Identify pharmacies that are successfully delivering multiple enhanced services and work with them to share best practice with other providers

This needs assessment provides a base from which a commissioning plans for pharmacy can be developed which combines our local priorities with national strategy for community pharmacy services. The PNA will be used as a basis for 'control of entry regulations' so that NHS England is clear and transparent about where services may or may not be needed in the future. Therefore the PNA needs to be explicit about its gaps in service. It will be used in the development of local service provision alongside specific health strategies and plans.

However, there may be aspirations to develop local services but these need to be developed in a cost effective way and in light of current financial constraints.

PNA Conclusions

Access to pharmacies

- ***Overall access in terms of location, opening hours and services is considered to be adequate to meet the needs of the population of Halton***
- ***The PNA has not identified a current need for new NHS pharmaceutical service providers in Halton***
    - Compared to the national average, Halton has a higher pharmacy: population ratio than the national average
    - However, there is wide variation in the pharmacy–to-population ratio across wards, even taking town centre locations in to account. Any decisions regarding new pharmacies need to take the population-to-pharmacy ratio in to account. Conversely, any closures need to be carefully monitored to determine the impact this will have on access, especially, in those wards where the population-to-pharmacy ratio is already low
    - There is a great deal of satisfaction with pharmacy services. Overall, members of the public find them accessible, friendly and helpful
    - Members of the public commented that it is not always easy to access pharmacy services in the evening, i.e. after 6pm, and weekends
    - The patient survey revealed that patients would like the option of getting hospital discharge and outpatient prescriptions filled at their local pharmacy
    - Any decision to extend existing locally commissioned services or introduce new ones should initially be done by discussion with existing providers

Tobacco Control

- There is adequate provision for smoking cessation services across the borough. Pharmacies are a key component of this provision, with easy access, and this should be maintained

Healthy Weight

- Local weight management services give opportunities to receive practical instruction in healthy eating and physical activity as well as behaviour change support. It would not be possible for pharmacies to provide these practical sessions but there may be a role for them in terms of the ongoing behavioural support, with adequate training
- Promotion of healthy lifestyles forms part of the essential services within the community pharmacy contract through the 6 campaigns. Tackling obesity would be a key local issue for consideration
- Some pharmacies already weigh and measure patient's height and calculate BMI, offering information on how to eat more healthily and reduce their weight. This provides opportunities to share good practice in this area

Alcohol

- Pharmacies do not currently provide services to reduce alcohol consumption. Evidence of effectiveness for pharmacies role in conducting screening for unsafe levels of alcohol consumption and offering brief interventions is limited. What little there is indicates that, at this point in time, alcohol brief interventions should not be commissioned from community pharmacy. However, we need to keep abreast of new research and respond if this position needs to change
- Under the essential services contract pharmacies should support six health education campaigns per year. Community pharmacies are well placed to take part in local and national campaigns around alcohol misuse. As a local JHWBS priority this should be considered

Planned care

- There is generally adequate access to both NMS and MURs across the borough
- Monitoring the targeting of MURs in line with nationally defined target groups is carried out quarterly as part of the contractual data submission. Consideration of which other patients would most benefit from an MUR or NMS is also important

Unplanned/urgent care

- There is currently adequate access to the Minor Ailment Scheme, Care at the Chemist (CATC), including 100-hour evening and weekend provision. The formulary has been extended to include teething, colic, ear wax and nappy rash and the protocols in use are also due for review which will be done via a rolling programme.
- Cross-border collaboration between boroughs (Liverpool, St Helens and Knowsley) has ensured both access and choice
- Ways of improving awareness of CATC amongst key target groups continues to be investigated

- Influenza vaccination for at risk adults is now widely available through pharmacies across the borough and this has greatly increased accessibility. The primary provider of influenza vaccination remains General Practice

Managing and identifying long term conditions, including NHS Health Checks and Hypertension

- There is some evidence from the literature that pharmacies can play an important role in helping patients to manage long-term conditions, particularly cardiovascular disease. Pharmacies are able to offer checks for high blood pressure and blood sugar, signposting affected individuals into primary care for definitive management
- Under the essential services contract pharmacies should support six health education campaigns per year. This is led by NHS England and the content of the campaigns is open to local influence subject to consultation

Cancers

- There are currently no plans to commission services for the prevention of cancers in pharmacies. Specialist equipment and procedures mean it is not feasible for them to provide cancer screening services
- As part of the essential services contract, the use of the six health education campaigns should include at least one on cancers as a local HWB priority

Sexual Health: Emergency Hormonal Contraception (EHC)

- There is adequate provision of EHC in all areas with high levels of deprivation. There is less provision from community pharmacies in Riverside ward but there is community sexual health service provision at the Health Care Resource Centre and the Widnes Walk-in centre. There is c-card provision to pharmacies providing EHC.

Mental Health

- Pharmacies are well placed to detect the early signs of mental health problems and could refer people in to the single point of access to mental health services and to participate in awareness raising campaigns
- Under the essential services contract pharmacies should support six health education campaigns per year. Community pharmacies are well placed to take part in local and national campaigns around mental health. As a local JHWBS priority this should be considered

Substance misuse

- Provision of needle & syringe exchange is through the community drugs service. This provision is adequate. However, there is an ambition to recommence the pharmacy provision of this service
- There is adequate provision of supervised administration services provided by community pharmacies across the borough

Older people

- Influenza vaccination for at risk adults is now widely available through pharmacies across the borough and this has greatly increased accessibility. The primary provider of influenza vaccination remains General Practice

Antimicrobial Resistance

- Pharmacies have a key role to play in raising awareness of the importance of using antibiotics appropriately. As part of the essential services contract, the use of the six health education campaigns should include at least one on antibiotic use

Palliative Care

- This service provides convenient access and can only be provided by community pharmacy
- This service is primarily designed to provide access to infrequent and unpredictably required specialist drugs
- Given the changes that have taken place recently provision is adequate as it stands at the moment but the CCG will continue to review this on an ongoing basis

1. Introduction and Purpose

The effective commissioning of accessible Primary Care Services is central to improving quality and implementing the vision for health and healthcare. Community Pharmacy is one of the most accessible healthcare settings. Nationally 99% of the population, including those living in the most deprived areas, can get to a pharmacy within 20 minutes by car. 96% of people living in the most deprived areas have access to a pharmacy either through walking or via public transport.

The Pharmaceutical Needs Assessment (PNA) presents a picture of community pharmacies and other providers of pharmaceutical services, reviewing services currently provided and how these could be utilised further. Community pharmacies can support the health and well-being of the population of Halton in partnership with other community services and GP practices. Services can be directed towards addressing health inequalities and supporting self-care in areas of greatest need. Mapping of service provision and identifying gaps in demand are essential to afford commissioners with the market intelligence they need to take forward appropriate and cost-effective commissioning of services.

The Health Act 2009 outlined the process of market entry onto a "Pharmaceutical List" by means of Pharmaceutical Needs Assessments and provided information to Primary Care Trusts for their production. It amended the National Health Service Act 2006 to include provisions for regulations to set out the minimum standards for PNAs. The regulations came into force on 24 May 2010 and

- required PCTs to develop and publish PNAs; and
- required them to use PNAs as the basis for determining market entry to NHS pharmaceutical services provision

Following the abolition of PCTs, this statutory responsibility has now been passed to Health and Well Being Boards (HWB) by virtue of the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, which came into force on 1st April 2013. These Regulations also outline the process that NHS England (NHSE) must comply with in dealing with applications for new pharmacies or changes to existing pharmacies.

The Health and Social Care Act 2012 further describes the duty of "commissioners", in accordance with Regulations, to arrange for the adequate provision and commissioning of pharmaceutical services for their population.

The PNA is thus a key tool, for NHS England and local commissioners, to support the decision making process for pharmacy applications and to ensure that commissioning intentions for services that could be delivered via community pharmacies, in addition to other providers, are incorporated into local planning cycles. Local commissioning priorities need to be driven by the Joint Strategic Needs Assessment (JSNA) of which the PNA is a key component.

See appendix 1 for policy context

2. Scope and Methodology

2.1. Scope of the PNA

The scope of the assessment of need must address the following principles:

- The safe and efficient supply of medicines
- Pharmaceutical care that provides quality healthcare and public health information and advice to all members of the population
- High quality pharmacy premises that increase capacity and improve access to primary care services and medicines
- Local enhanced services which increase access, choice and support self-care
- Locally commissioned enhanced pharmaceutical services that have the potential to reduce avoidable hospital admissions and reduce bed-days
- High quality pharmaceutical support to prescribers for clinical and cost-effective use of resources

2.2. Methodology and Data Analysis

Key principles of the PNA are:

- It is an iterative process involving patients, the public and key stake holders
- It is a developing, live document to be refreshed annually
- It continues to focus on identifying health needs which can be supported by pharmaceutical services and makes recommendations for the commissioning of those services
- It is developed through a multidisciplinary PNA Steering Group

Figure 1: PNA development process

Development of the Halton Health and Well Being Board's PNA has been initiated and overseen by the Public Health Evidence and Intelligence Team and a multi-professional steering group. The steering group consists of representatives from the following:

- Public Health (chair and officers)
- Community Pharmacy Contract leads from NHS England Cheshire & Merseyside
- Head of Medicines Management, NHS Halton Clinical Commissioning Group (CCG)

- Local Pharmaceutical Committee
- Healthwatch
- Halton and St Helens Voluntary and Community Action
- Halton Borough Council elected member, Portfolio holder for Health & Wellbeing

The content of the document is closely linked to the local JSNA and has been produced by means of a structured analysis and distillation of complex and comprehensive data sources in order to identify the following:

- the health and pharmaceutical needs of the population
- evidence of best practice in meeting need through community pharmacy services
- current local provision of pharmaceutical services, and subsequently
- gaps in provision of pharmaceutical services

The following information sources have been used for the purposes of this PNA:

- Joint Strategic Needs Assessment
- Joint Health & Wellbeing Strategy
- Census data
- Data on socio-economic circumstances of the local area
- Community pharmacy providers questionnaire
- Public pharmacy services questionnaire
- Core Strategy and Strategic Housing Land Assessment 2016

This PNA has undergone a formal 60 day consultation and relevant amendments have been made.

2.3 Consultation

A draft PNA was published 9am Wednesday 9 August 2017 inviting comments to be made prior to closing 5pm Wednesday 11 October 2017.

The draft document was distributed as follows:-

Community and Hospital Providers, All Local Pharmacies, Professional Bodies, NHS Bodies and Staff

- All 34 Community Pharmacies in Halton
- All 15 General Practices in Halton
- Bridgewater Community Healthcare NHS Foundation Trust
- North West Boroughs Healthcare NHS Foundation Trust
- Both main Hospital Trusts serving Halton population:
    - Warrington and Halton Hospitals NHS Foundation Trust
    - St Helens and Knowsley Teaching Hospitals NHS Trust

- Halton, St Helens and Knowsley Local Pharmaceutical Committee
- Mid Mersey Local Medical Committee
- Neighbouring Local Authority Health and Wellbeing Boards (or equivalent): St Helens, Warrington, Liverpool, Knowsley, Cheshire East, Cheshire West & Chester
- NHS England (NHSE)
- NHS Halton Clinical Commissioning Group (CCG)

Patients and Public

- Halton Healthwatch
- Voluntary Sector Groups via Halton and St Helens Voluntary and Community Action
- Patient Participation Groups in Primary Care via NHS Halton CCG

Full documentation was published on Halton Borough Council's website with an online facility to help readers make comments on the PNA. Respondents were offered paper copies of the PNA if required and they could also complete the survey using a copy of the questions supplied with the invitation letter. Written comments could therefore be made online, completion of the questionnaire electronically or print version sent back to the Public Health team.

Responses received during the consultation period can be found in Appendix 9.

2.4. PNA Review Process

The PNA will be reviewed as an integrated part of the annual commissioning cycle as well as when any changes to the pharmacy contractor list occurs. This action will be overseen by Halton Health and Well Being Board with input from the NHSE Pharmacy Contracts Group. The task is delegated to the Public Health Evidence & Intelligence Team and the multi-professional steering group who have developed the PNA. As a minimum the document will be checked once a year and updated with significant changes in the following areas:

- New pharmacy contracts
- Pharmacy closures
- Changes to pharmacy locations
- Pharmacy opening hours
- Local intelligence and significant issues relating to pharmacy enhanced service provision
- Appliance provision changes
- Significant changes in health need, housing developments or primary care service developments that may impact either complimentary or adversely on pharmacy based services
- Significant changes in workforce due to movement of local businesses/employers

Typically this would be in the form of issuing a Supplementary Statement, unless the changes were significant enough that a new PNA was warranted and did not form a disproportionate response to the level of change identified.

Successful applications for 'consolidations and mergers' as part of the revised pharmacy regulations would also necessitate the development of a supplementary statement. (See Appendix 1 Policy Context for details about this)

2.5 How to use the PNA

The PNA should be utilised as a service development tool in conjunction with the Joint Strategic Needs Assessment (JSNA) and the strategic plans from local commissioners. Mapping out current services and gaining a sense of future service needs will pinpoint the areas where the development of local pharmaceutical services may be necessary.

The PNA can be used by patients, current service providers, future service providers and commissioners alike in the following way:

- Maps and tables detailing specific services will mean patients can see where they can access a particular service
- Current service providers will be better able to understand the unmet needs of patients in their area and take steps to address this need
- Future service providers will be able to tailor their applications to be added to the pharmaceutical list to make sure that they provide the services most needed by the local community
- Commissioners will be able to move away from the 'one-size fits all approach' to make sure that pharmaceutical services are delivered in a targeted way
- NHSE will be in a better position to judge new applications to join the pharmaceutical list to make sure that patients receive quality services and adequate access without plurality of supply

2.6 Localities used for considering pharmaceutical services

Halton borough is split into 21 electoral wards. These are grouped into 7 Area Forums which comprise between one and four electoral wards. However, these are not used for developing universal public sector service provision. Halton has a natural physical divide in the form of the River Mersey with Widnes to the north and Runcorn to the south. However for the purpose of the PNA Halton was not split into localities as it is a geographically compact Unitary Authority. Where appropriate, information is presented at small geography level (ward, Super Output Area) to describe the health and wellbeing needs of local communities. In making a judgement of adequacy of provision, consideration has been given to provision in both Widnes and Runcorn. Spatial mapping of service provision against health need has been used throughout section 7 to assist in this decision making.

3. National Pharmaceutical Services Contract

All national NHS pharmaceutical service providers must comply with the contractual framework that was introduced in April 2005. The national framework is set out below and can be found in greater detail on the PSNC website:
http://www.psnc.org.uk/pages/introduction.html

The pharmaceutical services contract consists of three different levels:

- Essential services
- Advanced services

3.1. Essential Services and Prescription Volume

Consist of the following and have to be offered by all pharmacy contractors.

3.1.1. Dispensing - Supply of medicines or appliances, advice given to the patient about the medicines being dispensed and advice about possible interactions with other medicines. Also the recording of all medicines dispensed, significant advice provided, referrals and interventions made using a Patient Medication Record.

3.1.2. Prescriptions - During 2016/17 the GP practices in Halton issued a total of 2,847,044 individual prescription items with a further 49,287 items prescribed by other healthcare providers (total 2,896,331 individual prescription items). 92.7% of total prescription items *(2,683,819 items)* were dispensed by Halton pharmacies. 5% (*146,328)* were dispensed by pharmacies in bordering areas (boroughs in Cheshire & Merseyside). A further 1.15% (33,366*)* were dispensed nationwide.

3.1.3. Repeat dispensing - Management of repeat medication for up to one year, in partnership with the patient and prescriber. The patient will return to the pharmacy for repeat supplies, without first having to visit the GP surgery. Before each supply the pharmacy will ascertain the patient's need for a repeat supply of a particular medicine. The pharmacist will communicate all significant issues to the prescriber with suggestions on medication changes as appropriate.

3.1.4. Disposal of unwanted medicines - Pharmacies act as collection points for patient returned unwanted medicines from households and individuals. Special arrangements apply to Controlled Drugs (post Shipman Inquiry) and private arrangements must be adopted for waste returned from nursing homes.

3.1.5. Promotion of Healthy Lifestyles (Public Health) - Opportunistic one to one advice provided on healthy lifestyle topics such as smoking cessation, weight management etc. to certain patient groups who present prescriptions for dispensing. Also, involvement in local public health campaigns throughout the year, organised by the HWB and NHS England.

3.1.6. Signposting patients to other health care providers - Pharmacists and their staff will refer patients to other healthcare professions or care providers when appropriate.

3.1.7. Support for self-care - The provision of advice and support by pharmacy staff to enable patients to derive maximum benefit from caring for themselves or their families. The service will initially focus on self-limiting illness, but support for people with long term conditions is also a feature of the service.

3.1.8. Clinical Governance –pharmacists must ensure the following processes are in place:

- Use of standard operating procedures
- Patient safety incident reporting
- Demonstrating evidence of pharmacist Continuing Professional Development
- Operating a complaints procedure
- Compliance with Health and Safety legislation
- Compliance with the Disability Discrimination Act
- Significant event analysis
- Commitment to staff training, management and appraisals
- Undertaking patient satisfaction surveys

3.2. Advanced Services

There are six advanced services within the NHS community pharmacy contract. Community pharmacies can opt to provide any of these services as long as they meet the necessary requirements. These, together with full service specifications and funding details are available on the Pharmaceutical Service Negotiating Committee (PSNC) website http://psnc.org.uk/services-commissioning/advanced-services/

3.2.1. Medicines Use Review (MUR) & Prescription Intervention Service

This is an advanced service provided under the community pharmacy contractual framework. MURs can only be provided by pharmacies. The service includes MURs undertaken periodically or when there is a need to make an adherence-focused intervention due to a problem that is identified while providing the dispensing service (a prescription intervention MUR). The purpose of the MUR service is to improve patient knowledge, adherence and use of their medicines by:

- Establishing the patient's actual use, understanding and experience of taking medicines
- Identifying, discussing and resolving poor or ineffective use of medicines
- Identifying side effects and drug interactions that may affect adherence
- Improving the clinical and cost effectiveness of prescribed medicines and reducing medicine wastage

The pharmacist conducts a concordance medication review with the patient. The review assesses any problems with understanding current medication, its administration / patient compliance. The patient's knowledge of their medication regime is assessed and a report is provided to the patients GP. The MUR is conducted on a regular basis, e.g. every 12 months, or when pharmacist decides an intervention MUR is required. . MURs have to be conducted in a consultation area which ensures patient confidentiality and privacy. Pharmacists must successfully pass a competency assessment before they can provide MUR services. Each pharmacy can provide a maximum of 400 MURs per year unless there are particular local circumstances which merit additional MURs to take place. This must first be agreed with NHS England.

3.2.2. Appliance Use Review (AUR)

An Appliance Use Review was the second advanced service, introduced into the NHS community pharmacy contract April 2010. This service is similar to that above where it relates to patients prescribed appliances such as leg bags, catheters, and stoma products. This service can be provided by either a community pharmacy or appliance contractors and can be carried out by a pharmacist or a specialist nurse either at the contractor's premises or at the patient's home.

AURs should improve the patient's knowledge and use of any specified appliance by:

- Establishing the way the patient uses the appliance and the patient's experience of such use
- Identifying, discussing and assisting in the resolution of poor or ineffective use of the appliance by the patient
- Advising the patient on the safe and appropriate storage of the appliance
- Advising the patient on the safe and proper disposal of the appliances that are used or unwanted

3.2.3. Stoma appliance customisation (SAC) service

Stoma appliance customisation was the third advanced service introduced in April 2010. This service involves the customisation of a quantity of more than one stoma appliance, based on the patient's measurements or a template. The aim of the service is to ensure proper use and comfortable fitting of the stoma appliance and to improve how long they are used for, thereby reducing waste and unnecessary patient discomfort. This service can be provided by either pharmacy or appliance contractors.

3.2.4. New Medicines Service (NMS)

This service was introduced in October 2011. It can be provided by pharmacies only. It provides support with medicines adherence for patients being treated with new medicines in four conditions/therapy areas. These are Asthma / Chronic Obstructive Pulmonary Disease (COPD), Type 2 Diabetes, Hypertension and Antiplatelet / Anticoagulation therapy. The pharmacist provides face to face counselling about the medicine at the point when the patient first presents with their prescription at the pharmacy. Arrangements are then made for the patient to be seen 10-14 days later to assess adherence and discuss any problems with the new medicine. The patient is followed up 14 days later to check all is well at which point they exit this service.

3.2.5. NHS Influenza Vaccination Programme

As part of the community pharmacy funding settlement community pharmacies in England are now able to offer a seasonal influenza (flu) vaccination service for adults in at-risk groups. This includes:

- Pregnant women
- Those under age 65 with long-term conditions or who are immune-suppressed
- Anyone age over 65

The pharmacy service is not available for children who are eligible under the overarching NHS Influenza Vaccination Programme. They will continue to receive the vaccination through their usual primary care provision.

This service is the fifth Advanced Service in the English Community Pharmacy Contractual Framework (CPCF). Immunisation is one of the most successful and cost-effective health protection interventions and is a cornerstone of public health. High immunisation rates are key to preventing the spread of infectious disease, complications and possible early death among individuals and protecting the population's health. For most healthy people, influenza is an unpleasant but usually self-limiting disease. However those with underlying disease are at particular risk of severe illness if they catch it. .The aim of the seasonal influenza vaccination programme is to protect adults who are most at risk of serious illness or death should they develop influenza, by offering protection against the most prevalent strains of influenza virus

The service can be provided by any community pharmacy in England that fully meets the requirements for provision of the service and has notified NHS England of their intention to begin providing the service by completing a notification form on the NHS BSA website

3.2.6. NHS Urgent Medicines Supply Advanced Service (NUMSAS)

From 1st December 2016, community pharmacies across England have been able to register on the NHS Business Services Authority portal to provide the NHS Urgent Medicines Supply Advanced Service (NUMSAS) as part of a national pilot. The Service, which is commissioned by NHS England, will allow community pharmacies to supply a repeat medicine at NHS expense, following a referral from NHS111 and where the pharmacist identifies that the patient has an immediate need for the medicine and that it is impractical to obtain a prescription without undue delay.

Requests for medicines or appliances needed urgently account for about 2% of all completed NHS 111 calls.[iv] These calls normally default to a GP appointment to arrange an urgent prescription and as a result block access to GP appointments for patients with greater clinical need. Although requests for emergency repeat medication occur throughout the week, Saturdays generate the highest demand.

3.3. Enhanced Services

Are those commissioned, developed and negotiated locally based on the needs of the local population. Enhanced services are commissioned by NHSE either directly or on behalf of other organisations such as local authority public health teams or clinical commissioning groups. The PNA will inform the future commissioning need for these services. The term local enhanced services can only be used to describe services commissioned by NHSE.

3.4 Locally Commissioned Services

Under the current regulations, “locally commissioned services” may still be developed and negotiated based on the needs of the local population. These services can be commissioned from a pharmacy by the local authority public health teams (LAPHT), Clinical Commissioning Group (CCG) and NHS trusts. Both community NHS trusts and secondary care NHS trusts (hospital trusts) may commission services from community pharmacists. These services (under the older regulations) also used to be called “enhanced”.

It is possible for neighbouring organisations to commission similar services from pharmacies at differing remuneration rates or using different service specifications / patient group directions. This is because financial / commissioning arrangements for services are based on local negotiation and are dependent on available resources as well as local need. This does, however, lead to duplication of effort for commissioning staff and difficulties for locum pharmacists working across HWB /CCG boundaries. Wherever possible commissioners are advised to work together to eliminate such anomalies and provide continuity of patient care across local boundaries.

The continuity of local service provision is often difficult for contractors to achieve as individual pharmacists/locums who are accredited to provide these services may move around, thus gaps in service can appear, especially if training isn’t available for new staff. This should be addressed by both the contractors and commissioners, but may result in some of the information in this document

iv Based on NHS 111 data reported 2015/16.

relating to local service provision being subject to change. This should improve with self-declaration of competency.

Pharmacy based locally commissioned services will vary from area to area depending on needs but may include:

- Minor ailment management (usually commissioned by CCG)
- Hypertension screening (usually commissioned by CCG)
- Substance misuse medication services / Needle exchange scheme (usually commissioned by LAPHT)
- Palliative care services (usually commissioned by CCG)
- Emergency Hormonal Contraception service / Sexual health services (usually commissioned by LAPHT)
- Vascular screening (usually commissioned by LAPHT)
- Smoking cessation service (usually commissioned by LAPHT)

3.5. Funding the Pharmacy Contract

The essential and advanced services of the community pharmacy contract are funded from a national 'Pharmacy Global Sum' agreed between the PSNC and the Treasury. This is divided up and devolved to NHS England as a cash-limited budget which is then used to reimburse pharmaceutical service activity as per the Drug Tariff (www.drugtariff.com). Funding for locally commissioned services is identified and negotiated from commissioners own budgets.

3.6. Community Pharmacy Contract Monitoring

3.6.1. National Contract

NHSE requires all pharmaceutical service providers to meet the high standards expected by patients and the public. All Pharmacies are included within a programme of contract monitoring visits as independent providers of services provided under the national pharmacy contract. The delivery of any locally commissioned enhanced services is also scrutinized.

As stated within the NHS review 2008,[3] high quality care should be as safe and effective as possible, with patients treated with compassion, dignity and respect. As well as clinical quality and safety, quality means care that is personal to each individual. This statement is as meaningful to pharmacies as to other NHS service providers and is the principle that the NHSE adopts when carrying out the Community Pharmacy Contract Monitoring visits for essential, advanced services and locally commissioned enhanced services.

The community pharmacy contract assurance process follows a structured sequence of events including:

- A rolling programme of pre-arranged visits to pharmacies for observation of processes and procedures and a detailed interview with the pharmacist in charge and support staff
- Self-assessment declarations
- Scrutiny of payment submission processes
- Scrutiny of internal processes for confidential data management
- Recommendations for service development or improvement
- Structured action plan with set timescales for completion

In addition to the structured process outlined above, the NHSE will also take account of the voluntary submission of the findings from the annual community pharmacy patient questionnaire that is undertaken by the pharmacy contractor as well as any patient complaints relevant to pharmacy services. In cases where the professional standards of an individual pharmacist is found to fall below the expected level, the NHSE will work with the relevant professional regulatory body such as the General Pharmaceutical Council to ensure appropriate steps are taken to protect the public.

3.6.2. Locally Commissioned Public Health Services

Halton Borough Council has developed a Provider Assessment Process to support the commissioning of locally enhanced public health pharmacy services. The Council supports the local provision of:

- Emergency Hormonal Contraception (EHC)
- Nicotine Replacement Therapy (NRT)
- Intermediate Smoking Cessation Services
- Varenicline Initiation
- Supervised Consumption of Methadone
- Winter Flu Vaccination (Council Staff Only)
- Needle Exchange (Still in Development)

Pharmacies seeking to provide any of the above services need to register on the Councils electronic procurement system and complete a mandatory service questionnaire and quality questions to ensure that they meet the required minimum standards. They must also complete all of the relevant qualifications / training to deliver these services and submit a self-declaration of competency.

Services are monitored on a monthly basis using an electronic reporting tool and quality visits are conducted to premises on at least an annual basis.

3.6.3. Locally Commissioned CCG Services

NHS Halton CCG currently commissions two local services:

- Minor Ailments Service – Care at the Chemist
- On demand Access to Palliative Medicines
- Medicines to Support Admissions Avoidance (pilot)

Pharmacies seeking to provide any of the above services need to contact the Medicines Management Team at the CCG. They must also complete all of the relevant qualifications and/or training to deliver these services. Services are monitored on a regular basis using an electronic reporting tool or via monthly stock checks, communication with providers and feedback from patients and healthcare professionals. It is hoped that the CCG can work with the Local Authority Public Health team to review the monitoring process to ensure it is robust.

Via the Prime Ministers Challenge fund the CCG also worked with local pharmacies to pilot a number of additional services for the following:

- COPD Medicines Review Service
- Asthma Education in Schools
- Blood Pressure and Atrial Fibrillation Screening

These services have now ceased as of April 2017 but the evaluation and any learning is being used to assess how we can develop further services in the future, especially in relation to hypertension. The CCG is working with Public Health to jointly review how this can be developed and supported locally.

4. Overview of current providers of Pharmaceutical Services

4.1. Community Pharmacy Contractors

Community pharmacy contractors can be individuals who independently own one or two pharmacies or large multinational companies e.g. Lloyds, Boots, Sainsbury's etc. who may own many hundreds of pharmacies UK wide.

Halton has 34 "pharmacy contractors" who between them operate out of a total of 31 community pharmacy premises, plus 3 distance selling 'internet' pharmacies. The resident population of Halton is 126,528 (ONS[v] population estimate 2015) which equates to approximately one pharmacy for every 3,721 residents or 26.9 pharmacies per 100,000 population. This is the similar to the Cheshire & Merseyside rate (26) and better than the England rate of 21.5 pharmacies per 100,000 population.

Every pharmacy premise has to have a qualified pharmacist available throughout all of its contractual hours, to ensure services are available to patients. In general pharmacy services are provided free of charge, without an appointment, on a "walk–in" basis. Pharmacists dispense medicines and appliances as requested by "prescribers" via both NHS and private prescriptions.

In terms of the type of community pharmacies in our area there are:

25 - delivering a minimum of 40 hours service per week
6 - delivering a minimum of 100 hours service per week
3 - providing services via the internet or "distance selling"

Further details of community pharmacies operating in Halton can be found in Chapter 5 of this PNA, as well as in Appendix 3 & 4.

4.2. Dispensing Doctors

Dispensing Doctors services consist mainly of dispensing for those patients on their "dispensing list" who live in more remote rural areas. There are strict Regulations which stipulate when and to whom doctors can dispense. Halton **has no** dispensing doctor practices.

4.3. Appliance Contractors

These cannot supply medicines but are able to supply products such as dressings, stoma bags, catheters etc. Currently Halton **does not have** an appliance contractor physically located within its area, but patients can access services from appliance contractors registered in other areas.

4.4. Local Pharmaceutical Services (LPS)

This is an option that allows commissioners to contract locally for the provision of pharmaceutical and other services, including services not traditionally associated with pharmacy, within a single contract. Given different local priorities, LPS provides commissioners with the flexibility to commission services that address specific local needs which may include services not covered by the community pharmacy contractual framework. There are currently **no** LPS contracts in Halton.

v ONS = Office of National Statistics

4.5. Acute Hospital Pharmacy Services

There are 2 main Acute Hospital Trusts within Halton catchment area, namely St Helens & Knowsley Teaching Hospital NHS Trust and Warrington and Halton Hospital NHS Foundation Trust. Some Halton residents may also access services at the Countess of Chester Hospital NHS Foundation Trust. Hospital Trusts have Pharmacy Departments whose main responsibility is to dispense medications for use on the hospital wards for in- patients and during the out-patient clinics.

4.6. Mental Health Pharmacy Services

The population of Halton is served by the North West Boroughs Partnership NHS Foundation Trust. They employ pharmacists to provide clinical advice within their specialist areas and they also commission a "dispensing service" from a community pharmacy in order to dispense the necessary medications for their patients at the various clinics across the patch.

4.7. GP Out of Hours Services and Urgent Care Centres

There is currently **one** 'out of hours' service operating from two locations. The service also visits patients within their own homes if necessary. There are cross border arrangements with other Mersey CCGs that use the same provider to provide clinic appointments for patients who wish to be seen out of area. During normal pharmacy opening hours, patients attending these sites who subsequently require a medicine are provided with a prescription to take to a local community pharmacy. During evenings and part of the weekends, when pharmacy services may be more limited, patients may be provided with pre-packaged short courses of medication directly. By default this service operates a limited formulary and tends to provide medications needed for immediate, acute use e.g. course of antibiotics, or short term pain relief.

There are now two Urgent Care Centres in Halton that can see patients for urgent injuries or illnesses and will provide access to any medication deemed necessary as a result. Access to medication will be via a Patient Group Direction, Patient Specific Direction or via a prescription to take to their local pharmacy. This will depend on the nature of the problem and the medication required. Consideration is given to the availability of pharmacy services in the out of hours period, at weekends and bank holidays to ensure patients do not experience undue delay in accessing urgent treatment.

4.8. Bordering Services / Neighbouring Providers

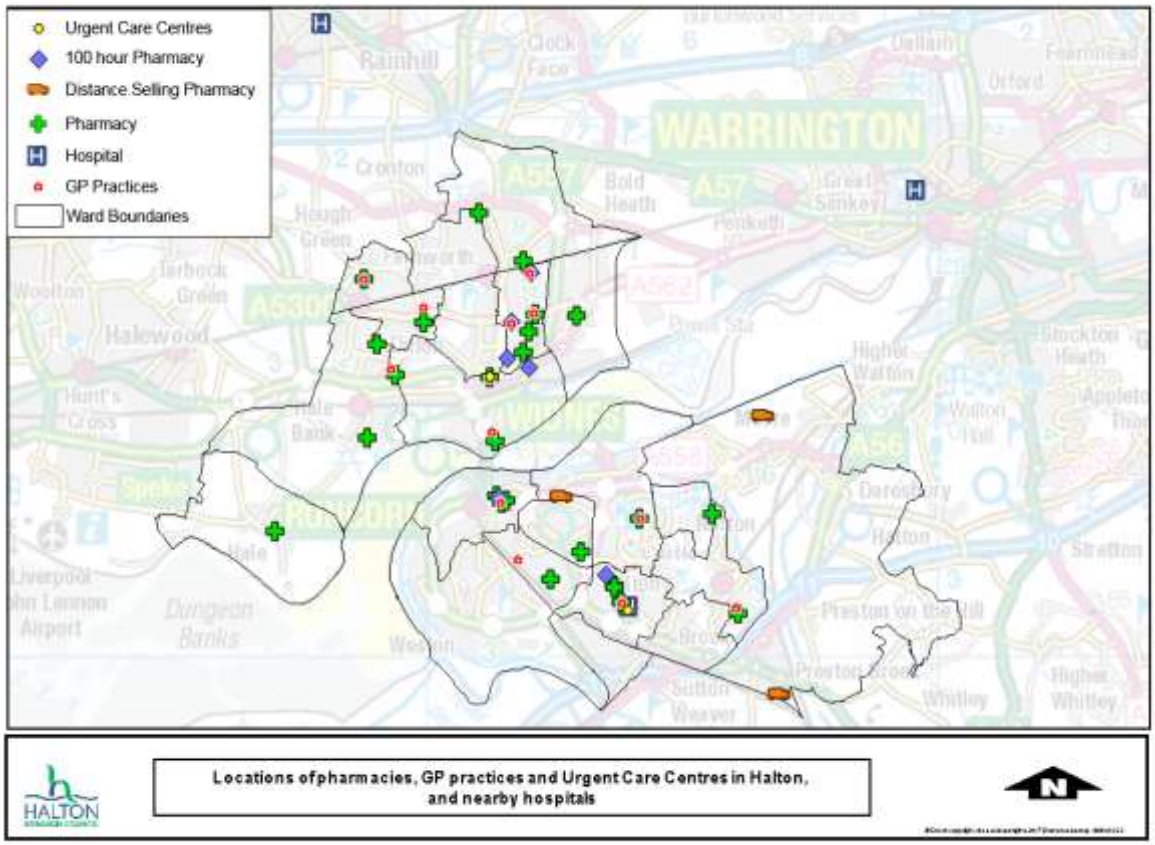
The population of Halton can access services from pharmaceutical providers not located within the Local Authority's own boundary. When hearing pharmacy contract applications or making local service commissioning decisions, the accessibility of services close to the borders will need to be taken into account. For further information on such services please refer to the relevant neighbouring Health and Well Being Boards own PNA.

5. Pharmacy Premises

5.1. Pharmacy locations and level of provision

As of November 2016 there are 31 pharmacies across Halton with a further 3 distance-selling 'internet only' pharmacies making a total of 34 pharmacies in Halton (see Map 1 and Appendix 3 for full list of community pharmacies). Nationally there are a total of 11,688 community pharmacies for a population of 54,786,327, giving an average of approximately one pharmacy for every 4,687 members of the population. Halton has one pharmacy for every 3,721 people (based on estimated resident population).

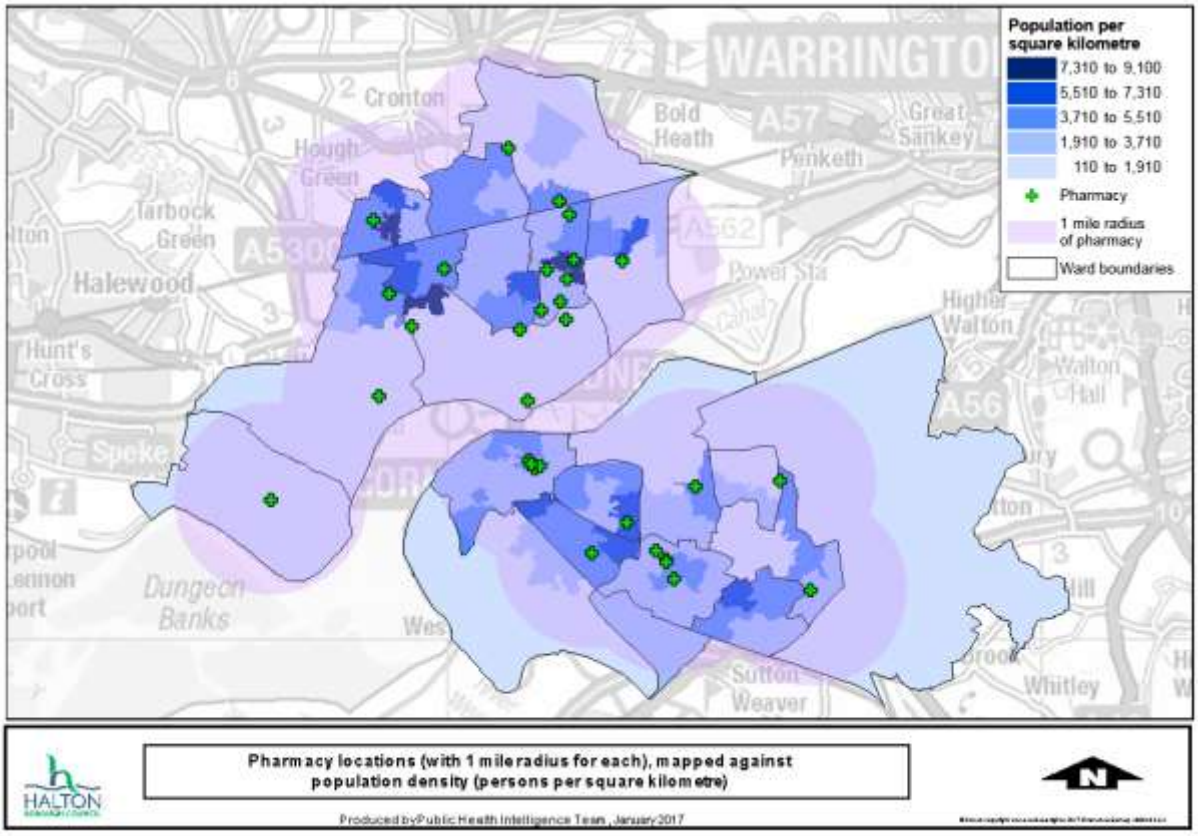
Map 1: Location of pharmacies in Halton mapped against other health services



There are 13 pharmacies in Runcorn and 18 in Widnes. This is excluding the three distance selling pharmacies which have their office base in Runcorn, on its industrial estates.

Map 2 shows that in all areas of high population density there is pharmacy provision within an 'as the crow flies' one mile distance. Only areas with the lowest population density have to travel more than one mile. (This map excludes the distance selling pharmacies).

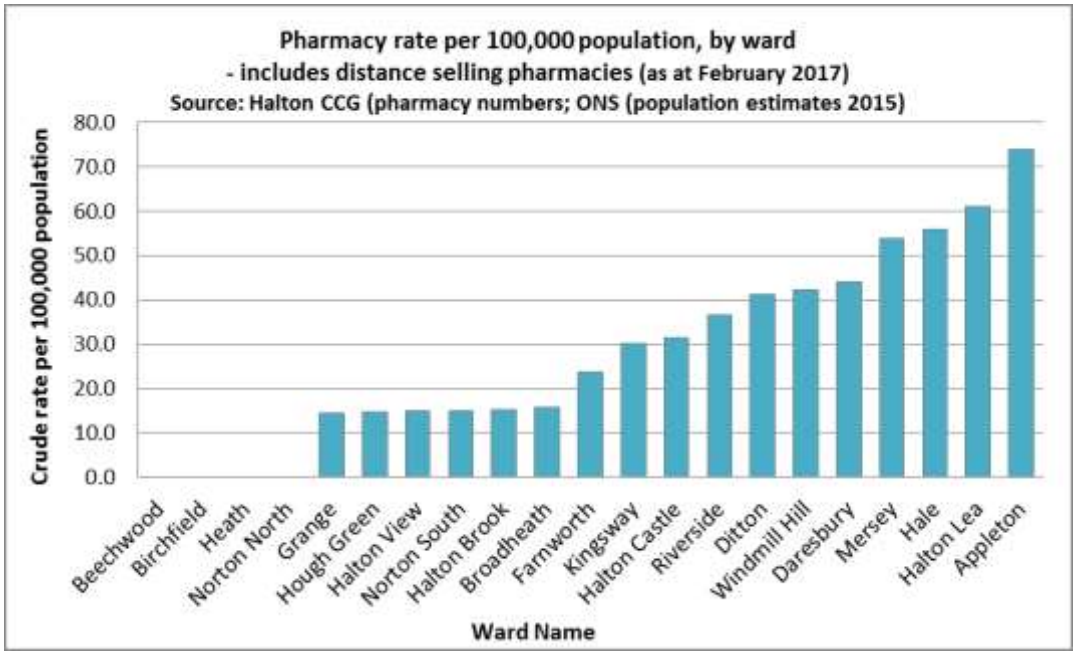
Map 2: Pharmacy location mapped against population density



Halton has a larger number of pharmacies in relation to the size of its population (26.9 per 100,000) when compared to the England (21.5 per 100,000). It also has a slightly larger number compared to Cheshire & Merseyside (26 per 100,000) and the North of England (24.4 per 100,000 population).

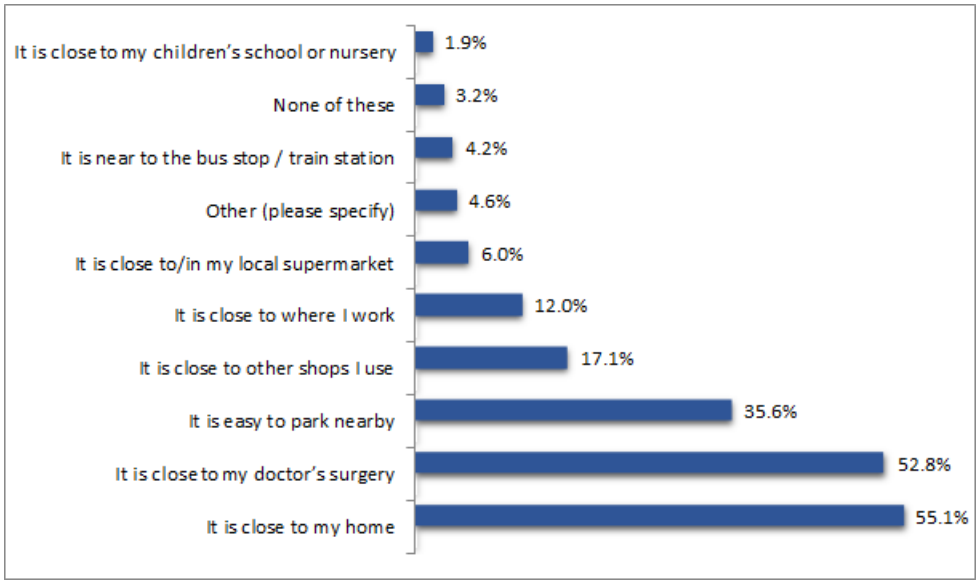
However, as Figure 2 shows this value ranges widely across the borough when analysed in terms of pharmacies per 100,000 population at electoral ward level. In several wards there are no pharmacies, while in others there are several (see Map 1). The three electoral wards containing the highest concentration of pharmacies are in the retail centres, Widnes Town Centre (Appleton ward), Halton Lea and Runcorn Old Town (Mersey ward). The high rate in Hale is more a reflection of the small population as it only has one pharmacy.

Figure 2: Crude rate of pharmacies in Halton wards per 100,000 population



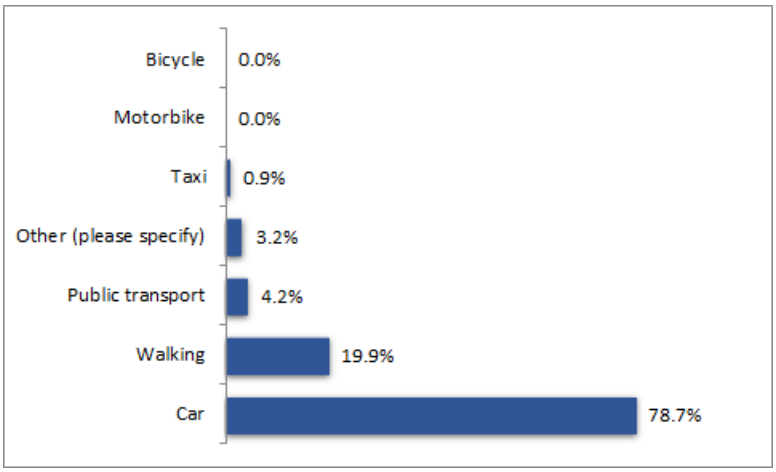
In the public survey of community pharmacy services 55% stated the most important reason for choosing the pharmacy they regularly use was that it was close to their home, with just under 53% stating they chose it because it was close to their doctor's surgery.

Figure 3: importance of location, question 5 of public survey of community pharmacy services, 2017



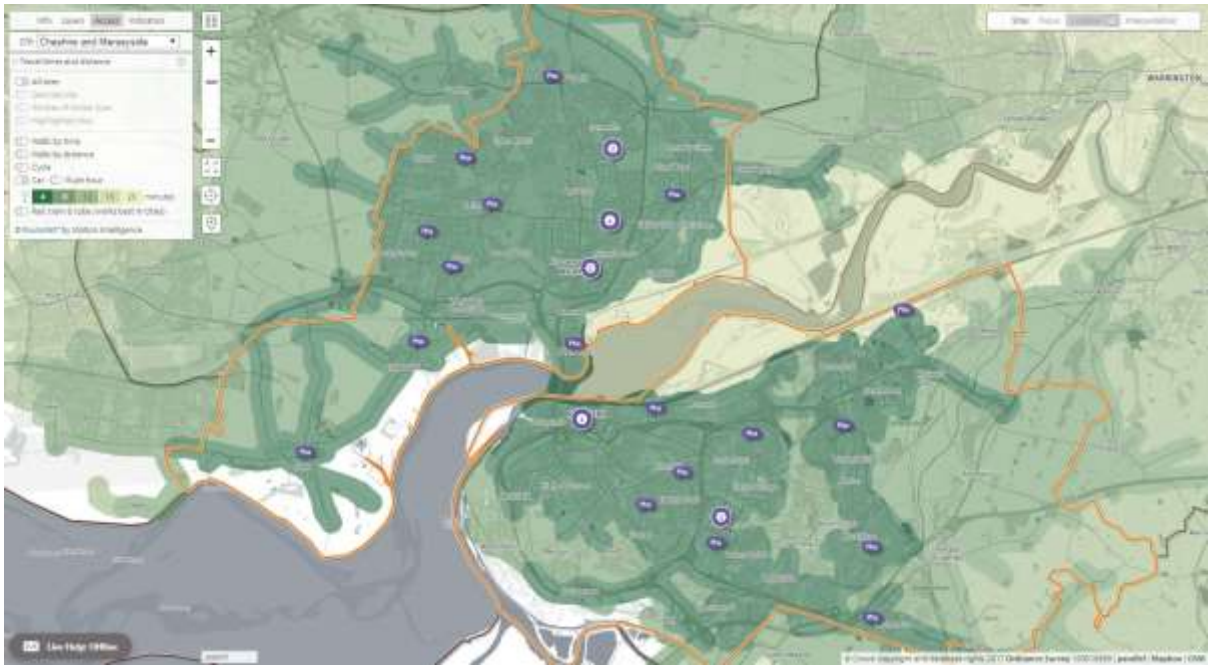
Respondents to the community pharmacy services survey were also asked how they got to the pharmacy. For the 2014 PNA 76% of people responded that they used the car and 26% that they walked. However, car usage has continued to increase and the percentage walking decrease to nearly 80% and 20% respectively. Only a small number of respondents used other forms of transport.

Figure 4: method used to get to the pharmacy, Q2 of public survey of community pharmacy services 2014

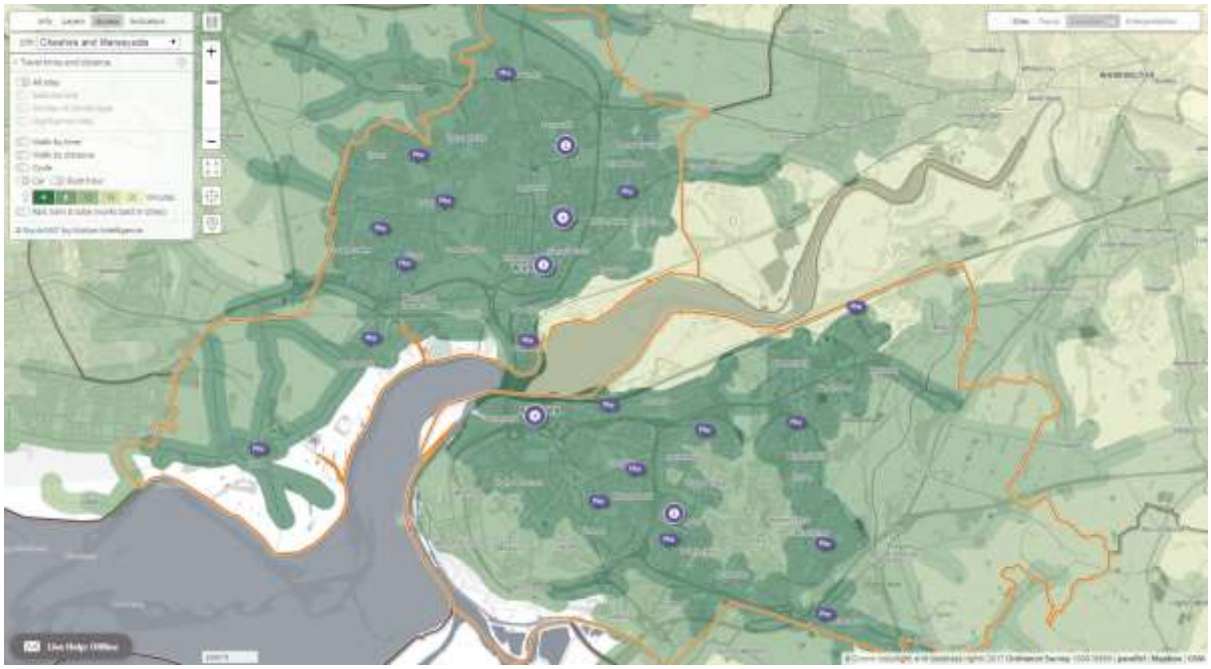


Mapping drive times during the day and during rush hour shows that no location in Halton is more than a 20 minute drive from a pharmacy.

Map 3: Drive times during the day

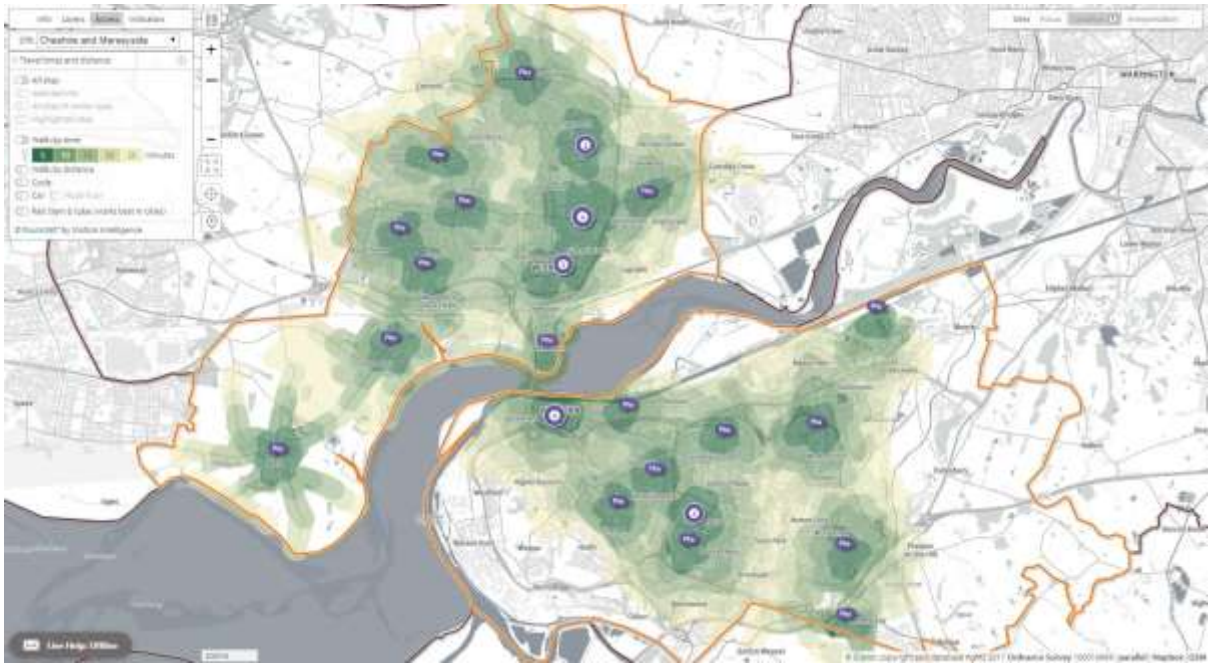


Map 4: drive times during rush hour



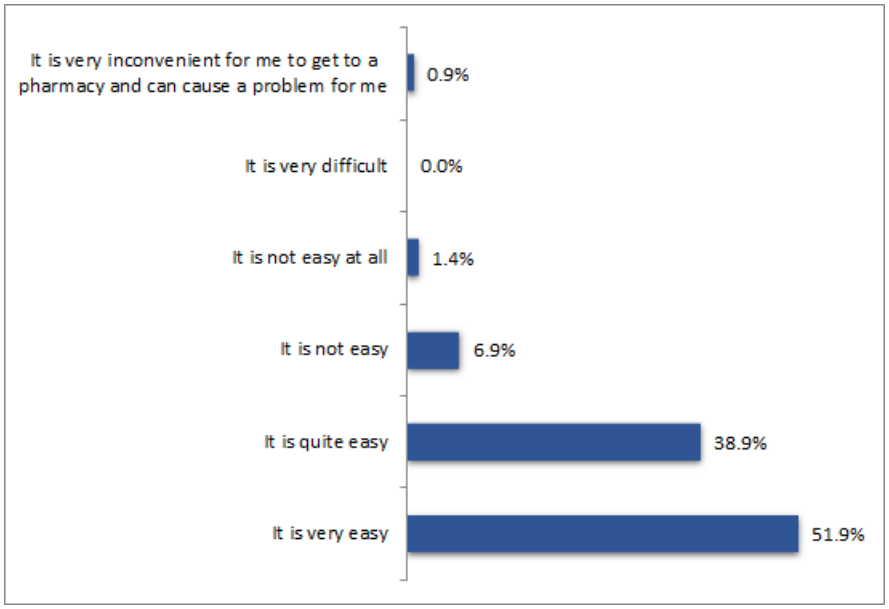
For those choosing to walk (about 20% of respondents to the public survey indicated they use this mode of transport), accessibility is slightly more limited. Access is easier in Widnes than Runcorn, with some areas being more than a 25 minute walk away from the nearest pharmacy (note these are predominantly areas without GP practices as well). These areas are no more than a 12-16 minute drive away even in rush hour times.

Map 5: walking times to community pharmacies



It is not surprising therefore that the majority of respondents to the public survey stated that it was very easy (39%) or quite easy (47%) to get to the pharmacy.

Figure 5: ease of access usual pharmacy, 2014 public survey of community pharmacy services



Conclusion
• All of this information, used together, means that access is adequate • This PNA has not identified a current need for new NHS pharmaceutical service providers in Halton.

5.2. Pharmacy opening hours, including 100 hour pharmacies and distance selling pharmacies

Under the new contract community pharmacies must be open for a minimum of 40 hours each week but they are free to set their own hours of opening as long as this minimum is provided. Half of the pharmacies are open for less than 50 hours per week. Ten pharmacies are open for 50 hours or more per week but less than 100 hours. The pharmacies that have extended opening hours are located in areas with good transport links. There are six 100-hour pharmacies which are open to the public for essential services. Full details of each pharmacy opening can be found in Appendix 3. There are 3 distance selling, 'internet only' pharmacies, and one of these is open for over 100 hours. These are not open to the public for essential services. The location of 100-hour and internet only pharmacies is shown in Map 1.

87% of respondents to the public survey of community pharmacy services said they were satisfied with the opening hours of their pharmacy. However, of those who included comments the most common related to availability of late night and weekend opening, especially how this created difficulties for those working full-time.

5.3. 100 hour and internet-based/mail order pharmacy provision

Of the six 100 hour pharmacies, 4 are in Widnes and 2 in Runcorn. They are identified on Map 1 by a blue marker. The three distance selling pharmacies are all located in industrial parks in Runcorn. They are identified on Map 1 by an orange marker. Further details of opening hours and locations of 100 hour and distance selling pharmacies can be found in Appendix 3.

5.4. Access for people with a disability and/or mobility problem

The majority of pharmacies with consultation areas have wheelchair access or are able to make provision for consultations and MURs for anyone confined to a wheelchair. In respect of people with mobility problems, all of the 31 pharmacies (excluding distance selling) have parking provision within 50 metres of the pharmacy. Twenty five out of the 31 pharmacies also have disabled parking available. The majority of pharmacies (26 out of 31 excluding distance selling) also have an entrance which is suitable for wheelchair access unaided.

A question on access for people with mobility problems was included in the public survey. 71% said this was not applicable to them, 21.9% said yes they were able to park close enough to the pharmacy for their needs, with 7% saying that they could not park close enough.

Additionally, Disabled GO, the UK leading source of information on access has independently assessed 24 of Halton's 31 community pharmacies. Information is gathered by sending a surveyor to visit each venue. Every venue on their website is contacted each year to find out if their access has changed. A venue owner or customer can contact them at any time to inform of changes to venues. They use 19 access criteria which have been designed in consultation with disabled people and represent important information that disabled people want to know about public venues.[vi]

vi. how we assess some of the key access features and key terms used in the access guides please click here.

- 19 of the 24 assessed have ramp/slope access to either manual or automatic doors
- 23 out of 24 have Mobility Impaired Walker status. This means the entrance to the building has no more than three medium steps. If there is more than one step a handrail must be provided. Internal level changes can be overcome by moderate/easy ramps and/or lifts
- All have seating available
- 15 out of 24 have hearing systems, meaning a sound enhancement system is available at certain locations within the premises

In respect of parking Disabled GO use a star system to designate the level of disabled access available:

12 out of 24 assessed were given Parking 3 stars: This is given when the venue has its own car park for use by patrons. This symbol will also be applied for venues within for example a shopping centre/retail park served by a car park belonging to the shopping centre/retail park as a whole.

3 out of 24 assessed were given Parking 2 stars: Blue Badge on street parking available. This is given if there is on street Blue Badge parking in the immediate vicinity of the venue or:

- The venue can provide parking if booked in advance to Blue Badge holders
- This last point could refer to a venue which has a car park for staff only but are happy to reserve a space for a Blue Badge holder
- All local parking restrictions should be checked before visiting the venue

5 out of 24 assessed were given Parking 1 star: This is given when there is a public car park near to the venue. This symbol indicates that there is a public car park within approximately 200 metres of the venue. This will refer to car parks such as NCP or council car parks.

3 out of 24 assessed were given no Parking stars

5.5. Access for clients whose first language is not English

In the contractor survey 11 out of the 34 pharmacies advised that they had a pharmacist or other member of staff who could speak at least one language in addition to English. This is an increase since the 2015-2018 PNA when only 7 pharmacies had this. The languages listed were Spanish, French, Chinese, Kurdish, Turkish, Arabic, Gujarati, Punjabi, Hindi and Urdu, with some pharmacies having more than one non-English language spoken. Only one said they did not use/have access to interpreting/language line services.

5.6. Pharmacy consulting rooms

In the contractor survey all pharmacies they were asked:

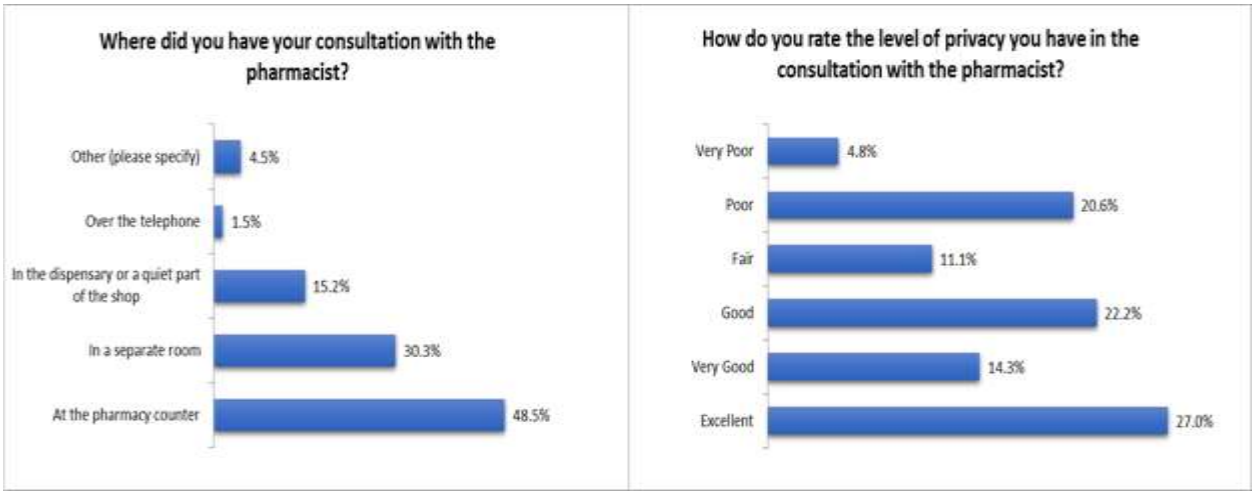
> *Is there a consultation area available that meets the criteria for Medicine Use Reviews where a patient and pharmacist can sit down together, talk at a normal speaking volume without being over heard by customers or staff and is clearly signed as private consultation?*

This question was asked irrespective of their answer to the question about whether they were commissioned to provide MURs as patients may wish to discuss other matters in a private, quiet space. All pharmacies now have this facility. All but one provides MURs and all but one provides NMS. Handwashing facilities were in the consulting room or close to it in 22 out of the 31 community pharmacies and 8 have toilet facilities. 7 are willing to undertake consultations in patients own homes or other suitable sites.

32.6% of respondents to the public survey had had a consultation with their pharmacist within the last 12 months, with 48.5% of consultations being undertaken at the pharmacy counter. 15.2% were conducted in the dispensary, or a quiet part of the shop and 30% of consultations where undertaken in a consultation room. This was a reduction in the percentage since the previous PNA when 43% of consultations occurred in a separate room. No question was asked about whether people had been offered the option of going to a private room.

55.6% of people found privacy levels excellent, very good or good, whilst 36.2% of people rated privacy levels between fair, poor or very poor. This is a reduction from the previous PNA were 69% of respondents rated privacy during consultation with a pharmacist positively and 32% rating in negatively.

Figure 6: consultations and satisfaction with privacy during them, 2014 public survey

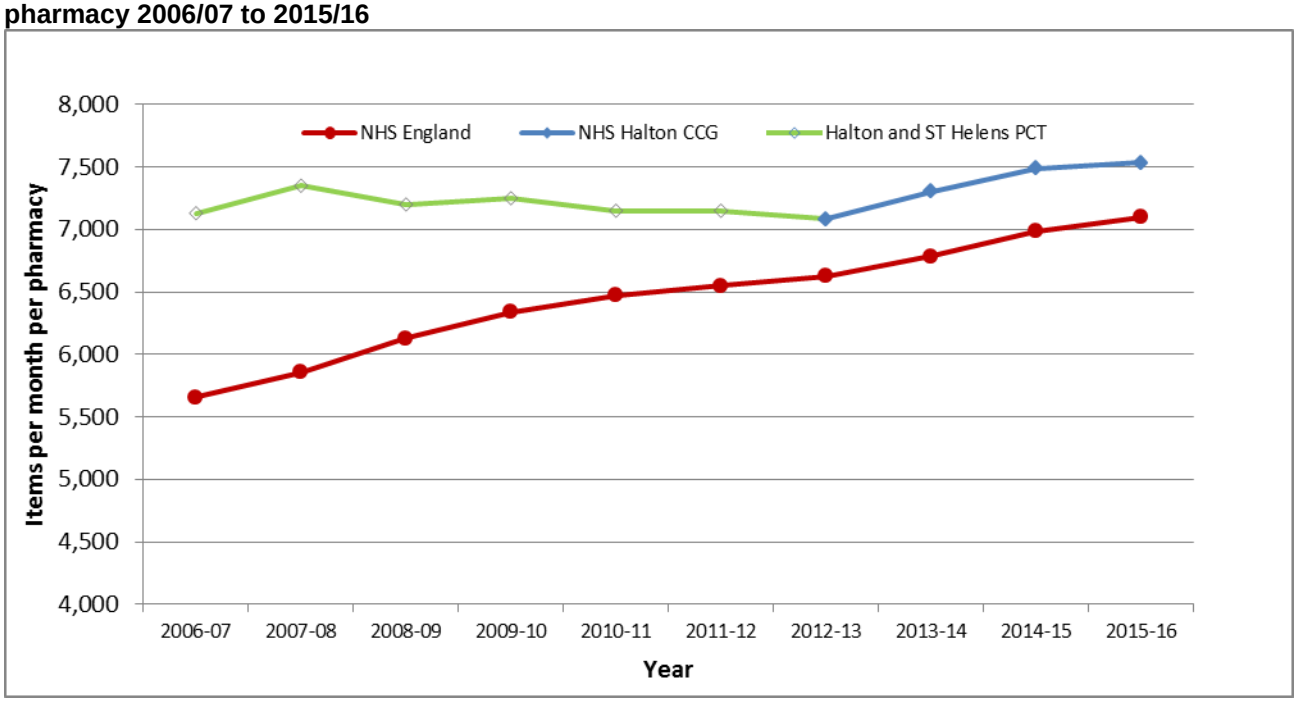


5.7. Prescribing

Benchmarking data is available from NHS Digital (formerly called the Health & Social Care Information Centre). However, trend data is only available at NHS Halton CCG level data from 2012/13. Data prior to 2012/13 is Halton and St Helens PCT. It is nevertheless useful to be able to analyse Halton prescribing against England data.

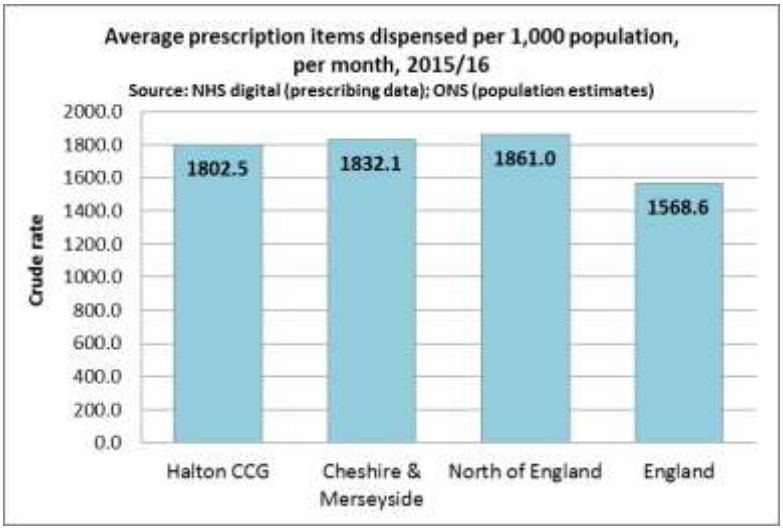
Figure 7 shows that Halton, as Halton & St Helens PCT up to 2012/13 then as NHS Halton CCG, community pharmacy dispensing volume pattern was consistently above NHS England levels when looking at average items dispensed per month, per pharmacy for the time period 2006/07 to 2015/16.

Figure 7: Average number of prescription items dispensed per month per community pharmacy 2006/07 to 2015/16



Further analysis of prescribing levels within Halton CCG, as a crude rate per 1,000 population, per month of prescriptions dispensed between 1 April 2015 and 31 March 2016 has been calculated. It shows that whilst Halton prescribing rate is above the England average it is slightly below the North of England and Cheshire & Merseyside levels.

Figure 8: Prescribing rate per month, 2015/16



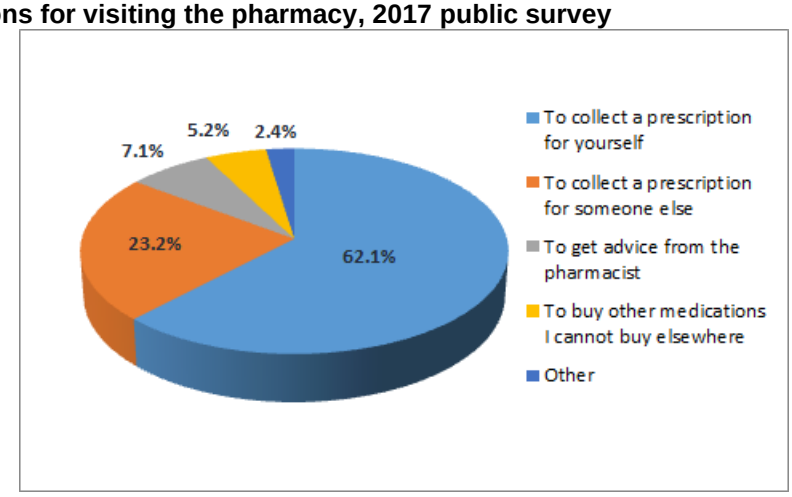
In terms of the types of diseases and conditions, drugs prescribed for cardiovascular disease accounts for the largest single cause, followed by conditions of the central nervous system. Together these accounted for just under half of all prescription items dispensed during 2015/16. The percentages are broadly similar to those seen across Cheshire & Merseyside and England as a whole, as Table 2 shows.

Table 2: Items dispensed by Halton CCG, NW CCG's and England during 2015/16, by Chapter (type of prescription)

	Halton		Cheshire & Merseyside		England		Diff in % from Halton	
Chapter Name	Items	%	Items	%	Items	%	C&M	England
Cardiovascular System	777,125	27.7%	16,083,274	28.5%	316,137,791	29.5%	0.8%	1.7%
Central Nervous System	577,474	20.6%	11,146,696	19.8%	199,597,238	18.6%	-0.8%	-2.0%
Gastro-Intestinal System	270,543	9.6%	5,456,260	9.7%	95,478,603	8.9%	0.0%	-0.8%
Endocrine System	240,842	8.6%	4,843,914	8.6%	103,393,012	9.6%	0.0%	1.0%
Respiratory System	214,203	7.6%	4,065,354	7.2%	70,421,889	6.6%	-0.4%	-1.1%
Nutrition And Blood	152,318	5.4%	3,226,850	5.7%	55,669,864	5.2%	0.3%	-0.2%
Infections	113,663	4.1%	2,157,660	3.8%	41,370,446	3.9%	-0.2%	-0.2%
Skin	98,752	3.5%	2,014,369	3.6%	38,377,652	3.6%	0.1%	0.1%
Musculoskeletal & Joint Diseases	88,917	3.2%	1,700,500	3.0%	33,290,091	3.1%	-0.2%	-0.1%
Obstetrics,Gynae+Urinary Tract Disorders	61,824	2.2%	1,322,164	2.3%	28,204,302	2.6%	0.1%	0.4%
Appliances	48,386	1.7%	1,015,446	1.8%	22,791,311	2.1%	0.1%	0.4%
Eye	41,393	1.5%	953,203	1.7%	20,022,108	1.9%	0.2%	0.4%
Immunological Products & Vaccines	31,843	1.1%	657,485	1.2%	13,785,818	1.3%	0.0%	0.1%
Ear, Nose And Oropharynx	28,233	1.0%	609,581	1.1%	11,791,558	1.1%	0.1%	0.1%
Dressings	20,580	0.7%	361,438	0.6%	8,495,245	0.8%	-0.1%	0.1%
Stoma Appliances	15,669	0.6%	279,395	0.5%	5,225,951	0.5%	-0.1%	-0.1%
Malignant Disease & Immunosuppression	10,063	0.4%	204,200	0.4%	4,300,867	0.4%	0.0%	0.0%
Incontinence Appliances	4,622	0.2%	92,208	0.2%	1,973,821	0.2%	0.0%	0.0%
Anaesthesia	4,227	0.2%	93,751	0.2%	1,652,832	0.2%	0.0%	0.0%
Other Drugs And Preparations	3,748	0.1%	67,365	0.1%	1,185,416	0.1%	0.0%	0.0%
Preparations used in Diagnosis	0	0.0%	0	0.0%	61	0.0%	0.0%	0.0%
Total	**2,804,425**		**56,351,113**		**1,073,165,876**			

The majority of people using the pharmacy get a prescription as the 2017 public survey shows, 2 out of 3 doing so within the month prior to completing the survey.

Figure 9: Reasons for visiting the pharmacy, 2017 public survey



66% of people were informed of how long it would take to have their prescription filled. 15% were not told and would have liked to have been with 16% not told but stated that they did not mind this. 83% of people said that they thought they waited for a reasonable period of time for their medicines.

81% percent of people surveyed, stated that they got all the medicines they needed, however, 18% stated that they did not.

58.8% of people stated that the reason for not receiving their entire prescription was because 'The pharmacy had run out of my medicine'. Of the remainder the most common reason was that the

prescription had not arrived at the pharmacy when they went to collect it (14.5%) with 5.9% of respondents stating their doctor had not prescribed something they wanted.

When people had not received all the items prescribed, 9.4% got them later the same day, 34.4% of people received their medicines the day after, with the majority, 81%, receiving it within two or more days. However, 18.8% had waited over a week. Unfortunately, there is no way to determine the impact of these longer waiting periods on the patient, or whether this was measured at the pharmacy and alternative arrangements discussed.

66.3% of people stated that they would like to be able have their hospital prescription dispensed at their local chemist, while 7.2% said 'No'. 26.5% had never used a hospital pharmacy.

5.8. Prescription Delivery Services

Although community pharmacies are not contracted to do so, 28 out of 34 offer a Home Delivery Service free of charge. This service improves access to medicines for a wide range of people. 42% of public survey respondents said the pharmacy they use offers a delivery service, 7.1% said they did not but 50.9% were either not aware of the service or had never used it. The delivery of medication is a service valued by local residents, as determined by responses to the 2017 pharmacy services survey.

5.9. Monitored Dosage Systems

A monitored dosage system (MDS), usually in the form of a box or a blister pack divided into days of the week, is a medication storage device designed to simplify the administration of solid oral dose medication. As such they are one way of overcoming unintentional non-adherence to medication. Prime candidates for MDS are patients at risk of confusing their medication, including those whose ability to manage their medication is affected by disability or their living arrangements or who have multiple medication.[4] If patients have significantly impaired mental self-care abilities, MDS dispensing is likely to be of little help to them.[5][6]

However, filling MDS is a time-consuming process. The 28 day packs may increase the likelihood of confusion and mistakes by patients when presented with four separate MDS packs at a time.[7] Any changes to the patient's prescription within the 28 days may result in substantial waste. There is the possibility that increases in dispensing errors may result from the required repackaging of medicines.

- 28 out of 31 community pharmacies provide MDS free of charge
- 8 out of 31 community pharmacies provide MDS at a charge
- 10 out of 31 community pharmacies provide MDS free only to patients who have a disability (as defined by the Disability Discrimination Act)

5.10. Patient & Public satisfaction with pharmacy services

As per the previous public survey, the vast majority of people were very satisfied with the services they received. Convenience, expertise and friendly, helpful staff were the most commonly cited things people valued when they visited the community pharmacy. Being able to get advice on minor ailments quickly without visiting the GP, handling of repeat prescriptions and the delivery service were also valued. Typical respondent views can be summed up by one respondent who stated:

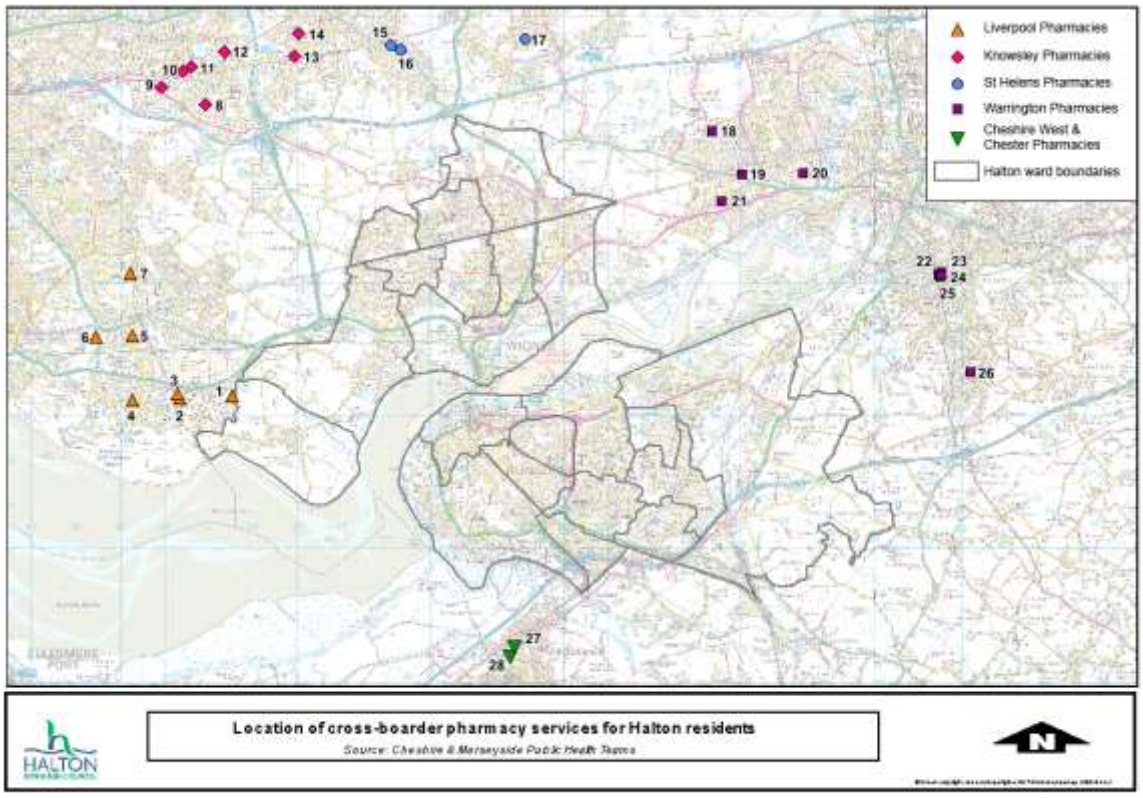
'Your local pharmacy where you know the staff there and are a friendly community local business. Very personal touch.'

72.7% of respondents to the pharmacy services survey 2017 were satisfied with the range of services pharmacies provide and 23% stated that they wished pharmacies could provide more services for them.

5.11. Access to and provision of community pharmacy services in local authorities bordering Halton

The framework for this PNA has been based largely on the 2015 PNA, which was a collaborative process across Cheshire & Merseyside. Halton has geographic borders with a number of local authorities, namely Liverpool, St. Helens, Knowsley, Warrington, Cheshire East, and Cheshire West & Chester. This approach facilitated the identification of pharmaceutical services along the borders of neighbouring boroughs that Halton's population may access. For example, a pharmacy in a neighbouring borough may be closer to a resident's home or place of work although they are registered for NHS Services with GP practices in Halton. Map 6 shows the locations of these cross border pharmacies. The numbers in Map 6 below correspond to the list of pharmacies in Appendix 5.

Map 6: Pharmacies in other boroughs most likely to be used by Halton residents



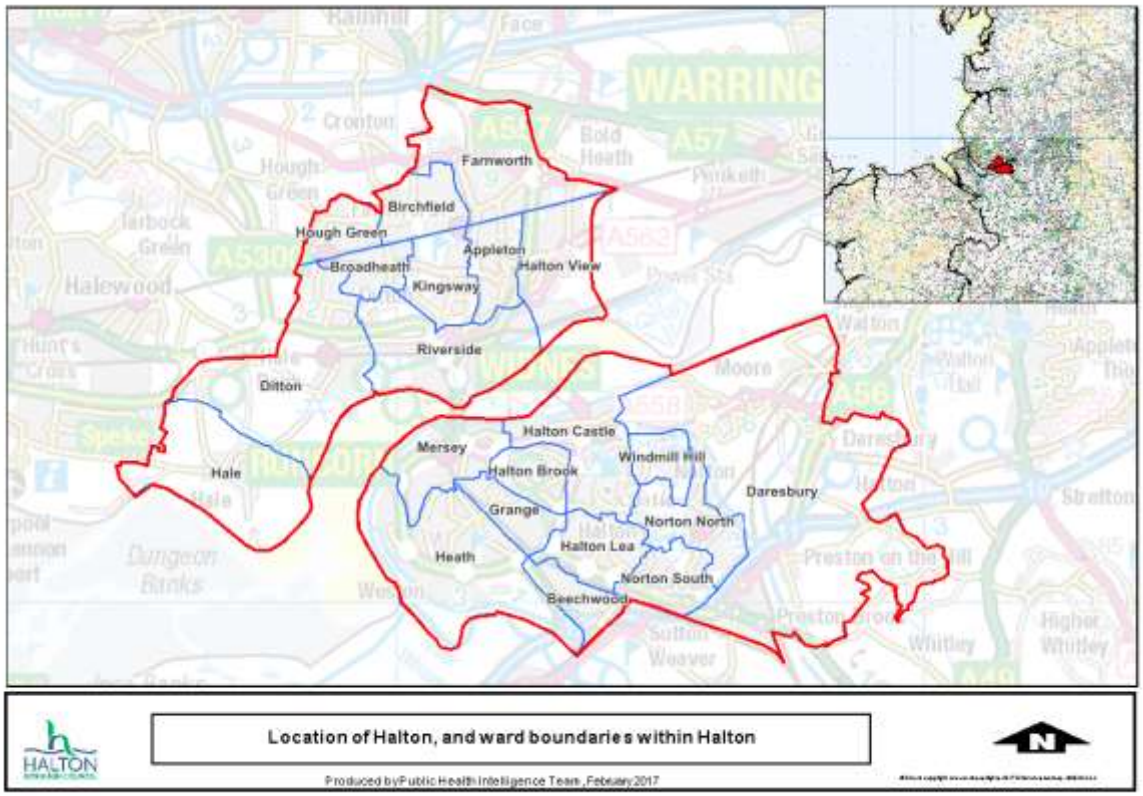
Analysis of the information supplied identified that there is adequate service provision on the borders of Liverpool, St. Helens, Knowsley, Warrington and Cheshire West & Chester. A list of the pharmacies together with their opening times is available in Appendix 5. There is also good access to pharmacies with several open at weekends and at least one on a Sunday. Most pharmacies have a consultation room and the majority provide MURs. Cross-border collaboration between Halton and the boroughs of Liverpool, St Helens and Knowsley has increased both access and choice to Care at the Chemist (CATC) minor ailments scheme.

6. Population and Health Profile of Halton

6.1. Location

Halton is made up of the towns of Runcorn and Widnes, located on the Mersey estuary. It has a legacy of chemical industry and 1960s Runcorn New Town development providing an influx from the neighbouring city of Liverpool. With the reduction of the chemical industry the area has struggled with high local unemployment rates. Newer service and communication industry developments have taken place in Daresbury & Manor Park and the science park has high quality laboratories.

Map 7: Location of Halton Borough



6.2. Population Structure and Projections

The estimated resident population of an area includes all people who usually live there, whatever their nationality. Members of UK and non-UK armed forces stationed in the UK are included, and UK forces stationed outside the UK are excluded. Students are taken to be resident at their term time address.

6.2.1. Resident population

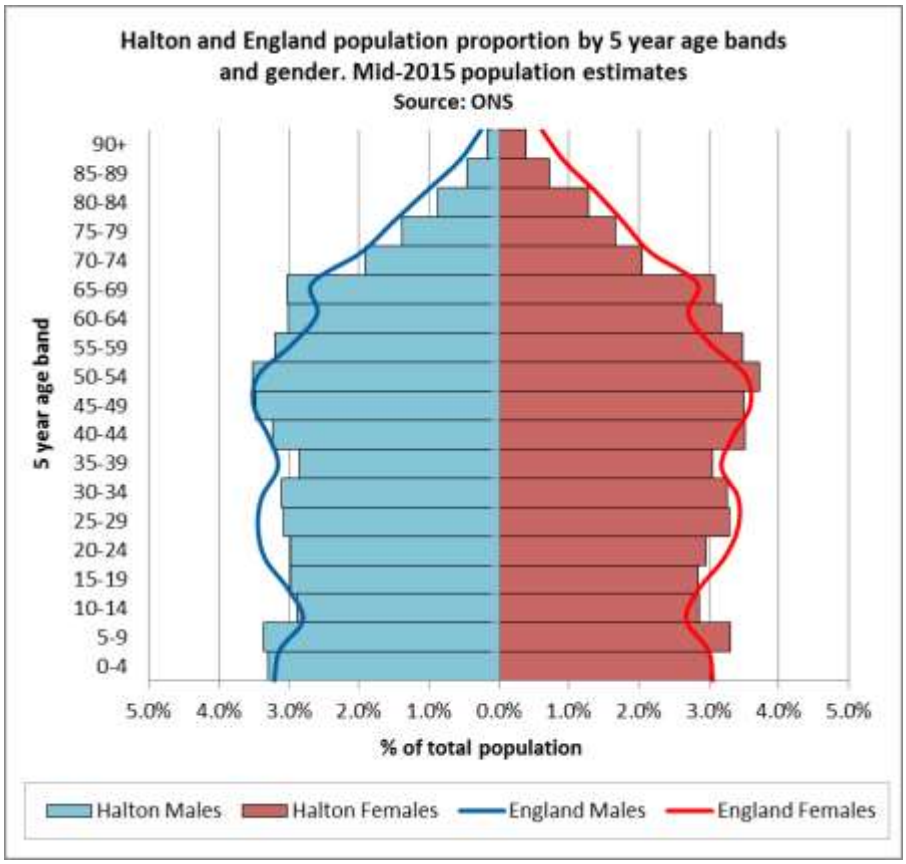
Population estimates are **estimates** of what the resident population make-up should look like at that time, based on previous years' births, deaths and net migration. Mid-2015 population estimates:

- Halton has 126,528 persons
- 49% of these are male and 51% female

The population age structure is detailed in Figure 10. Compared to the England average the resident population of Halton has a slightly different structure:

- Age bands covering 0-14 year olds: slightly larger proportion than England
- Age bands covering 15-19 year olds: similar proportion to England
- Age bands covering 20-34 year olds: smaller proportion than England
- Age bands covering 35-49 year olds: similar/slightly smaller proportion than England
- Age bands covering 50-64 year olds: larger proportion than England
- Age bands covering 65+ year olds: slightly smaller proportion than England

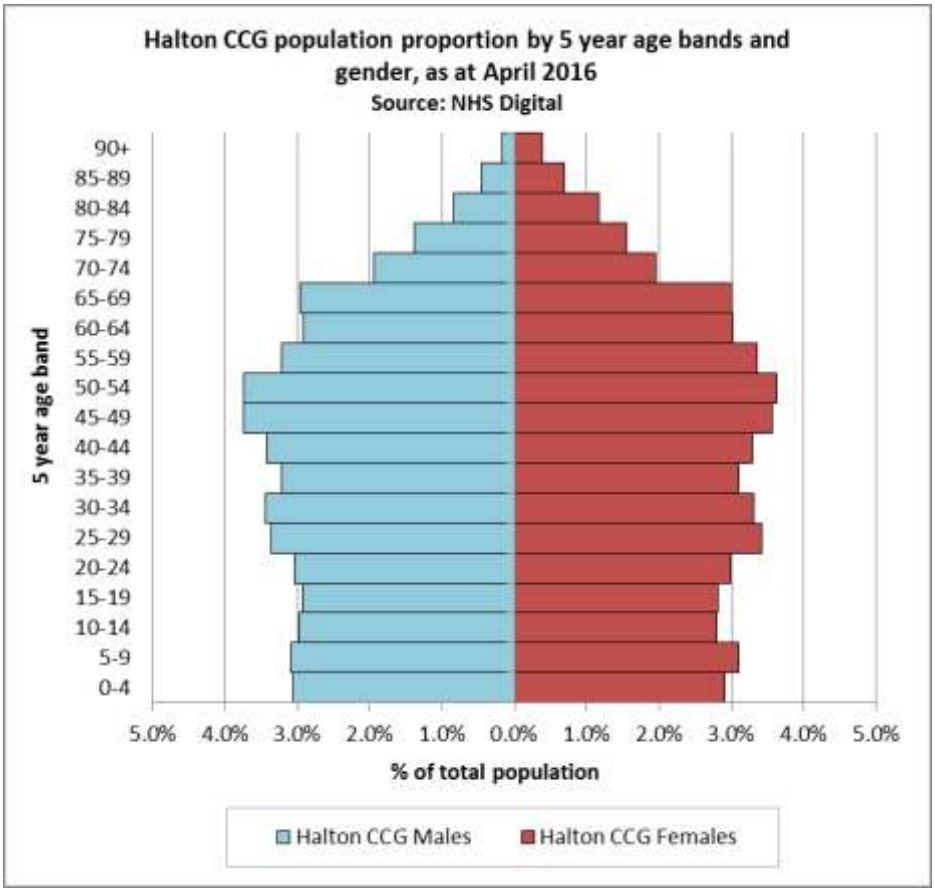
Figure 10: Halton resident population compared to England, mid-2015 estimated age and gender structure



6.2.2. GP Registered Population

The majority of people who reside in Halton are registered with a Halton GP for their primary health care. However, there is not a 100% match. People who move into and out of the borough may prefer to stay with their original GP. This means some people residing in neighbouring boroughs are registered with Halton GPs and some Halton residents will be on a GP register outside the borough. There are more people registered with a Halton GP than there are residents, 130,147 registered (as at April 2016) compared to 126,528 resident (2015 mid-year estimate). The age profile is very similar.

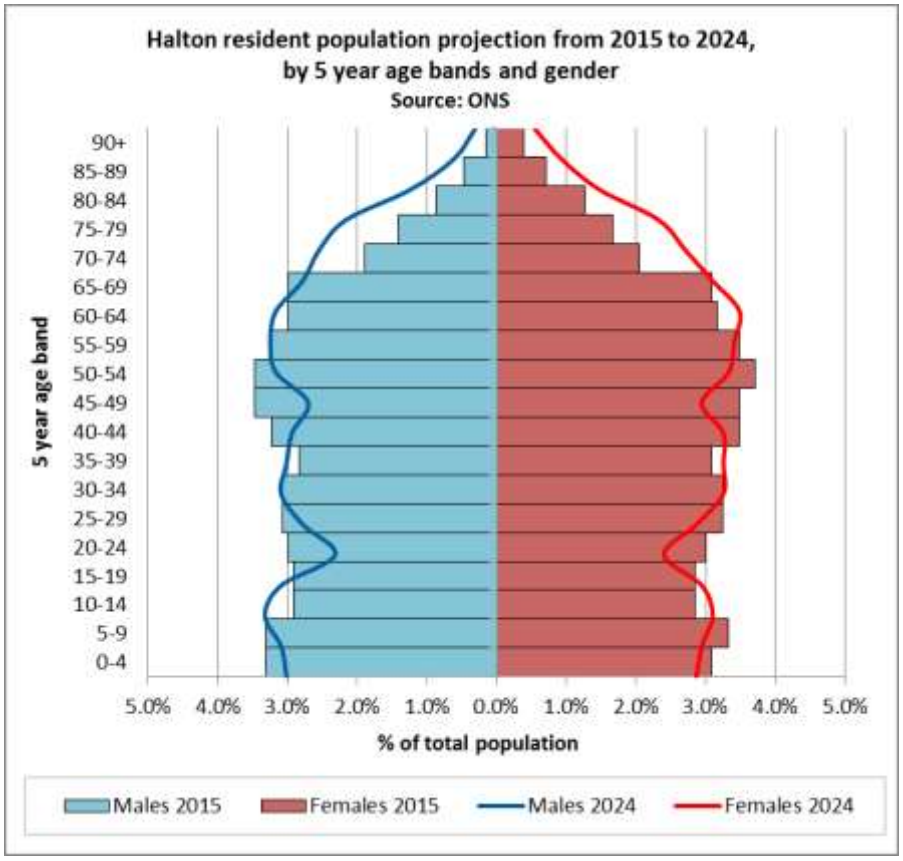
Figure 11: GP registered population age and gender structure, as at April 2016



6.2.3. Resident Population Forecasts

Although currently Halton's population structure is 'younger' than that of England i.e. it has higher proportions than England in the younger age bands and lower proportion in the 65+ age bands, the borough's population structure is predicted to shift over the next decade. Figure 12 shows that the 5-14 age bands are predicted to increase as a proportion of the overall population. The 'working age' population is predicted to shrink whilst the largest proportion increase will be in the 65+ age population. This 'ageing population' is likely to increase pressures on NHS and social care as this age group makes up a disproportionately large percentage of GP consultations, hospital admissions and social services. This is likely to have an impact on prescribing levels and therefore pharmacy workload, assuming current prescribing patterns persist.

Figure 12: Population projections 2015 to 2024



The projections form a "baseline" view of what the population dynamics would be in the given areas if recent demographic trends were to continue into the future. It is important to note that these projections are consistent across all local authorities in England.

- In the short term (2015 - 2018) Halton's population is projected to grow by less than 1% from 126,600 to 127,400
- In the medium term (2015 - 2021) Halton's population is projected to grow by over 1% from 126,600 to 128,300
- In the long term (2015 - 2024) Halton's population is projected to grow by 2% from 126,600 to 129,100. This is still lower than the North West region which is projected to grow by 3.5% and nationally, which is projected to grow by over 6.5%.
- Younger people (0 - 15 year olds) - population projected to be similar (2015 - 2024)
- Working age (16 - 64 year olds) - population projected to decline by just over 3% (2015 - 2024)
- Older people (65+) - population projected to grow by 25% from 21,500 in 2015 to 26,800 in 2024

Following national and regional trends, Halton's population continues to age with older people making up an increasing proportion of the population. The growth in the numbers of older people will increase the demands for both formal and informal support. Small decreases in the working age population mean there are fewer people to provide and pay for this additional support.

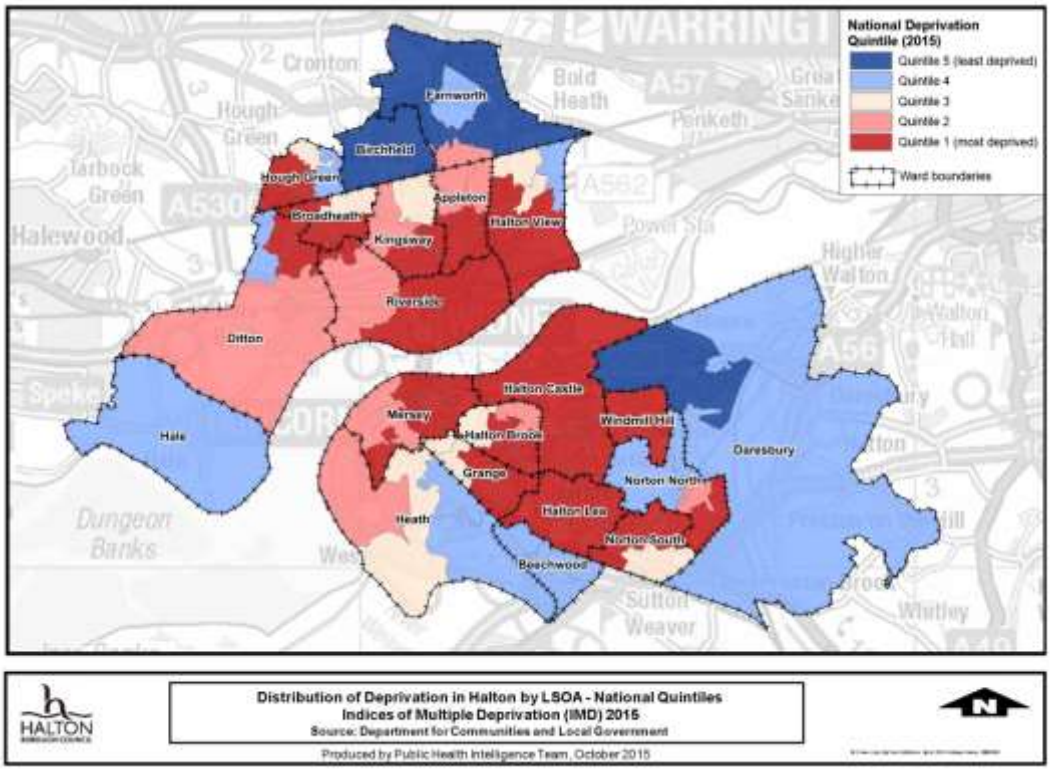
6.3. Deprivation and socio-economic factors

The English Indices of Deprivation 2015 (ID 2015) are the government's official measure of deprivation and they update ID 2007 and ID 2010. The Index of Multiple Deprivation 2015 (IMD 2015) is constructed by combining seven domains, each of which relates to a major social or

economic deprivation. The scores for each domain are combined into a single deprivation score for each small area in England. This, therefore, allows each area to be ranked relative to one another according to their level of deprivation.

Halton is ranked as the 27th most deprived local authority in England (out of 326 local authorities) putting it in the most deprived 10% nationally. In 2010 it was also the 27th most deprived local authority. This means that Halton's relative level of deprivation has stayed the same, even though its deprivation score has decreased slightly. The most deprived ward in Halton is Windmill Hill, while the least deprived ward in Halton is Birchfield. Map 8 shows the levels of deprivation across the borough, by lower super output area or LSOA (statistical geographical areas of approximately 1,500 population).

Map 8: Levels of deprivation in Halton, IMD 2015



6.4. Future Planning

6.4.1. Housing Development

The last Strategic Housing Land Availability Assessment (SHLAA) 2016[8] estimates the numbers of households needed to meet demand over the next 11 years and beyond. The report assesses the borough's potential level of new housing supply within three key phases:

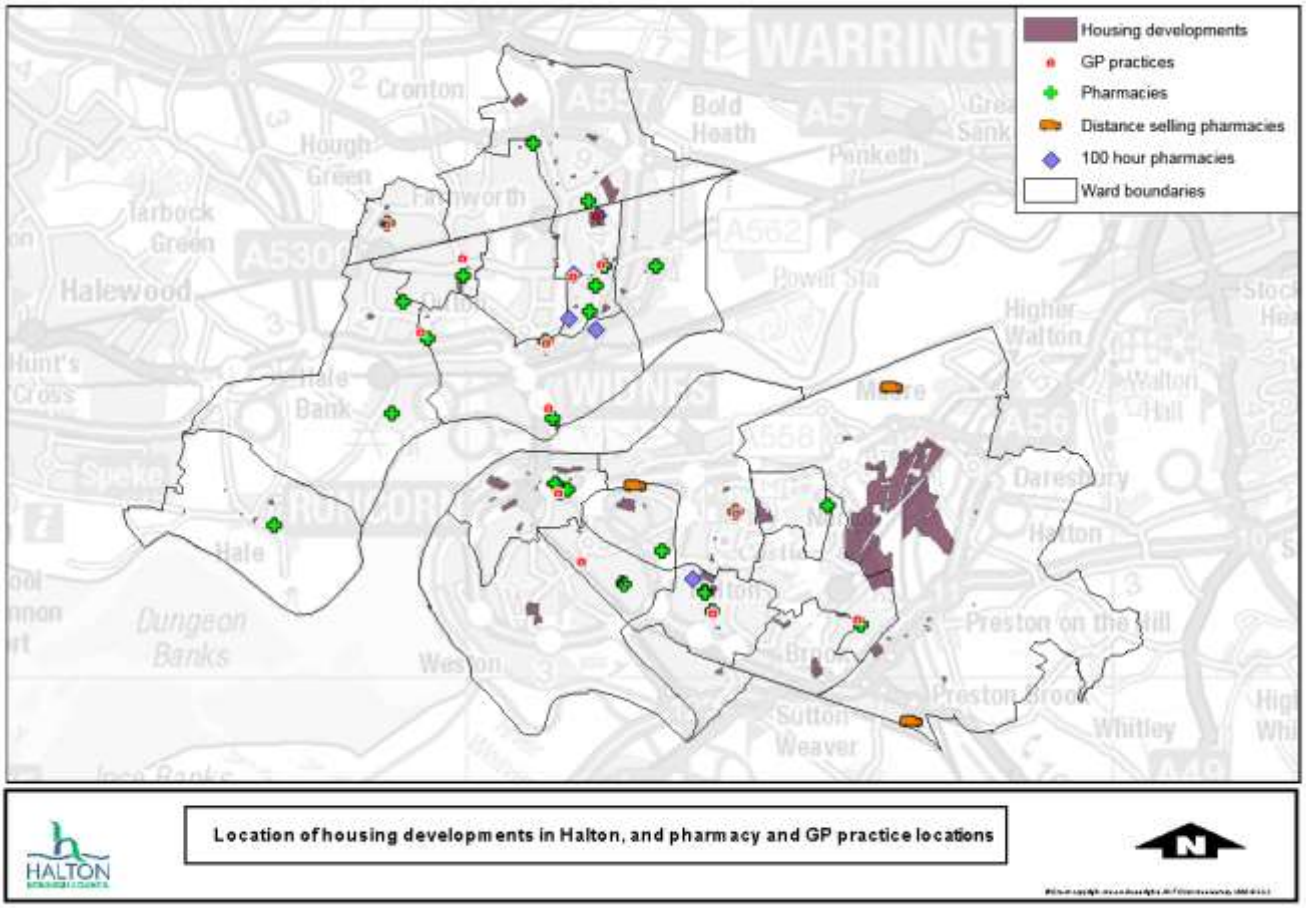
- 0-5 years: 'Deliverable' supply of residential sites
- 6-10 years: 'Developable' supply of residential sites
- 11+ years

In total the SHLAA identifies land supply with a potential for 9,803 dwellings. This is comprised of: a supply of specific deliverable sites (including sites under construction and with planning permissions) capable of delivering 4,658 dwellings within the next 5 years; a supply of specific developable sites capable of delivering 3,123 dwellings, with 2,012 dwellings in the period 6-10 years. A borough-wide windfall allowance of 68.3 dwellings each year is also included as a source of supply, whilst an allowance is also included for the non-delivery or slippage of sites without permission. This has led to a deliverable supply of 4,751.7 dwellings within the next 5 years, with a supply of 5,357.3 dwellings for the period beyond that

The Core Strategy[9] and Mid Mersey Strategic Housing Market Assessment 2015[10] identify there is a net need for 119 new affordable homes to be made available each year, meaning 25% of new developments built should be affordable housing, subject to site viability assessment. There is also an aim to reduce the number of people affected by the under occupancy penalty. Both also recognise the needs of vulnerable groups. This includes the need for current or future homes to have suitable aids and adaptations to meet disability needs as well as the need for 71 units of additional older persons housing per year between 2014 and 2037.

The geographical location of the deliverable supply of housing for the next 0-5 years (within the 'life' of this PNA) is shown in Map 6, alongside pharmacy locations. The shaded areas are those where developments exceed 50 homes. There are numerous smaller developments across both Widnes and Runcorn. The map indicates that additional pharmacy provision will not be required, as plans are located within areas of adequate existing provision.

Map 9: Housing developments



6.4.2. Mersey Gateway Bridge

In October 2017 a new six lane toll bridge over the Mersey between the towns of Runcorn and Widnes opened to relieve the congested and ageing Silver Jubilee Bridge. The original plan was that both the new Mersey Gateway Bridge and the Silver Jubilee Bridge would be tolled with most local residents receiving up to 300 free one-way trips per year. However, in late July 2014 an agreement was reached with central government that Halton residents would be exempt from toll fees. All residents living in homes Council Tax bands A-F can pay a £10 annual fee to claim their free trips. Blue Badge holders will also be able to register for unlimited travel on the bridges after providing copies of the front and back of their Blue Badge and paying a one-off £5 admin fee. Others can also register to receive discounts on journeys.

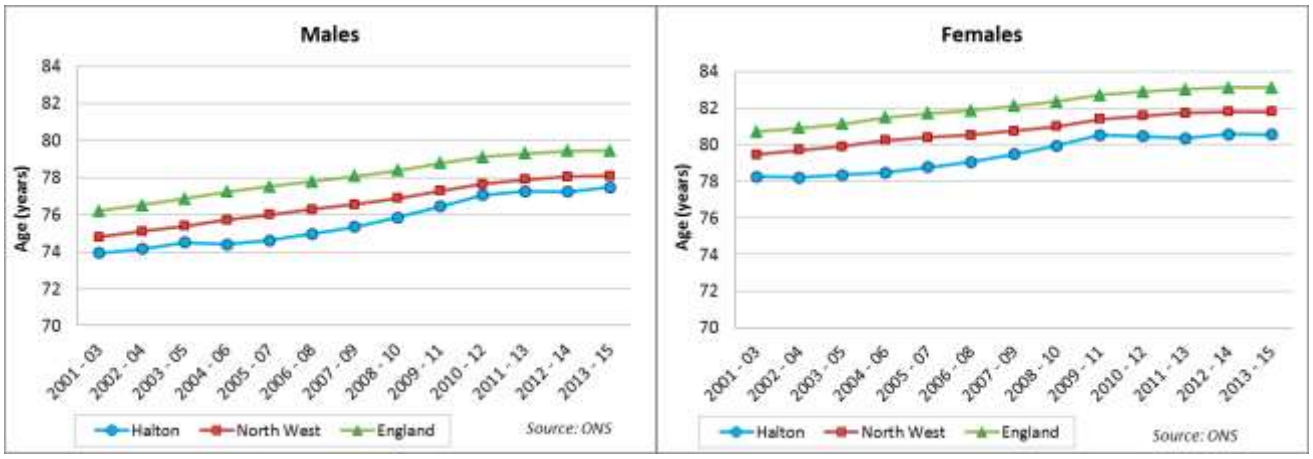
Therefore the new bridge should have little to no adverse effects on access to healthcare including pharmacies, despite the immediate closure of the Silver Jubilee Bridge for maintenance when the Mersey Gateway Bridge opened.

6.5. Life Expectancy

As a result of the reduction in mortality, life expectancy has improved but remains substantially below the North West and England rates. The gap between the national and local life expectancy rates has reduced over recent years. However, Halton women have some of the lowest life expectancy in England.

Reducing all age all-cause mortality inequalities between Halton and the national average will in turn reduce the life expectancy difference.

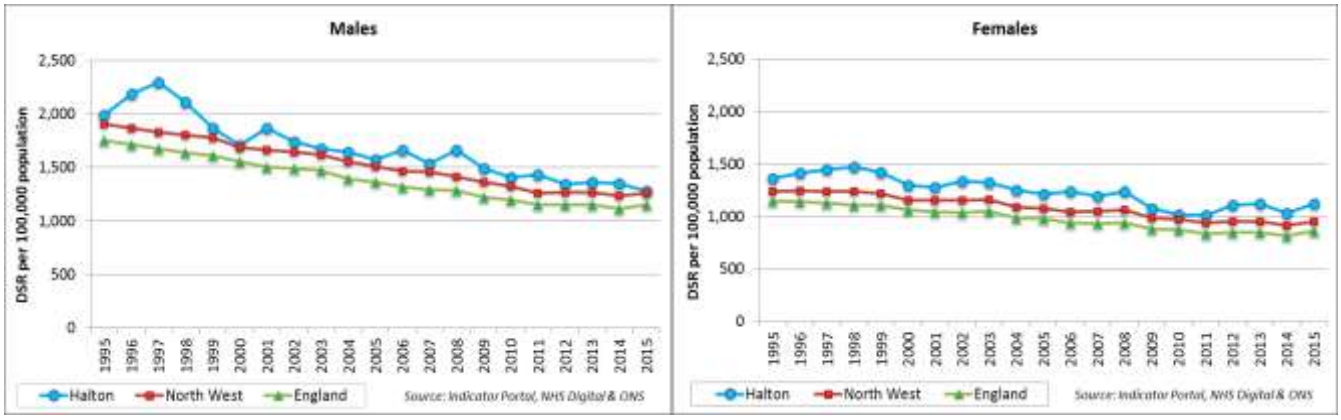
Figure 13: Trend in life expectancy at birth, males and females, 2001-03 to 2013-15



6.6. All Age All-Cause Mortality

Reducing all age all-cause mortality is one of the key priorities for the partner organisations in Halton as it is key to tackling health inequalities. Whilst mortality rates have declined, they remain above the national and regional averages.

Figure 14: Trends in all age all-cause mortality for males and females, 1995 to 2015



6.7. Health & Wellbeing Board Priorities

The Joint Strategic Needs Assessment (JSNA) has been used to inform leaders and commissioning decisions about the health and wellbeing needs of the borough as well as the wider determinants that impact on these issues. Following an extensive engagement and prioritisation process Halton's Health and Wellbeing Board agreed a core set of priorities for its 2018-21 Joint Health and Wellbeing Strategy (JHWBS). With a focus on prevention and early detection, these are:

Children and Young People: improved levels of early child development

Generally Well: increased levels of physical activity and healthy eating and reduction in harm from alcohol

Long-term Conditions: reduction in levels of heart disease and stroke

Mental Health: improved prevention, early detection and treatment

Cancer: reduced level of premature death

Older People: improved quality of life

Action plans for each priority are overseen by various multi-agency partnership groups.

7. Pharmacy Activity that supports local priorities

7.1. Tobacco Control

7.1.1. Level of Need

Smoking is the most significant modifiable risk factor for both heart disease and cancer. In men, it accounts for 59% of social class differences in death rates between 35 and 69 years.[11]

According to the 2016 Health Profile[12] the adult smoking rate in Halton (2015) was 20.1%, a reduction since the 2009 Health Profile when the rate was estimated to be 30.5%. However, this is a slight increase on the 2014 figure. This compares to the England average of 19.5% with the worst rate in England being 32.3% and the best being 7.5%. Despite the reductions in smoking levels locally these figures show that the borough rates remain significantly worse that the England average even though the gap has narrowed. Data from a collaborative Lifestyles survey conducted across all Merseyside boroughs 2012/13 showed higher rates than those seen in the Health profile. Differing methodologies make direct comparisons problematic. However, despite differing figures both demonstrate the significant burden smoking continues to exert on borough residents.

As such, tobacco control has a major role to play in reducing health and social inequalities. The borough's strategy has been to reduce exposure to second-hand smoke, prevent people from starting smoking in the first place, and help smokers to quit.

With regards to helping smokers to quit, the local authority public health team (LAPHT) provides and commissions a range of smoking cessation services with efforts to support smokers to quit being offered as part of a comprehensive tobacco control and smoking cessation plan. All GP practices in Halton are actively involved in providing smoking cessation support, predominantly by practice nursing staff or by GPs providing a brief intervention (BI) and referral to the specialist smoking cessation service, depending on patient need and wishes. General practice staff can refer patients to the Specialist NHS Stop Smoking Service if they require more intensive support.

7.1.2. Evidence of effective interventions in the community pharmacy setting

Evidence suggests that community pharmacies have a key role to play in providing advice, support and even BIs for smoking cessation.[13][14][15][16][17][18] Details of how they can provide this support can be found in guidance such as that published by Pharmacy Health Link.[19] However, this requires adequate training to enhance confidence and skills,[20][21] something pharmacy staff may feel they lack.[22] Training on how to match patient history and smoking status can enable pharmacy staff to tailor advice more accurately.[23] This is based on evidence that community pharmacist smoking cessation support can have similar success rates as that of nurses but lower than that of specialist advisors. There is also some evidence that involving community pharmacy support staff in BIs around smoking can increase the provision and the recording of smoking status in patient's medication records.[24] Whilst other studies show community pharmacy smoking cessation services may produce lower quit rates than group-based support, the latter are more intensive and cost more. Nevertheless, pharmacy-led smoking cessation support can have significant impact on quit rates. [25]It is important to note that assessment of pharmacy success rates need to take client demographics in to account as these may be different to those accessing the same services via other settings.[26] Both types of support are cost effective.[27][28] Quit rates will vary also depending on the number of sessions offered by the pharmacy.[29] Despite these differences the key message remains that the evidence strongly points to community pharmacies having a key role to play in local efforts to support people to stop smoking.[30][31] Both patients and pharmacy staff view smoking cessation counselling by community pharmacy staff positively.[32]

7.1.3. Local provision

Halton has 24 pharmacies providing smoking cessation services (Map 10 and Appendix 4), 14 in Widnes and 10 in Runcorn. Under Local Commissioned Services pharmacies can offer three levels of support to those wanting to stop smoking. Most provide all three levels of service (11 out of 14 in Widnes and 9 out of 10 in Runcorn). Two provide intermediate services only and 2 Varenicline only.

Stop Smoking Voucher Dispensing Service

The stop smoking dispensing service dispenses of nicotine replacement therapy (NRT) against vouchers issued by the Specialist Smoking Cessation Service.

Stop Smoking Intermediate Service

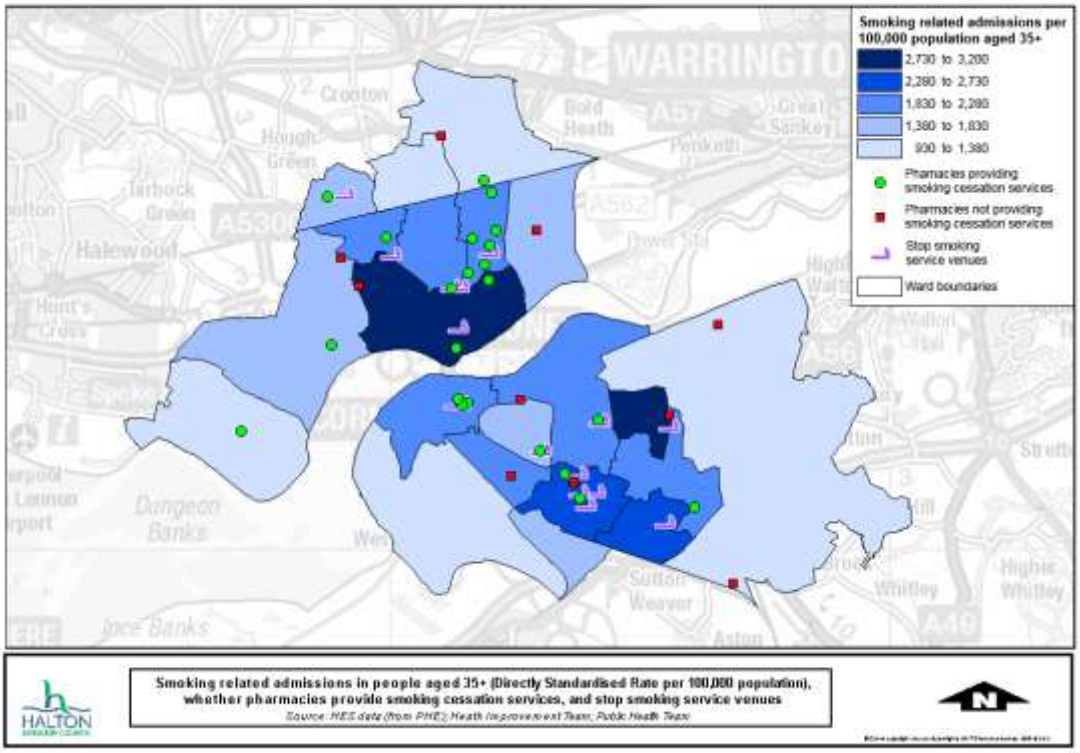
The Pharmacy Stop Smoking Intermediate Service has been established to deliver one-to-one support and advice to the user, from a trained pharmacist or a member of the Pharmacy team. Where appropriate nicotine replacement therapy is supplied or a referral is made to the person's GP for a prescription of alternative stop smoking drugs. The service is provided during normal pharmacy opening hours but may not necessarily be available on every day that the pharmacy is open.

Varenicline

Commissioners from Cheshire and Merseyside LAPHTs have developed a Patient Group Direction (PGD) for the administration of Varenicline. This enables community pharmacies to directly assess the clinical suitability of patients for and provide products such as *Champix,* which has a higher quit rate than NRT products, directly to patients without the need for a prescription from a GP.

82% of respondents to the local community pharmacy services survey stated that they think advice on stopping smoking and/or vouchers for nicotine patches/gum etc. should be available through community pharmacies. This suggests the public see this as a good venue for support to quit smoking.

Map 10: Provision of pharmacy and other community smoking cessation services



Map 10 shows that in all wards with high levels of smoking related admissions (dark blue colour on map) there is at least one specialist stop smoking service clinic or one pharmacy providing smoking cessation support. Therefore provision of community smoking cessation support is adequate.

Conclusions

- There is adequate provision for smoking cessation services across the borough. Pharmacies are a key component of this provision, with easy access, and this should be maintained

7.2. Healthy Weight

7.2.1. Level of Need

Achieving and maintaining a healthy weight through action to address physical activity and healthy eating is one of the six priorities of the 2017-2022 One Halton: Joint Health and Wellbeing Strategy. It is associated with 35 health conditions including cardiovascular disease and some cancers. Halton child and adult obesity levels are above the national average.

According to 2016 Health Profile[33] 3 out of 4 Halton adults are overweight or obese (74.7% in 2013-15), higher than the England average of 64.8%, the best rate in England being 46.5% and the worst 76.2%. The North West rate was 66.6%. Some other key statistics[34] include:

- 88% of Year 9 pupils drink at least one sweet drink (not fruit juice) per day; 83% eat at least one take-away meal a week; only 21% eat 5 or more portions of fruit or vegetables per day; 57% eat breakfast everyday whereas 19% never do
- Up to Years 7-9 over 90% of Halton children participate in at least two hours of high quality physical activity/school sports in a typical week. However, in keeping with the North West and England picture this drops for Year 10-11 (75%) and drops again for Year 12-13 (42.4%). Across all year groups levels in Halton are higher than the North West and England rate
- Obesity levels in both Reception and Year 6 are statistically higher than the North West and England rates
- Fruit and vegetable consumption (5-a-day) is lower in Halton adults than for Merseyside. Women tend to consume more than men and older people more than younger people
- People with long-term illness, disability (physical and/or learning) or poor general health are significantly more likely to be obese than those without (33% compared to 21%)
- Regional and local survey data shows that people with low levels of mental wellbeing are less physically active and have poorer diets. National research shows that nearly half of people with a diagnosis of severe mental illness also have long-term physical health problems yet they have less access to preventative and early interventions
- Malnutrition is a common problem amongst people who are homeless; they face significant barriers to meeting a healthy diet, eating for fullness rather than nutritional value
- Oral health of older people in care homes is poorer than the general population

7.2.2. Evidence of effective interventions in the community pharmacy setting

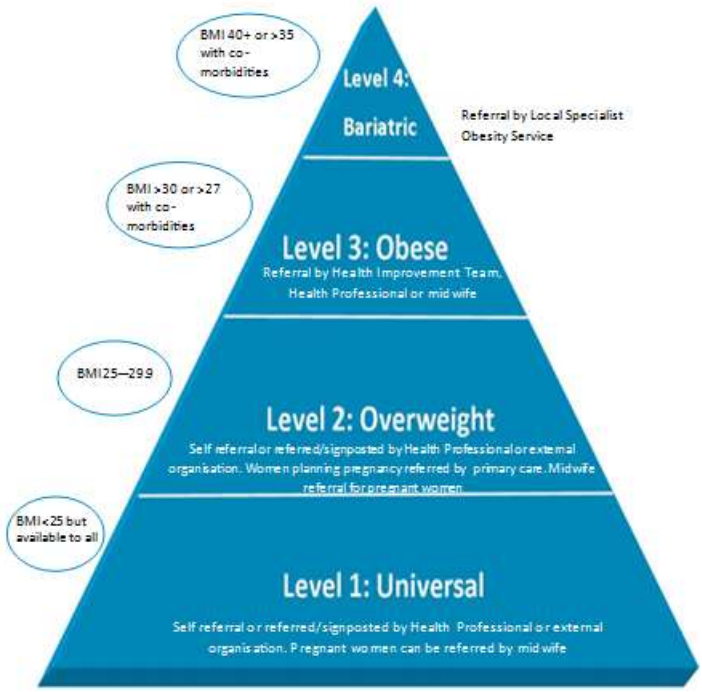
A review of the role of community pharmacy in delivering the public health agenda reviewed three studies concerning weight management interventions delivered by community pharmacists. In two studies positive impacts on weight and waist circumference were found for programmes that offered behaviour change support.[35] NICE guidance on obesity[36] includes pharmacists in the range of primary healthcare professionals who should take action to support behaviour change in relation to weight loss. It also maintains that, with training, pharmacy support staff could also fulfill this role. However, it does not contain specific recommendations for pharmacies. A systematic review of alcohol reduction, smoking cessation and weight management interventions included 5 high quality studies on weight management within community pharmacy settings. Of the three studies that compared pharmacy-based with primary care-based interventions, none of the pharmacy-based interventions showed any significant differences in anthropometric outcomes compared with controls. They concluded that primary care, including pharmacy settings, were not as cost effective as community settings in producing positive weight management outcomes.[37] This is supported by other reviews and studies such as Gordon[38] and Phimarn[39]

Added to this there are differing perceptions among the public and pharmacy staff even when prescribing weight loss medications or over-the-counter weight loss products, with issues such as conflict of interest[40] and preference for dietician-led or commercial weight loss programmes.[41]. However, accessibility and availability of products work in pharmacies favour, especially were non-commercial educational materials are available. Pharmacy-led programmes may be able to bring about desired outcomes (weight loss, reduction in waist circumference and blood pressure).[42][43][44][45] Programme components, appropriate training and resources need to be carefully considered as not all programmes show similar positive results.[46] This includes the need to take different population groups in to account.[47] Barriers include training[48] as well as capacity and reimbursement.[49][50]

7.2.3. Local Provision

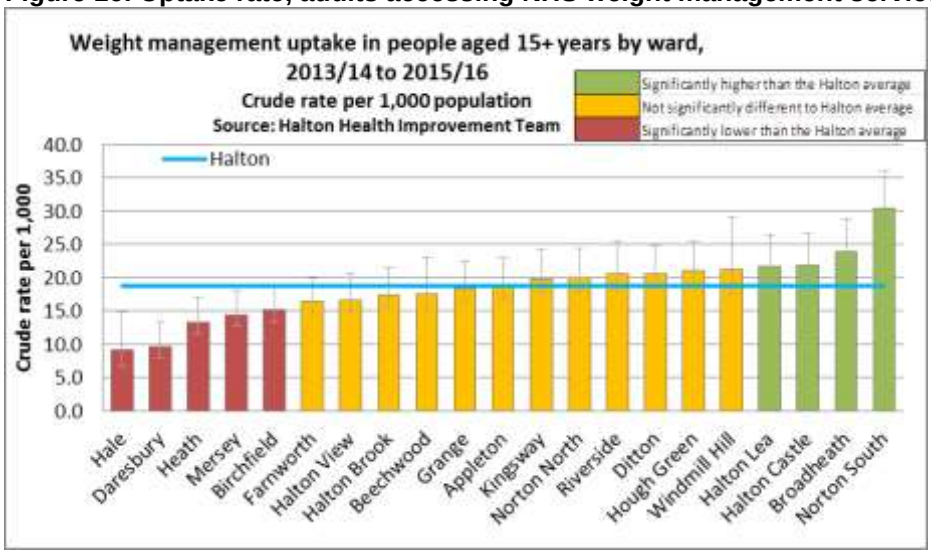
Current weight management services in Halton are commissioned in line with original[51] and subsequent NICE guidance. Sessions encompass group exercise sessions, advice on nutrition and motivational behaviour change support. Service provision is provided in Tiers, with most people accessing Tier 2 weight management services.

Figure 15: Halton Weight Management Service provision



For 2013/14 to 2015/16 the rate of people accessing the specialist (Tier 2) weight management services was higher in the more deprived wards in the borough (Figure 16).

Figure 16: Uptake rate, adults accessing NHS weight management services, 2013/14 to 2015/16



Weight management service outcomes data is based on NICE[52] and Department of Health[53] guidance that an effective programme should aim to elicit a 3% to 5% weight reduction in obese adults during a 3 month period. Performance data is not currently available at postcode level so it has not been possible to map local outcomes. There is a rolling programme of people completing the programmes, with data collection at 12 weeks and follow up at 6 months and 2 years for complex clients. Overall for 2015/16 this showed that over half of clients completing the 12 week programme had lost 3% of more weight and had made substantial improvements to their health scores including self-esteem scores. A third had lost 5% or more weight.

Although not commissioned to do so, some pharmacies did report they offer patients Body Mass Index calculations by weighing and measuring them and offering lifestyle advice. However, it is not possible to determine which types of intervention they provide and to what standards they are operating. It does offer an opportunity to engage with pharmacies on this issue as a way of helping people to access the specialist weight management services. In the patient & public survey 72% stated that they would like to see weight management services within community pharmacies.

Conclusions

- Local weight management services give opportunities to receive practical instruction in healthy eating and physical activity as well as behaviour change support. It would not be possible for pharmacies to provide these practical sessions but there may be a role for them in terms of the ongoing behavioural support, with adequate training.
- Promotion of healthy lifestyles forms part of the essential services within the community pharmacy contract through the 6 campaigns. Tackling obesity would be a key local issue for consideration.
- Some pharmacies already weigh and measure patient's height and calculate BMI, offering information on how to eat more healthily and reduce their weight. This provides opportunities to share good practice in this area.

7.3. Alcohol

7.3.1. Level of Need

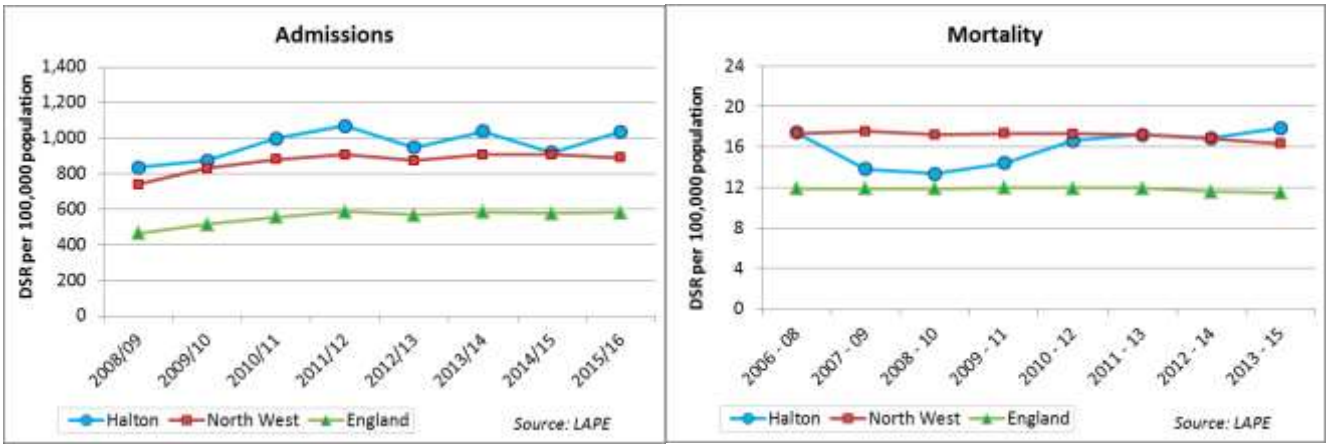
Levels of alcohol use have been rising over recent years. Alcohol misuse is directly linked to deaths from certain types of diseases, such as liver cirrhosis. This trend can be seen in Figure 17. For Halton it is one of the major causes of the gap in life expectancy.

Nationally, rates for hospital admission episodes for alcohol-specific conditions have increased since 2008/09. Halton's rate has remained statistically significantly higher than England's during this period.

For deaths from alcohol-specific conditions in Halton, the rate is also significantly higher than England. The Halton death rate was similar to England between 2007 and 2011; however, it has increased during recent years.

Both admission and especially death rates are much higher for men than women. Most deaths due to alcohol are amongst men.

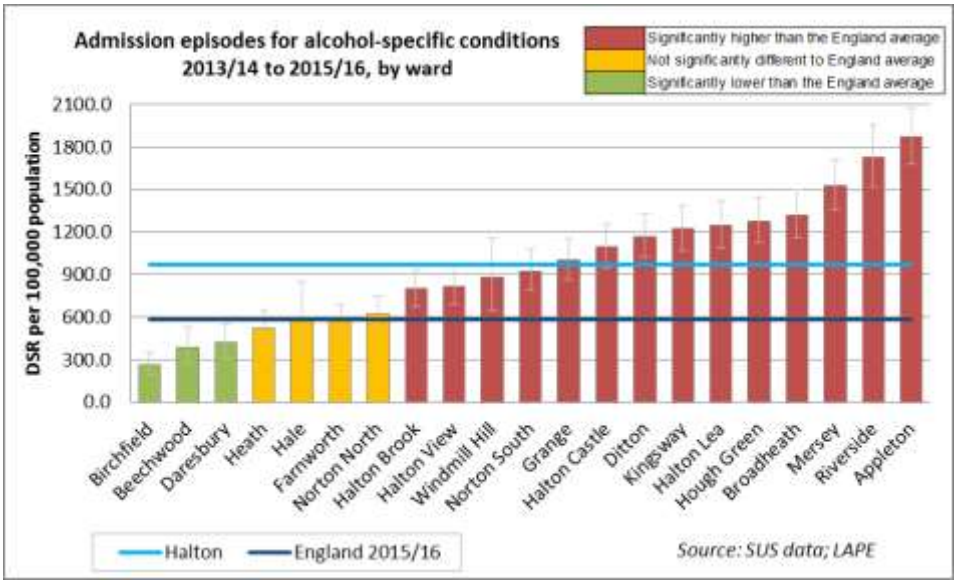
Figure 17: Hospital admission episodes and death due to alcohol-specific conditions, all ages, directly age-standardised rate (DSR) per 100,000 population



The increase in alcohol use amongst adults has generally seen a corresponding increase in alcohol-specific admission episodes. However, the admission rate has, overall, remained at a similar level for both England and Halton since 2011/12.

The impacts alcohol has on admission episodes for alcohol-specific conditions are not experienced uniformly across the borough as Figure 18 shows.

Figure 18: Ward level alcohol-specific admission episodes in Halton, 2013/14 to 2015/16



Admissions to hospital amongst those aged under 18 have seen falling rates in recent years. Again, this is a reflection of the changing pattern of alcohol use amongst young people. Further details of hospital admissions can be found in the JSNA[vii] and the Local Alcohol Profiles for England (LAPE) annual profile.[viii]

7.3.2. Evidence of effective interventions in the community pharmacy setting

There is little in the published research on this area. However, community pharmacies have been effective in supporting people to stop smoking using BIs. There has been some evidence in the early literature that such an approach is also effective for alcohol within other primary care settings.[54][55]

Research undertaken in the North West indicates that alcohol BI and referral to services is acceptable to both pharmacies and the public. However, this research did not consider the effectiveness of such services.[56] This level of public and pharmacist support has been shown elsewhere as well.[57] Given the UK Department of Health's stated aim to include community pharmacies in BI to reduce alcohol harms, an important Randomised Control Trial (RCT) study was conducted in all community pharmacists in the London borough of Hammersmith and Fulham.[58] However, this study and one other showed that BI for alcohol via community pharmacies is not effective. Brown et al therefore recommend that, at this point in time, such services should not be delivered.[59] Despite this the 2011 NICE commissioning guide[60] recommends the targeting of alcohol BI, including via community pharmacies, to specific populations. However, success when doing this is not clear cut. A study targeting men showed good uptake[61] but another targeting women accessing emergency hormonal contraception did not.[62]

7.3.3. Local provision

Alcohol was one of the five 2013-2016 JHWBS priorities. Within the 2017-22 strategy the Generally Well priority has a focus on healthy weight and alcohol. The key principles of the JHWBS include an emphasis on wellbeing, prevention and early detection across the life course. This is in line with the national alcohol strategy.

---

vii http://www4.halton.gov.uk/Pages/health/JSNA.aspx
viii http://www.lape.org.uk/

Pharmacy-based alcohol services have been established or commissioned in other areas of the UK, but these vary considerably in their design and have been subject to little evaluation. Locally community pharmacies support national and local alcohol harm awareness campaigns as part of the national pharmacy contract. Due to the lack of evidence on effectiveness, there are no pharmacy enhanced or locally commissioned alcohol services in the borough.

44% of respondents to the local community pharmacy services survey stated that they think advice and treatment for alcohol problems should be available through community pharmacies. 33% stated they did not think these services should be available through the community pharmacy and 22% were unsure. This is a substantially lower 'Yes' response than for all other services apart from drugs services.

Conclusions

- Pharmacies do not currently provide services to reduce alcohol consumption. Evidence of effectiveness for pharmacies role in conducting screening for unsafe levels of alcohol consumption and offering brief interventions is limited. What little there is indicates that, at this point in time, alcohol brief interventions should not be commissioned from community pharmacy. However, we need to keep abreast of new research and respond if this position needs to change
- Under the essential services contract pharmacies should support six health education campaigns per year. Community pharmacies are well placed to take part on local and national campaigns around alcohol misuse. As a local JHWBS priority this should be considered

7.4. Planned care

7.4.1. Level of Need

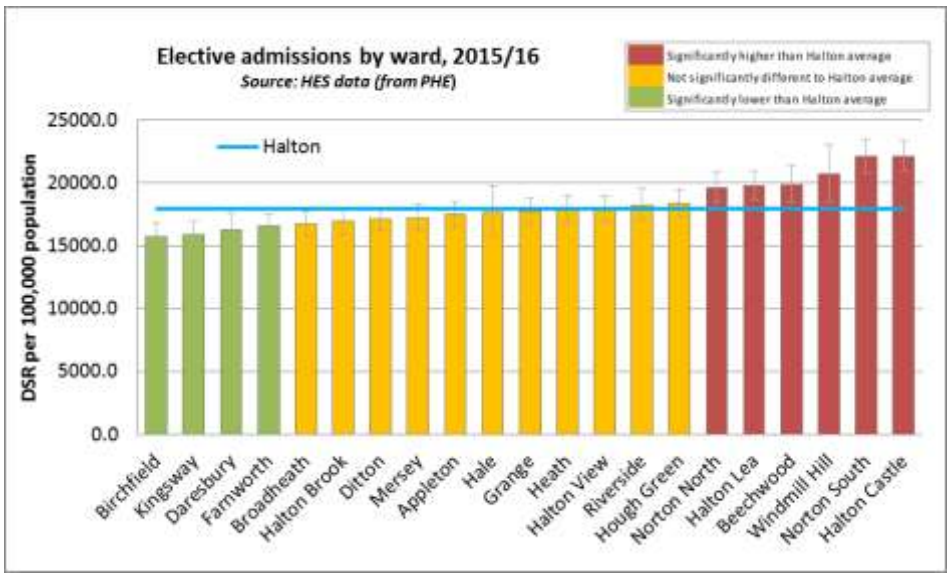
Based on changing population numbers and age structures it is estimated that the number of people being admitted to hospital for a planned procedure will increase. Diseases of the digestive system, cancers (neoplasms), diseases of the musculoskeletal system, and eye and adnexa account for just over 61% of planned admissions.

Table 3: Elective hospital admissions, top 10 causes, 2015/16

ICD-10 Chapter	Elective Admissions	Percentage
Diseases of the digestive system	5493	25.2%
Neoplasms	3068	14.1%
Diseases of the musculoskeletal system and connective tissue	2741	12.6%
Diseases of the eye and adnexa	2108	9.7%
Diseases of the genitourinary system	1465	6.7%
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	1208	5.6%
Diseases of the circulatory system	1095	5.0%
Factors influencing health status and contact with health services	1063	4.9%
Injury, poisoning and certain other consequences of external causes	577	2.7%
Diseases of the respiratory system	464	2.1%
HES data via Public Health England (PHE)		

Figure 19 shows that hospital admission rates are not uniform across the borough. Rates are statistically significantly higher than the borough average in Norton North, Halton Lea, Windmill Hill Beechwood, Norton South and Halton Castle. They are statistically significantly lower than the borough average in Birchfield, Kingsway, Daresbury and Farnworth.

Figure 19: Rate of elective admissions by ward, Halton 2015/16



7.4.2. Evidence of effective interventions in the community pharmacy setting

(See also Long-term conditions)

Medicines adherence support services are an important part of the community pharmacist's role.[63] A study of 10,000 adults aged 35+ found that 76% of women but only 63% of men had obtained medicines or asked for advice with only 12% asking for advice but not obtaining medicines.[64] The difference in gender is not surprising and offers some particular challenges to targeting men for advice especially around lifestyle issues. As a Men's Health project in Knowsley found, most men being targeted for a health check (in the pilot year 400 men aged 50-65 were given a health check) had never had such lifestyle advice from a pharmacist. However, once on-board the majority made a positive lifestyle change.[65] Despite these differences this and other studies demonstrate that pharmacies are an important first port of call for advice on minor ailments.[66]

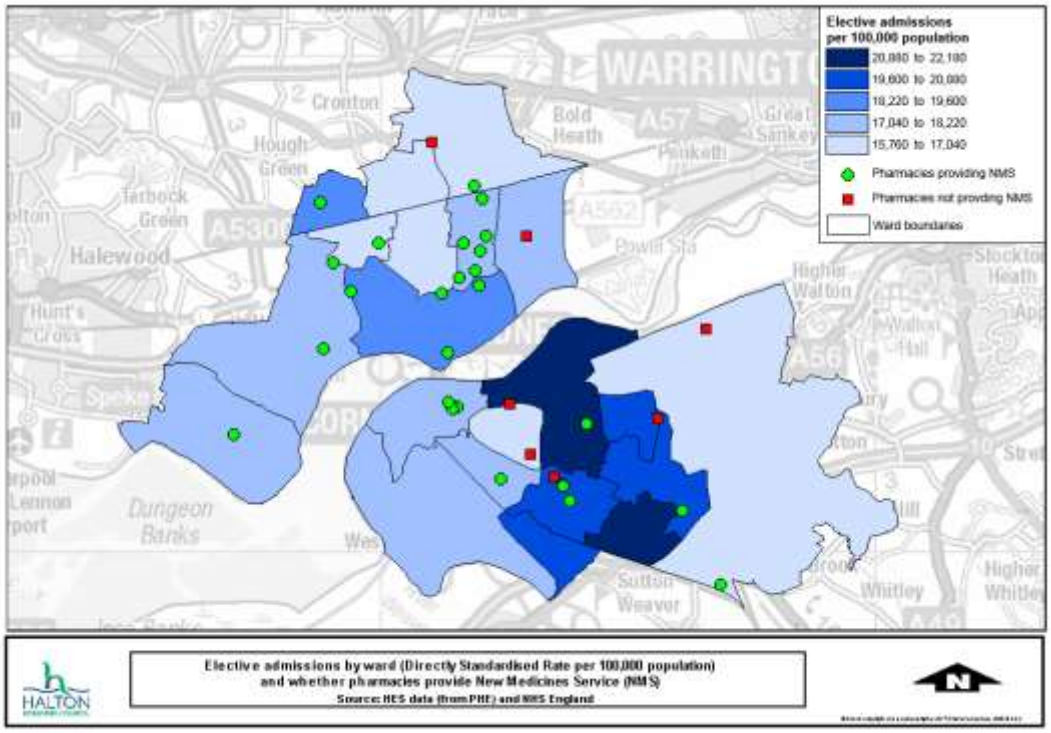
Many people do not use their medicines correctly[67] with limited health literacy[ix] impeding patients understanding of medicines instructions.[68][69] This could lead to medicines wastage, with cost implications for the healthcare system[70] as well as long-term conditions not being optimally managed. Whilst pharmacists recognise that limited health literacy can impact on medication adherence, difficulties in identifying those with low levels of health literacy impedes potential action. More training and advice on the use of aids to identify levels of health literacy need to be employed to increase awareness and confidence amongst pharmacy professionals.[71]

[ix] Evidence shows that health literacy - "the capacity to obtain, interpret and understand basic health information and services and the competence to use such information and services to enhance health" - is a more useful predictor of the use of preventative services than level of education.

7.4.3. Local provision

New Medicines Service (NMS) was introduced in October 2011, as an advanced service, and provides support with medicines adherence for patients being treated with new medicines in four conditions/therapy areas. These are Asthma / COPD, Type 2 Diabetes, Hypertension and Antiplatelet / Anticoagulation therapy. The pharmacist provides face to face counselling about the medicine at the point when the patient first presents with their prescription at the pharmacy. Arrangements are then made for the patient to be seen 10-14 days later to assess adherence and discuss any problems with the new medicine. The patient is followed up 14 days later to check all is well at which point they exit this service. All but seven Halton pharmacies provide NMS as Map 11 shows, giving a good geographical spread in both Widnes and Runcorn.

Map 11: Pharmacies providing new medicines service (NMS)



Medicines Use reviews (MURs) form part of the pharmacy contract, as an advanced service. MURs are structured reviews undertaken by an accredited pharmacist to help patients manage their medicines – to improve their understanding, knowledge and use of medicines they have been prescribed.

The introduction, in October 2011, of three national target groups for MURs was designed to help community pharmacy demonstrate to commissioners the benefits of the MUR service and provide assurance that it is a high quality, value for money service that can yield positive health outcomes for patients who will benefit most. The national target groups are:

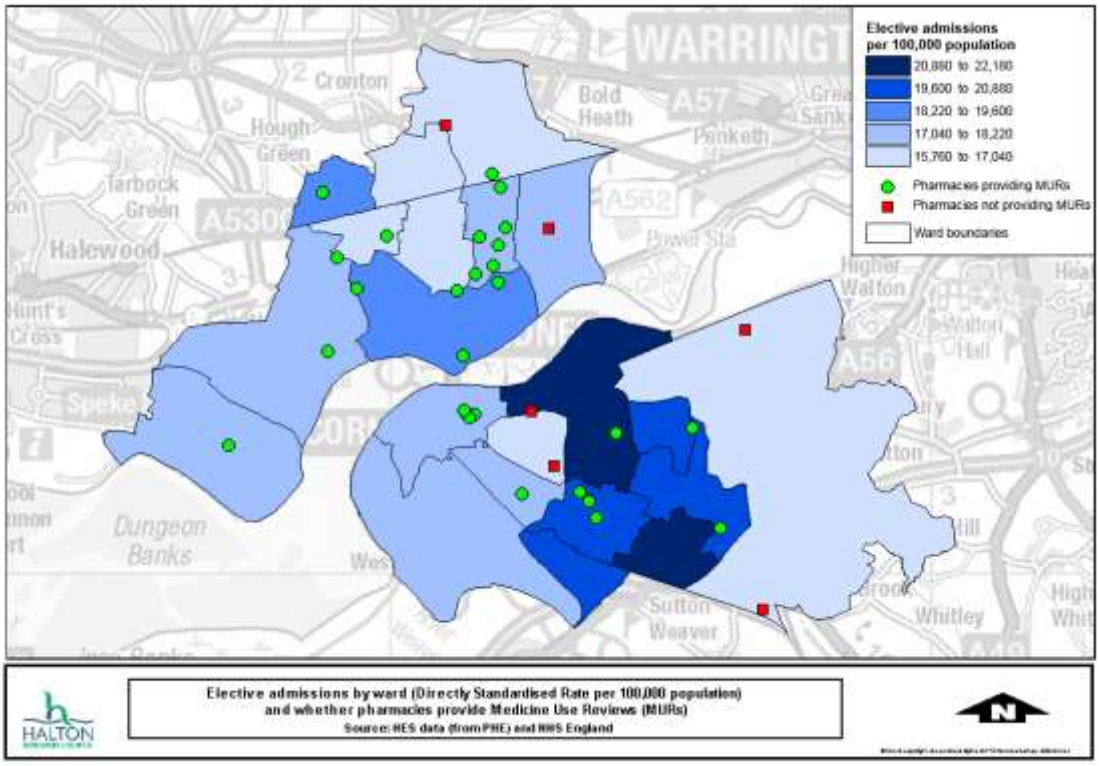
- Patients taking high risk medicines
- Patients recently discharged from hospital that had changes made to their medicines while they were in hospital. Ideally patients discharged from hospital will receive an MUR within four weeks of discharge but in certain circumstances the MUR can take place within eight weeks of discharge
- Patients with respiratory disease

At least 50% of all MURs undertaken by each pharmacy in each year should be on patients within the national target groups. MURs can also be carried out on patients who are not within the target groups. Pharmacists will select patients who will benefit from the MUR service.

MURs are conducted either on a regular basis, e.g. every 12 months, or when the pharmacist feels it is a necessary intervention. They must be conducted in a consultation area to ensure patient confidentiality and privacy. Pharmacists must successfully pass a competency assessment before they can provide MUR services.

86% of respondents to the local community pharmacy services survey stated that they think review or medicines on repeat prescription e.g. when to take them, what they are for and side-effects, should be available through community pharmacies.

Map 12: Pharmacies providing medicines use reviews (MURs)



All areas with high levels of elective admissions have at least one pharmacy conducting MURs. Only six Halton pharmacies do not provide MURs (4 in Runcorn and 2 in Widnes). The areas which do not have pharmacies conducting MURs have lower admissions. This gives good geographical spread in both Widnes and Runcorn.

Conclusions

- There is generally adequate access to both NMS and MURs across the borough
- Monitoring the targeting of MURs in line with nationally defined target groups is carried out quarterly as part of the contractual data submission. Consideration of which other patients would most benefit from an MUR or NMS is also important
- Engaging pharmacy staff in the emerging health literacy work in Halton should be explored

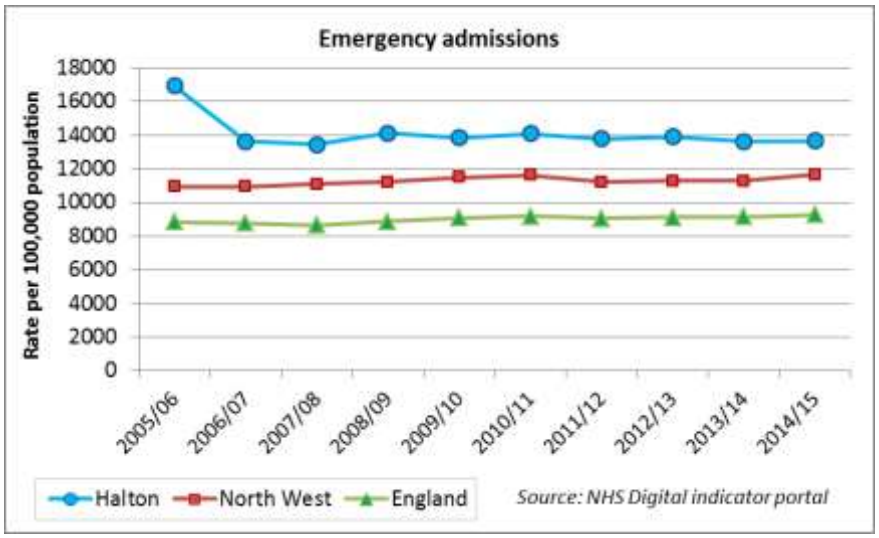
7.5. Unplanned/Urgent Care

7.5.1. Level of Need

In 2014, NHS England set a target to reduce total emergency admissions by 3.5%, 'as a clear indicator of the effectiveness of local health and care services in working better together to support people's health and independence in the community'.[72] Emergency admissions to hospital can be avoided if local systems are put in place firstly to identify those at risk prior to attendance and target primary care services, and secondly to identify those emergency department attendees better cared for outside of hospital and provide a safe route into more appropriate community care. The majority of patients admitted to hospital as an emergency are older people. In order to avoid perverse incentives that might keep older people out of hospital when it is legitimate for them to be admitted, the indicator is presented as a rate for patients of all ages. The indicator also acts as a proxy for the delivery of services for older people generally.

The level of unplanned (non-elective or emergency) admissions in Halton is statistically significantly higher than both the North West and England, a position that has been consistent over time.

Figure 20: Trend in emergency hospital admissions, all age, persons, indirectly standardised (crude) rate per 100,000 population, 2005/06 to 2014/15



Additionally, data is available to help monitor NHS success in prevention and treatment outside hospital of certain acute illnesses that are amenable to management in primary care.[x]

[x] Indicator specification: https://indicators.hscic.gov.uk/download/NCHOD/Specification/Spec_03L_521ISR7E.pdf

Figure 21: Emergency hospital admissions: acute conditions usually managed in primary care, all age, persons, indirectly standardised (crude) rate per 100,000 population, 2005/06 to 2014/15

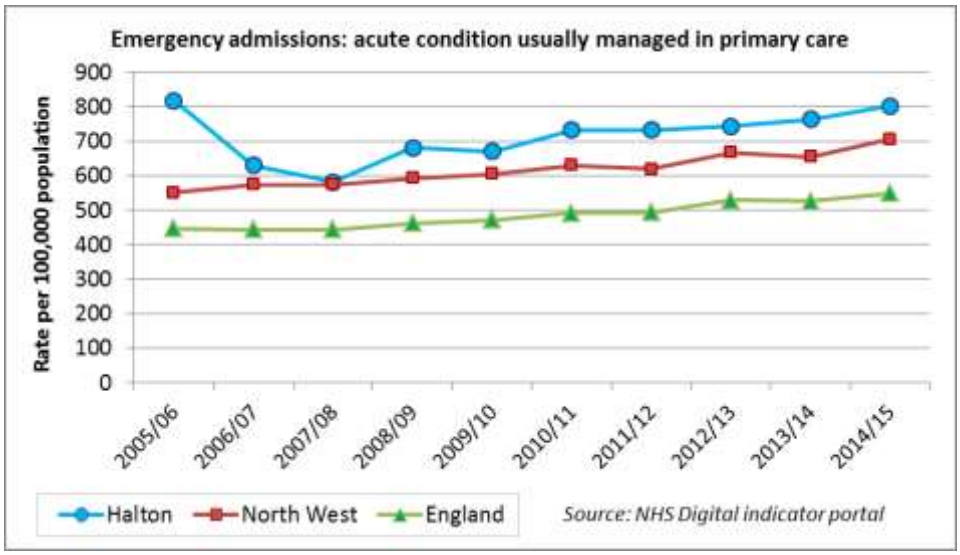


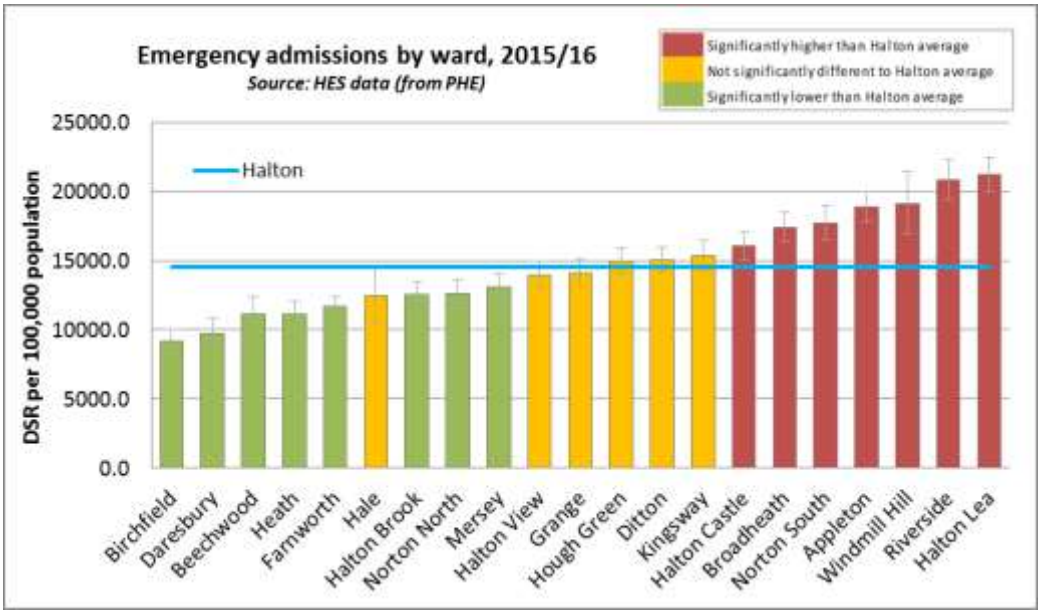
Table 4 illustrates that, as with elective admissions, the top four reasons for people being admitted to hospital as an emergency case make up nearly 58% of all such admissions.

Table 4: Emergency hospital admissions, top 10 causes, 2015/16

ICD-10 Chapter	Emergency Admissions	Percentage
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	3764	21.66%
Injury, poisoning and certain other consequences of external causes	2456	14.13%
Diseases of the respiratory system	2385	13.72%
Diseases of the circulatory system	1461	8.41%
Diseases of the digestive system	1389	7.99%
Diseases of the genitourinary system	1160	6.67%
Certain infectious and parasitic diseases	871	5.01%
Diseases of the musculoskeletal system and connective tissue	738	4.25%
Mental and behavioural disorders	604	3.48%
Diseases of the skin and subcutaneous tissue	479	2.76%
HES data via PHE		

As with planned admissions, rates for non-elective admissions vary widely across the borough as Figure 22 shows. For 2015/16 there were seven wards with rates statistically significantly higher than the borough average, eight with rates statistically significantly lower than the borough average, with only 6 having rates that were not statistically significantly different to the borough average.

Figure 22: Rate of non-elective (emergency) admissions by ward, Halton 2015/16



7.5.2. Evidence of effective interventions in the community pharmacy setting

Several of the research papers identified by the literature search included in their health outcomes reduction in unplanned/emergency admissions. An enhanced medicines management scheme of patients with heart failure post discharge from hospital included community pharmacists as part of multi-disciplinary teams. This improved patient outcomes and decreased unplanned readmissions.[73] Unfortunately, a scheme focused on medicine reviews of high risk elderly found no difference in hospital admissions but did result in modest prescribing savings. However, it was not possible to determine the cost-effectiveness of this intervention.[74] Similarly a study by Walker et al also failed to reduce hospital readmissions. Using a quasi-experimental study evaluating post discharge health care resource use of patients discharged from hospital, the study intervention added a pharmacist to the discharge team to identify and reconcile medication discrepancies at discharge.[75]

Results revealed that whilst the pharmacist identified medication discrepancies at discharge and reconciled all of them, no significant differences in hospital readmission rates and emergency department visits were found. The authors do note that the strength of the intervention might have been compromised by (1) broad inclusion criteria that might not have identified patients at high risk for hospital readmission and (2) the pharmacist not completing follow-up calls for all intervention patients. Other studies have helped to identify and reconcile medications changes, as well as reducing hospital admissions[76] and readmissions.[77]

The discharge medicines review service provided by community pharmacists in Wales is designed to ensure that patients returning home from hospital are prescribed the right medicines and gives them an opportunity to ask their pharmacist about their medicines. Evaluation has shown it benefits patients, results in reductions in readmissions to hospital and provides a possible three to one return on investment.[78] The service will now be incorporated into the contractual framework for community pharmacies in Wales.[79]

The community pharmacist is an important first port of call for advice on minor ailments.[80] A survey conducted in support of the development of the White Paper of pharmacies found that 14% of people had used pharmacies to treat one-off common conditions, such as colds, coughs, aches and pains, and stomach problems.[81] Thus, increasing the use of minor ailments schemes would be beneficial for both GP workload and A&E attendance. Other studies have shown that helping patients to take medications correctly, such as for asthma and COPD can reduce emergency hospital admissions associated with these conditions.[82] A study in London demonstrated pharmacy-based minor ailment schemes are feasible and acceptable in the refugee community.[83] Programmes can be cost saving, especially when societal costs are included, and can increase access to healthcare.[84] They can provide the same health-related outcomes and quality of life measures at lower cost, compared to treating minor ailments in primary or emergency secondary care.[85] From a patient perspective, inaccessibility of the GP and perceived non-serious nature of the condition enhance the likelihood of using the community pharmacist, whilst lack of privacy and perceived potential of misdiagnosis are the main concerns.[86]

Attributes of a community pharmacy and its staff may influence people's decisions about which pharmacy they would visit to access treatment and advice for minor ailments. In line with the public's preferences, offering community pharmacy services that help people to better understand and manage symptoms, are provided promptly by trained staff who are friendly and approachable, and in a local setting with easy access to parking, has the potential to increase uptake amongst those seeking help to manage minor ailments. In this way it may be possible to shift demand away from high-cost health services and make more efficient use of scarce public resources.[87]

Influenza vaccination

For most people, influenza (flu) is an unpleasant illness making people feel unwell for several weeks, but it's not serious in healthy people. However, certain people are more likely to develop potentially serious complications of flu, such as bronchitis and pneumonia. This can result in emergency hospital admissions or even death. The following groups of people are now offered free NHS influenza vaccination each year:

- Those aged 65 years and over (see also section on older people)
- Pregnant women
- Those who have certain medical conditions[xi] –
    - chronic (long-term) respiratory disease, such as asthma, COPD or bronchitis
    - chronic heart disease, such as heart failure
    - chronic kidney disease
    - chronic liver disease, such as hepatitis
    - chronic neurological conditions, such as Parkinson's disease or motor neurone disease
    - diabetes
    - problems with your spleen – for example, sickle cell disease, or if you have had your spleen removed
    - a weakened immune system due to conditions such as HIV and AIDS, or as a result of medication such as steroid tablets or chemotherapy

xi Note this list is not definitive and GPs clinical judgement will be used to assess if a person has an underlying illness that may be exacerbated if they catch the flu

- Those living in a long-stay residential care home or other long-stay care facility
- People receiving carer's allowance, or who are the main carer for an elderly or disabled person whose welfare may be at risk if they fall ill
- Healthcare workers with direct patient contact or social care workers

Research has shown that immunisation services can be safely provided in community pharmacy settings,[88] that the review of medication records is a useful tool in flagging up those 'at risk' and inviting them to take part in the programme.[89] Such programmes are also well received by both patients and doctors.[90]

7.5.3. Local provision

Two Urgent Care Centres operate across Halton. The Widnes Centre replaced the walk-in-centre at the Health Care Resource Centre, just outside the main town centre. The Runcorn centre replaced the minor injuries unit on the Halton hospital site. Opening from early morning until late evening, the centres have extended access to x-ray, ultra-sound scanning and a range of bio-chemical and haematology diagnostic services. The centres have medical as well as nursing staff on site and are able to receive patients via paramedic staff.

The centre in Runcorn has an extensive medication stock provided through, Patient Specific Directions and Patient Group Directions (PGDs) as well as the facility for medication to be provided on an FP10 prescription. This is maintained by Warrington and Halton Hospitals NHS Foundation Trust (WHHFT).

The Widnes site uses a combination of PGDs and FP10 prescriptions. The medication stock on site is maintained by WHHFT but the centre is managed by Bridgewater Community NHS Foundation Trust.

There is a community pharmacy located at the Health Care Resource Centre, Widnes, which is open until early evening Monday to Saturday. A number of community pharmacies are located in Halton Lea which is close to the Runcorn Urgent Care Centre, including a 100 hour pharmacy which is open evenings and weekends. All pharmacies offer an over the counter service which provides medication for a range of minor ailments and injuries. Additionally there is commissioned provision of Care at the Chemist, NMS and MURs (see planned care section for NMS and MURs).

Minor Ailments Scheme: Care at the Chemist (CATC)

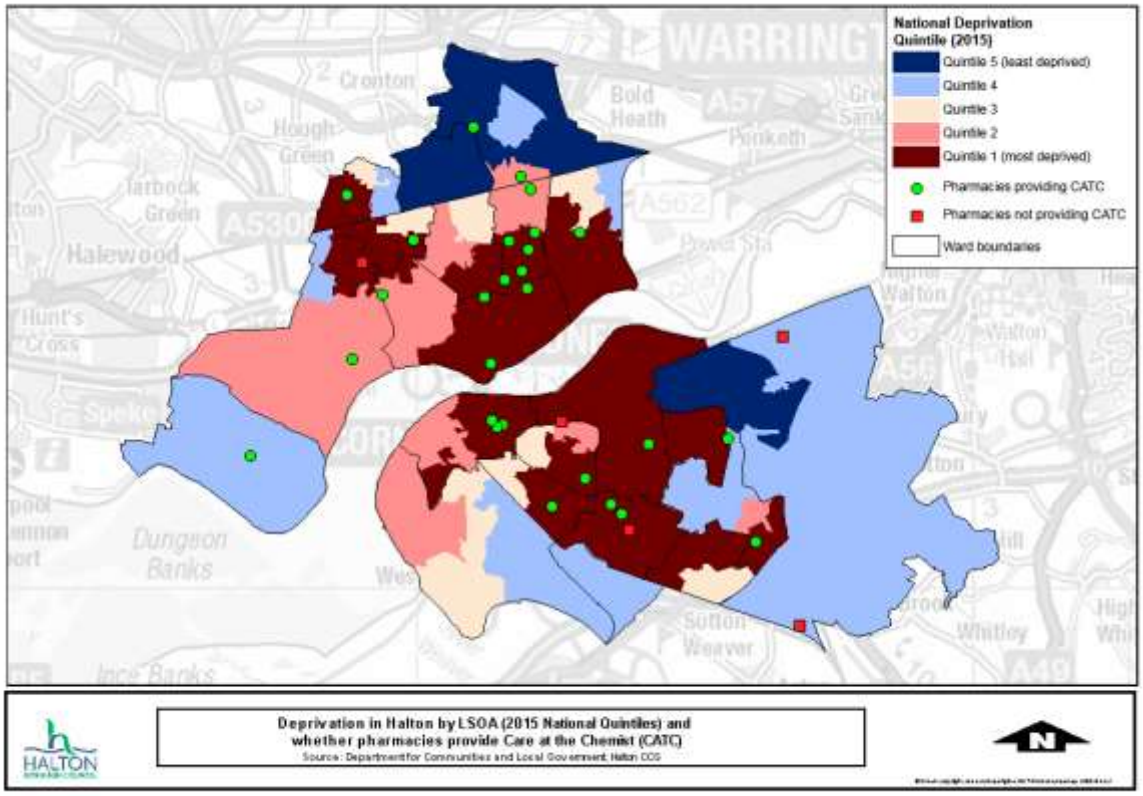
Unlike GPs, community pharmacies are a 'walk up and get seen' service. As such they are a key resource for advice on treating minor, self-limiting, ailments and the purchase of appropriate over-the-counter medicines. CATC takes this concept a stage further. Patients can attend a participating community pharmacy and ask to be seen under the scheme. If the condition is covered by the scheme the patient will receive a consultation and be provided with advice or medication as appropriate from a dedicated formulary. This service is open to patients within Halton CCG and is delivered by accredited Halton pharmacies who have signed up to participate in scheme. The service cannot be commissioned from Internet only pharmacies. The aim of the service is to improve access and choice for people with minor ailments by promoting self-care through the pharmacy, including provision of advice and where appropriate medicines, without the need to visit their GP practice. There is a defined list of conditions that can be treated under the scheme and an extensive formulary. The service provides additional benefit by creating capacity within general practice to provide services to patients requiring more complex management such as the management of long term conditions.

In April 2015 NHS Halton CCG increased the number of pharmacies that provide this service to 29 of its 31 patient facing community pharmacies (see Map 13). The service is well used, with data showing higher uptake in pharmacies in the more deprived wards of Halton. Available data illustrates a large variation in client uptake between pharmacies. The most common ailments patients access the service for are pain, fever, headache, coughs, colds, stomach upset and head lice.

In order to support patient access to this service and overcome difficulties in provision at border locations around the CCG there is a mutual agreement for pharmacies from neighbouring CCGs of Liverpool, St. Helens and Knowsley to provide Minor Ailment Services to residents of Halton.

89% of respondents to the local community pharmacy services survey stated that they think treatment of minor services should be available through community pharmacies. 7% said they should not be provided and 4% were unsure.

Map 13: Pharmacies providing Care at the Chemist service



Influenza vaccination amongst at risk people aged under-65

The NHS Influenza Vaccination Programme is offered to a range of 'at risk' patients under the age of 65 as well as to all those aged 65 and over (see older people's section for more details in vaccination uptake amongst those aged 65+). Some of these annual invites have been established for many years, whilst others are more recent. As described in section 3.2.5 the NHS Influenza Vaccination Programme is now commissioned as part of the advanced services for both at risk adults under age 65 and all adults aged 65+. This annual, seasonal influenza vaccination programme continues to be implemented primarily through GP practices although pharmacies are now offer patients another venue at which to have their vaccination. This increased access is especially important in Halton. Table 5 shows that, for those under age 65 in 'at risk groups,' whilst uptake amongst Halton CCG registered populations is similar to the Merseyside Area Team level and mostly higher than England,

all fall substantially short of the 75% World Health Organization (WHO) recommended national uptake target.

Table 5: Influenza vaccination uptake rates for those at risk under age 65 years, 2015/16

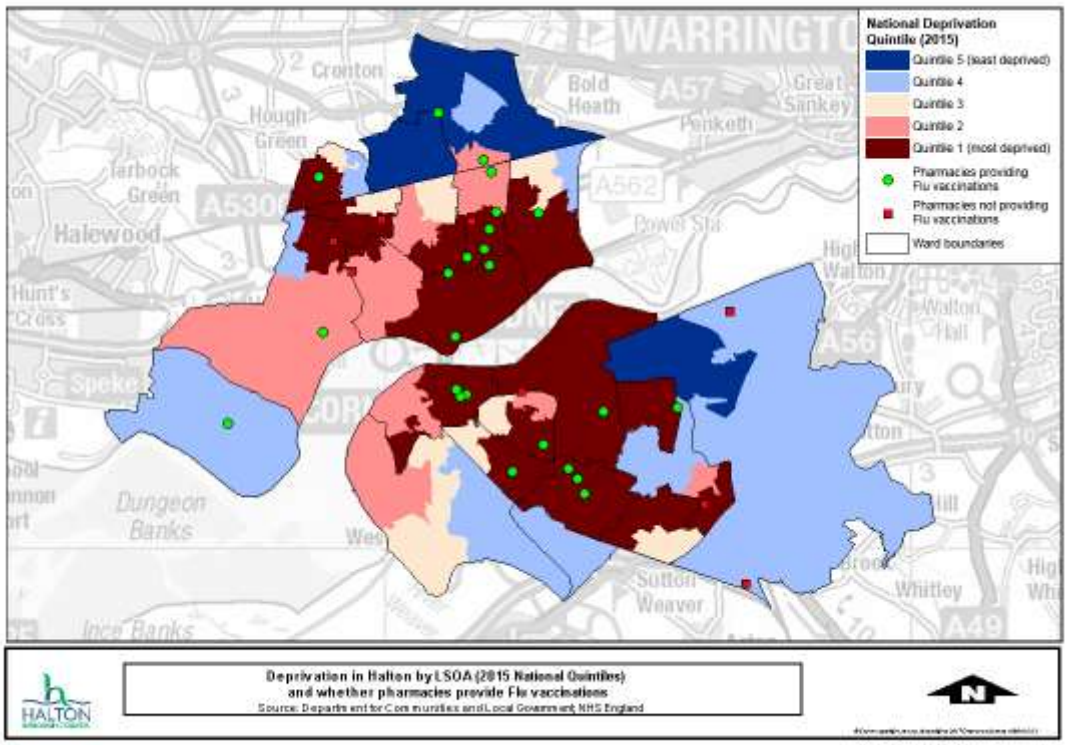
	Halton CCG	Merseyside Area Team	England
All those at risk aged under 65 years	47.6%	48.3%	45.1%
Chronic heart disease	51.4%	51.6%	48.6%
Chronic respiratory disease	50.6%	51.0%	47.4%
Chronic kidney disease	57.4%	58.4%	53.5%
Chronic liver disease	50.5%	50.0%	42.5%
Chronic neurological disease (including stroke/TIA, cerebral palsy and MS)	52.1%	51.2%	49.0%
Diabetes	64.1%	66.4%	65.5%
Immunosuppression	56.3%	56.8%	52.9%
Pregnant women	49.1%	45.8%	42.3%

Source: ImmForm, Department of Health, via NHSE public health team

(For influenza vaccination uptake amongst those aged 65+ see section 7.11)

Under the advanced services contract, most Halton pharmacies now provide NHS Influenza vaccinations to adults in at risk categories. However, 8 do not, including some in areas of high deprivation where emergency admissions are higher.

Map 14: Pharmacies providing NHS Influenza Vaccination to at risk adults



85% of respondents to the local community pharmacy services survey stated that they think treatment of minor ailments should be available through community pharmacies. 10% said they should not be provided and 5% were unsure.

Medicines to Support Admissions Avoidance

There are a number of medications that can support early discharge or admissions avoidance if readily available within the community setting but are not commonly used and as such not routinely stocked by community pharmacies. If a small number of pharmacies were to stock the medications this would support prompt and effective treatment of patients with a number of infections such as cellulitis, some respiratory tract infections and urinary tract infections. Access to a small number of other drugs such as vancomycin for immediate treatment of Clostridium difficile would also support timely treatment and admissions avoidance for this type of patient.

The CCG has commissioned two pharmacies to stock a limited formulary of medicines that will support this agenda. The aims and requirements of the service are:

- To support admissions avoidance and early discharge for specific appropriate conditions and to improve the care of these patients
- Maintain an agreed stock of medicines used to treat specific conditions such as cellulitis, respiratory tract infections, urinary tract infections, Clostridium difficile and suspected DVT at designated community pharmacies. This is intended for supply by community pharmacies against FP10 prescriptions issued.
- Ensuring access to the agreed stock of medicines is available during normal working hours including weekends and evenings.
- Supporting patients, carers and clinicians by providing them with up to date information and advice where appropriate.

This service is being piloted at the moment to assess longer term viability and impact. Two pharmacies have been selected following expressions of interest from across the locality. One of these pharmacies has already gone live with the second following during the summer 2017.

Conclusions

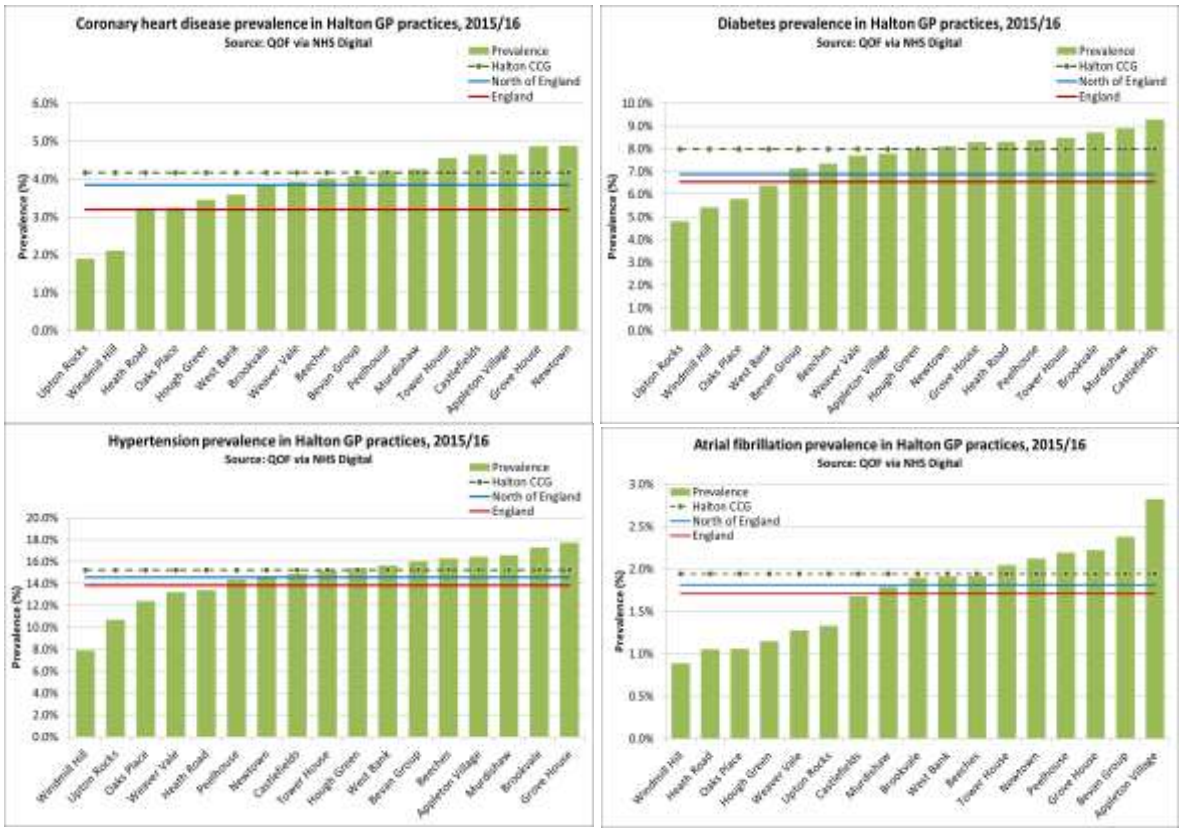
- There is currently adequate access to the Minor Ailment Scheme, Care at the Chemist (CATC), including 100-hour evening and weekend provision. The formulary has been extended to include teething, colic, ear wax and nappy rash and the protocols in use are also due for review which will be done via a rolling programme.
- Cross-border collaboration between boroughs (Liverpool, St Helens and Knowsley) has ensured both access and choice
- Ways of improving awareness of CATC amongst key target groups continues to be investigated
- Influenza vaccination for at risk adults is now widely available through pharmacies across the borough and this has greatly increased accessibility. The primary provider of influenza vaccination remains General Practice

7.6. Supporting and identifying people with Long Terms Conditions, including cardiovascular disease and hypertension

7.6.1. Level of Need

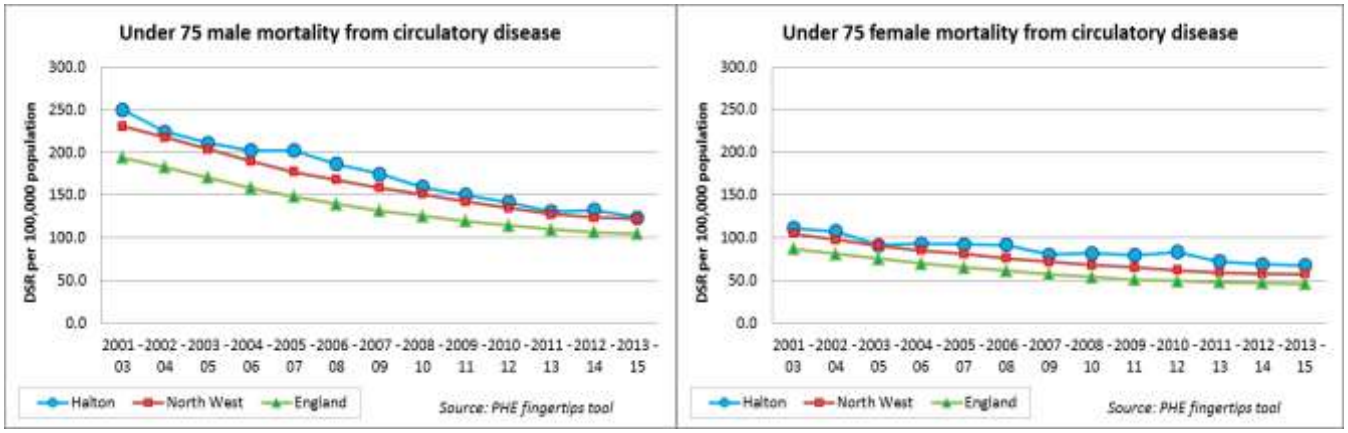
The known prevalence of cardiovascular disease, diabetes and hypertension is higher in Halton than for its comparators. Whilst this may in part be due to proactive case finding estimated prevalence rates are also higher than the England averages suggesting these long-term conditions place a higher burden on the local population and healthcare provision.

Figure 23: Diagnosed prevalence of coronary heart disease, diabetes, hypertension and atrial fibrillation, 2015/16



The impact of this level of need can be seen ultimately in death rates. Rates have fallen substantially over the last two decades. Rates are still higher than the North West and England averages but the gap has narrowed, especially for males.

Figure 24: Trend in death rates from all circulatory diseases for people aged under 75 years (ICD10 I00-I99), directly age standardised (DSR) per 100,000 population all age, 2001-03 to 2013-15



7.6.2. Evidence of effective interventions in the community pharmacy setting

Research studies on the community pharmacy role in reducing the risk and improving outcomes for patients with cardiovascular disease (CVD) are one of the areas where evidence of effectiveness is strongest.

Hypertension (High blood pressure)

Community pharmacy-based initiatives are particularly effective in reducing high blood pressure.[91][92][93] High blood pressure is a major risk factor for cardiovascular disease and stroke. Yet, data has shown a high percentage of undiagnosed high blood pressure in the population. Community pharmacies can play an effective and cost-effective role in both opportunistic screening[94][95] and management of high blood pressure.[96][97][98][99][100][101][102] This is especially effective when done as part of a wider multidisciplinary team collaborative.[103][104] Such collaborative models have been recognised as of value by both the Royal College of General Practitioners and Royal Pharmaceutical Society [105 This is the case for both uncontrolled high blood pressure[106] and when it is already well controlled.[107] Initiatives are most cost effective when managing high risk patients.[108] There is also a high degree of patient satisfaction with community pharmacist led high blood pressure management programmes.[109][110][111] This is especially so amongst those with long term conditions where a long-term relationship underpins high levels of engagement.[112] There are opportunities to expand this role beyond medicines advise and adherence to the inclusion of dietary advise. This should focus on preventing or treating high blood pressure through reducing sodium (salt) intake, as part of a comprehensive approach to improving outcomes. Support and training is needed to do this.[113]

Managing long-term conditions

In addition to screening and management of high blood pressure, community pharmacy is an effective setting for risk assessment and management of cholesterol and management of people at risk of cardiovascular disease.[114] They are less effective for more complex, multi-component interventions aimed at addressing medicines management and lifestyles as part of one programme.[115][116] Even when successful such complex interventions may not be cost-effective.[117] NICE produced public health guidance on proactive case finding to reduce health inequalities in deaths from cardio-vascular disease and smoking-related deaths.[118] It included a recommendation to provide services in places that are easily accessible to people who are disadvantaged (such as community pharmacies and shopping centres) and at times to suit them. However, an evaluation of

the North Tees Health Checks programme, pharmacy element, was carried out in 2010/11.[119] Conducted by interviewing staff from community pharmacy, staff members from the commissioning Primary Care Trusts and with Local Pharmaceutical Committee members it found a number of challenges presented covering 4 categories:

(1) establishing and maintaining pharmacy Healthy Heart Checks, (2) overcoming IT barriers, (3) developing confident, competent staff and (4) ensuring volume and through flow in pharmacy.

It thus concluded that delivering NHS Health Checks through community pharmacies can be a complex process, requiring meticulous planning, and may incur higher than expected costs. Given these barriers, the local implementation of the NHS Health Checks programme should continue to be run through GP practices until such barriers can be overcome. It is clear from the evidence that community pharmacies can play a role in supporting people with long-term conditions.

Community pharmacy-based interventions can be effective in the management of those with Type 2 diabetes and the pharmacist can be an important member of the multidisciplinary team managing patients with diabetes.[120][121] Research has shown interventions can reduce HbA1c levels,[122][123][124][125][126] improve glycaemic control,[127][128][129] bring about improvements in CVD risk in patients with diabetes[130] and general adherence to clinical guidelines through patient education and medicines assessments.[131] They can be effective in targeting those at high risk providing them with point-of-care blood glucose testing and referral being more effective and cost effective than targeting and referral alone. This can reduce emergency hospital admissions. Type 2 diabetes and other CVD screening is effective in diagnosing new cases and bringing about positive therapy changes[132][133] and simple tools can be developed to do this.[134]

Long-term condition management initiatives run in the community pharmacy setting do not have to be pharmacist-led to be effective. A peer health educator programme in which GPs referred older patients with hypertension to a community-pharmacy based volunteer health programme was well received by patients and GPs.[135]

Self care

Pharmacists are more likely to see self-care in terms of patient responsibility and active involvement in their care than in broader concepts of patient autonomy and independence. In particular pharmacist see they have a lead role in medicines-related self-care support.[136] There are opportunities for community pharmacists to provide self-care support to those with long-term conditions as they are regular users of pharmacy services. Whilst many patents see they are already actively engaged in self-care e.g. medicines adherence, many others suggest they need support of professionals as well as family and friends. However, the reasons for patients a lack of awareness of the role community pharmacists can play plus a reluctance to use them for self-care support needs to be understood. This would enable support from community pharmacists to be tailored and 'marketed' more effectively to both patients and general practitioners/ primary care staff.[137][138[139]

7.6.3. Local provision

Many of the commissioned services already described will support people in the borough who have an identified long term condition such as MURs and CATC. For those who have a newly diagnosed condition for which medication is prescribed the NMS can be offered.

NHS Health Checks is a vascular health checks[140] initiative aimed at reducing the burden of cardiovascular disease and mortality, including inequalities in this burden. It is a public health programme for people aged 40-74 which aims to prevent heart disease, stroke, diabetes; kidney

disease and dementia. Together these conditions account for a third of the difference in life expectancy between the most deprived areas and the rest of the country.

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

- Local stop smoking services
- Physical activity interventions
- Weight management programmes
- Alcohol use interventions
- Signposting to dementia services

Locally NHS Health Checks programme is delivered through all GP practices. Up to March 2017, 27,520 (72.6%) eligible patients (between the ages of 40 to 74 and not currently on a GP disease register) were invited for a Health Check and of these 12,418 (45.1%) of those invited during the year had a Health Check. In an attempt to boost the number of patients receiving Health Checks, health trainers from the Health Improvement Team have been located in some practices. This offer has the advantage of being able to sign patients up for appropriate lifestyle services rather than making a referral. The role of the community pharmacies will be required to focus on the management of any medication needs that may result from the health check including the provision of stop smoking aids. It is expected that for an annual population of people invited for a Health Check to primary care 1,264 will be smokers and 1,214 obese or overweight, 515 will require statins and 138 will require medication for high blood pressure. The pharmacy has a very clear role in provision of this medication and support to enable compliance.

In addition to Health Checks there are well established disease registers within GP practices to ensure the proactive management of patients with established long-term conditions such as cardiovascular disease, diabetes, respiratory disease, asthma and others.

Hypertension – Cheshire & Merseyside level work

Hypertension was identified as a priority for action in Cheshire and Merseyside by the Champs public health collaborative service. The Cheshire & Merseyside Public Health Leads Group is working on a system wide approach for the prevention, detection and treatment of high blood pressure. At the heart of the strategy[141] is the ambition to ensure local communities have the best possible blood pressure and that Cheshire & Merseyside becomes the most improved sub-region in England for blood pressure outcomes.

The strategy is being led by the Cheshire & Merseyside Blood Pressure Partnership Board which has representation from local authorities, health and the voluntary sector. Halton is well represented at this Board. Sustainability and Transformation Plans also called Five Year Forwards View Plans have provided an opportunity to act as a lever to implement the Blood Pressure strategy through NHS partners and settings

Pharmacy has been identified as an ideal setting to reach the community and it is expected that pharmacy will play a key role in not just providing medication support but also for carrying out early identification of hypertension through blood pressure testing and provide additional healthy lifestyle advice and signposting within the wider health system. The advent of Healthy Living Pharmacy is expected to act an enabler for this (see Appendix 6 for information on Healthy Living Pharmacies).

87% of respondents to the local community pharmacy services survey stated that they think tests to check blood pressure, cholesterol and whether they might get diabetes or other conditions should be available through community pharmacies. 82% stated that smoking cessation and/or nicotine replacement therapy should be available and 72% thought weight management should be available.

Conclusions

- There is some evidence from the literature that pharmacies can play an important role in helping patients to manage long-term conditions, particularly cardiovascular disease. Pharmacies are able to offer checks for blood pressure, blood sugar and signpost affected individuals into primary care for definitive management
- Under the essential services contract pharmacies should support six health education campaigns per year. This is led by NHS England and the content of the campaigns is open to local influence subject to consultation

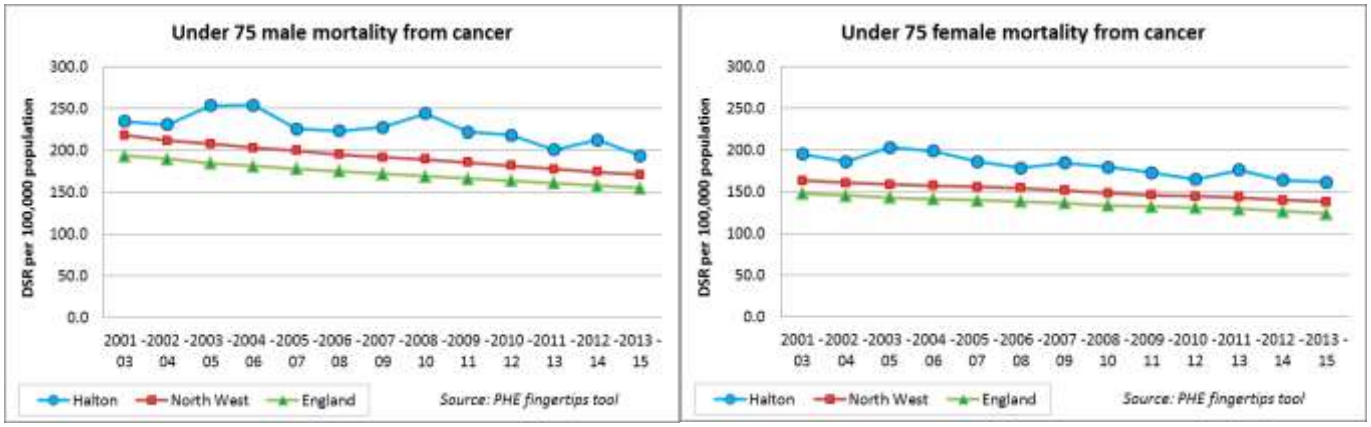
7.7. Cancers

7.7.1. Level of Need

Whilst the evidence indicates that substantial reduction in deaths from cancers can be achieved by healthy lifestyles, interventions to bring about this change are long-term. Local assessment suggests capacity in secondary care is not a significant issue. In the short term the most likely way to improve survival times and reduce deaths from cancer is to get people who have symptoms to come forward for treatment earlier.

Figure 25 shows that Halton has significantly higher mortality rates than England and also the North West since 2001-03. Overall, the cancer mortality rates for both males and females have declined, but the male rate remains higher than for females. Cancer remains one of the top priorities for the borough and is included in the 2017-2022 JHWBS.

Figure 25: Trend in death rates from all cancers for people aged under 75 years (ICD10 C00-C97), directly age standardised (DSR) per 100,000 population all age, 2001-03 to 2013-15



7.7.2. Evidence of effective interventions in the community pharmacy setting

See also tobacco control

The community pharmacy is an ideal place for the public to obtain information on cancer. Pharmacy-based information, such as touch screen technology, appears to be effective in raising awareness of sun risks, and trained pharmacists are more likely to be proactive in counselling clients. However, the effect of this advice on the behaviour of clients is currently unknown.[142] This could be rolled out to include awareness campaigns about skin and bowel cancer and cancer screening. Feedback from health improvement campaigns shows the community pharmacy is an acceptable location for cancer prevention campaigns[143] including discussions about prevention and early detection of cancer.[144] For those with established cancers pharmacies can play an important role in identifying common drug-related problems via medication therapy management services.[145] Oral anticancer medications offer patients advantages over traditional intravenous anticancer therapy. However, patients and their caregivers must be well educated in how to use them to reduce risk and achieve the best possible outcomes. Whilst oncology teams play the central role in this, community pharmacists can make an important contribution. This can include an understanding of patient and system barriers with these medications, proper administration and adherence, drug and food interactions, safe handling and disposal.[146] However, this is not without its challenges and issues such as safe infrastructure with education and training are needed.[147]

7.7.3. Local provision

The local Cancer Strategy emphasises prevention and early detection. Local activity supports the national campaign messages of *Be Clear on Cancer* programmes through a combination of approaches including social marketing, public awareness, as well as with public and clinical staff training. Social marketing is used to encourage people with symptoms to seek medical advice. The *Be Clear on Cancer* campaigns use a wide range of outlets and vehicles to spread the key messages, with pharmacies being an important outlet. It is not possible for pharmacies to offer cancer screening. Both breast and cervical screening require specialist equipment and staff. The bowel screening programme is based on home testing that is posted direct to laboratories. Pharmacies can have an active role in encouraging participation in screening and helping people order bowel screening kits from the central Hub. Cancer is a local JHWBS priority. As such, and based on the evidence, it would be appropriate to include cancer screening and sun awareness as one of the six health education campaigns pharmacies should support each year as part of their essential services, national contract

Conclusions

- There are currently no plans to commission services for the prevention of cancers in pharmacies. The need for specialist equipment and procedures means it would not be feasible for them to provide cancer screening services
- As part of the essential services contract, the use of the six health education campaigns should include at least one on cancers as a local HWB priority

7.8. Sexual Health

7.8.1. Level of Need

Improving the sexual health of the population is a national and local priority with the most recent national public health strategy[148] and sexual health framework outlining the reasons and approach.[149]

Locally our population suffers from poor sexual health. Teenage conception rates have fallen overall in recent years but remain above the national and regional rates (Figure 26). This is also the case for abortions amongst under-18s (Figure 27). For teenage conceptions the gap between Halton and England is statistically significant but this is not so for the percentage of teenage conceptions that result in abortion.

The borough also has seen an overall decrease in the number of sexually transmitted infections (STIs) and HIV being diagnosed. Halton's overall rate of STIs for 2015 was below the Cheshire & Merseyside average and was the third lowest of the nine local authorities in the sub-region (Figure 28).

Figure 26: Teenage conception rates 1998 to 2015

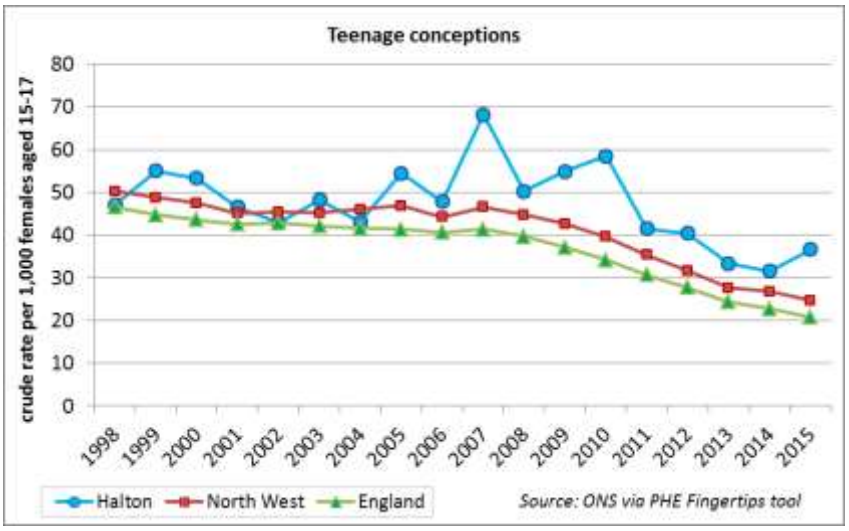


Figure 27: Percentage of conceptions amongst women aged under18 leading to abortion, 1998 to 2015

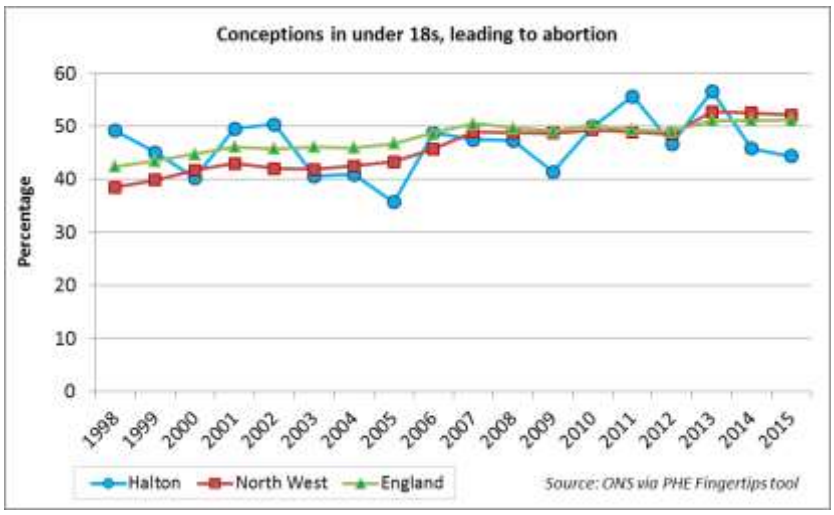


Figure 28: Sexually transmitted infection rates in Halton 2012 to 2015 and compared to other local authorities in Cheshire & Merseyside, 2015

7.8.2. Evidence of effective interventions in the community pharmacy setting

NICE guidance on contraceptive services for young people (up to the age of 25),[150] key recommendations include:

- Establish collaborative, evidence-based commissioning arrangements between different localities to ensure comprehensive, open-access services are sited in convenient locations, such as city centres, or near to colleges and schools. Ensure no young person is denied contraceptive services because of where they live
- Ensure pharmacies, walk-in centres and all organisations commissioned to provide contraceptive services (including those providing oral emergency contraception) maintain a consistent service. If this is not possible, staff should inform young people, without having to be asked, about appropriate alternative, timely and convenient services providing oral emergency contraception
- Doctors, nurses and pharmacists should where possible, provide the full range of contraceptive methods, especially long-acting reversible contraception (LARC), condoms to prevent transmission of STIs and emergency contraception (both hormonal and timely insertion of an intrauterine device). Adequate consultation time should be set aside
- Provide additional support for socially disadvantaged young people to help them gain immediate access to contraceptive services and to support them, as necessary, to use the services. This could include providing access to trained interpreters or offering one-to-one sessions. It could also include introducing special facilities for those with physical and sensory disabilities and assistance for those with learning disabilities
- Ensure all young women are able to obtain free emergency hormonal contraception, including advance provision
- Offer support and referral to specialist services (including counselling) to those who may need it. For example, young people who misuse drugs or alcohol and those who may have been (or who may be at risk of being) sexually exploited or trafficked may need such support. The same is true of those who have been the victim of sexual violence
- Ensure young men and young women know where to obtain free advance provision of emergency hormonal contraception
- In addition to providing emergency hormonal contraception, professionals should ensure that all young women who obtain emergency hormonal contraception are offered clear information about, and referral to, contraception and sexual health services
- Encourage all young people to use condoms and lubricant in every encounter, irrespective of their other contraceptive

- Ensure staff are familiar with best practice guidance on how to give young people aged under 16 years contraceptive advice and support.[xii] Ensure they are also familiar with local and national guidance on working with vulnerable young people

A review of the contribution of community pharmacists to the public health agenda[151] found:

- Emergency hormonal contraception (EHC) can be effectively and appropriately supplied by pharmacists
- Pharmacy supply of EHC enables most women to receive it within 24 hours of unprotected intercourse
- Community pharmacies are highly rated by women as a source of supply and associated advice for EHC on prescription, by Patient Group Directions (PGDs), or over-the-counter (OTC) sales
- 10% of women, choose pharmacy supply of EHC in order to maintain anonymity
- Pharmacists were positive about their experience of providing emergency hormonal contraception through PGDs and over-the-counter sales
- The role of pharmacy support staff in provision of EHC services is reported by pharmacists to be important

There is support from both customers and pharmacists for the provision of a wider range of sexual health services beyond EHC, including short supply progesterone-only pill[152][153] and progestogen only injections[154] to ensure ease of access to effective contraception as well as chlamydia screening.[155] In particular pharmacy-based EHC consumers are at high risk of chlamydia and would be willing to accept a chlamydia test from the pharmacy.[156 Although pharmacies in the UK cannot provide sexual and reproductive healthcare beyond retail condoms and EHC, a Scottish pilot study suggests that for women obtaining EHC from a pharmacy, simple interventions such as supplying 1 month of a progesterone-only pill, or offering rapid access to a sexual health clinic, hold promise as strategies to increase the uptake of effective contraception after EHC.[157]

NICE guideline NG68[158] recommends that all existing services that are likely to be used by those most at risk of contracting STIs should provide condom schemes. This could include services provided by the voluntary sector (such as advice projects and youth projects), school health services and primary healthcare (including GP surgeries and community pharmacies). There should be links made between such condom schemes and local sexual and reproductive health services. For example, they should consider:

- Providing condoms with information about local sexual health services
- Displaying posters and providing leaflets advertising local sexual health services where condoms are available

7.8.3. Local provision

Across Halton emergency hormonal contraception is provided by a host of providers at different times:

- Pharmacy under patient group direction (locally commissioned service)
- GP's
- Walk in Centre

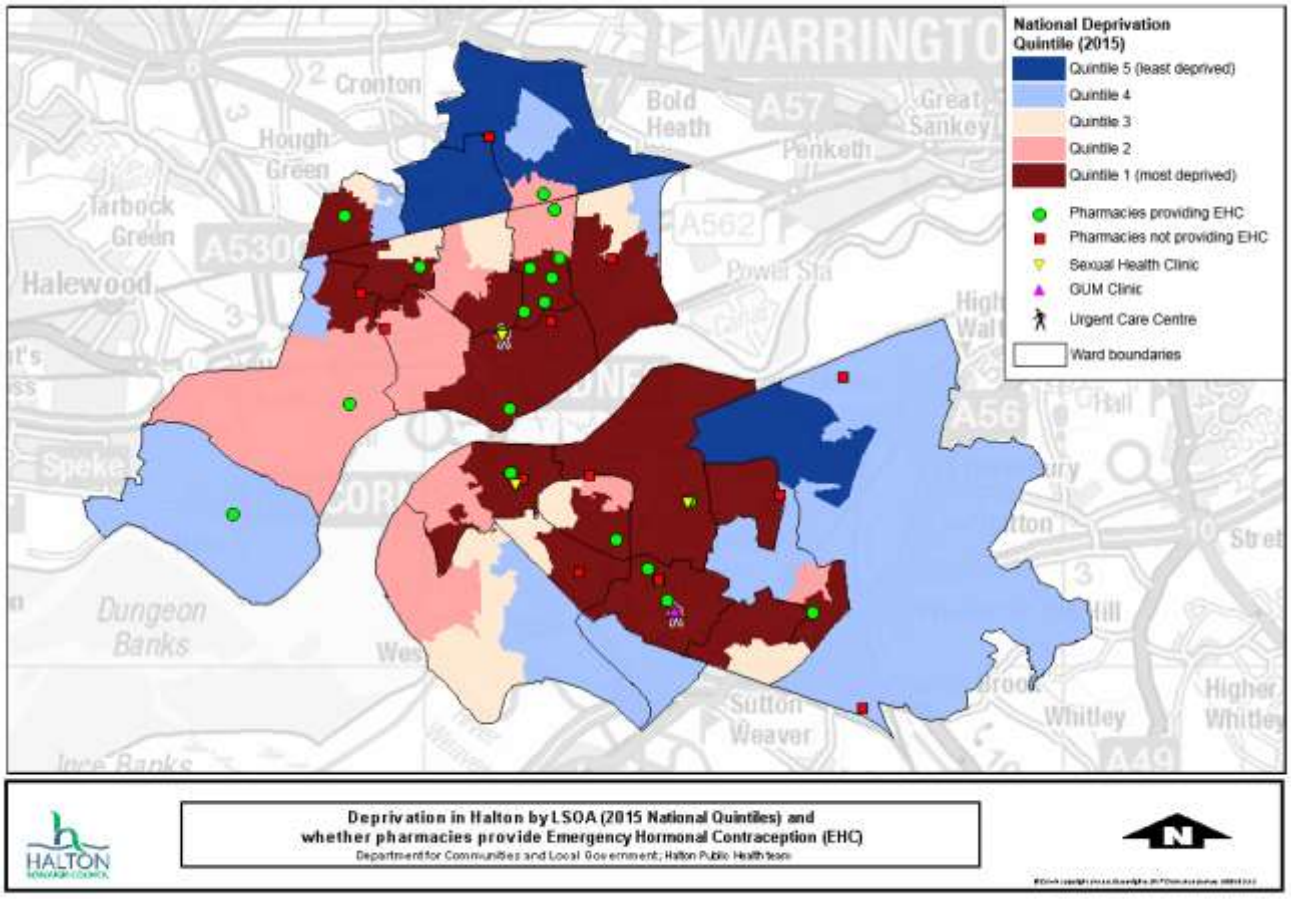
xii. Department of Health (2004) Best practice guidance for doctors and other health professionals on the provision of advice and treatment to young people under 16 on contraception, sexual and reproductive health. London: Department of Health.

- A & E
- Community Sexual Health Services
- School nursing
- Genito-urinary medicine (GUM)

19 pharmacies provide Emergency Hormonal Contraception (EHC) as a locally commissioned service during the pharmacy's normal opening times. Pharmacists must be accredited to provide the service. They also provides advice and signposting in respect of contraception and sexual health. Whilst pharmacies providing EHC can advise and signpost people to other services, neither chlamydia screening or screening for other STIs, is commissioned. 15 pharmacies do have toilet facilities that clients could use for screening and pregnancy testing, 5 of which are commissioned and provide EHC. The c-card scheme enables people to access free condoms. These are available at community sexual health clinics and pharmacies that provide EHC.

Map 15 shows the level of deprivation and the distribution of pharmacy EHC services in the borough. Some pharmacies that have been commissioned to provide the service are currently not providing it. From previous experience this is generally due to accredited pharmacists moving on from that location or accreditation requirements for pharmacists not being completed.

Map 15: Emergency Hormonal Contraception provision by community pharmacies and other community healthcare providers



Whilst the map shows that there are parts of the borough with high deprivation levels and no community pharmacy EHC provision, there is community healthcare EHC provision, including the Urgent Care Centres, in the surrounding areas. Deprivation is only a proxy measure of need. Therefore given the geographical spread of provision in both Widnes and Runcorn overall provision is adequate.

85% of respondents to the local community pharmacy services survey stated that they think advice on contraception and supply of EHC should be available through community pharmacies. 7% thought it should not be available and 9% were unsure. This is an increase on the last PNA when only 72% thought these services should be provided.

Conclusions

- There is adequate provision of EHC in all areas with high levels of deprivation. There is less provision from community pharmacies in Riverside ward but there is community sexual health service provision at the Health Care Resource Centre and the Widnes Urgent Care Centre. There is c-card provision to pharmacies providing EHC

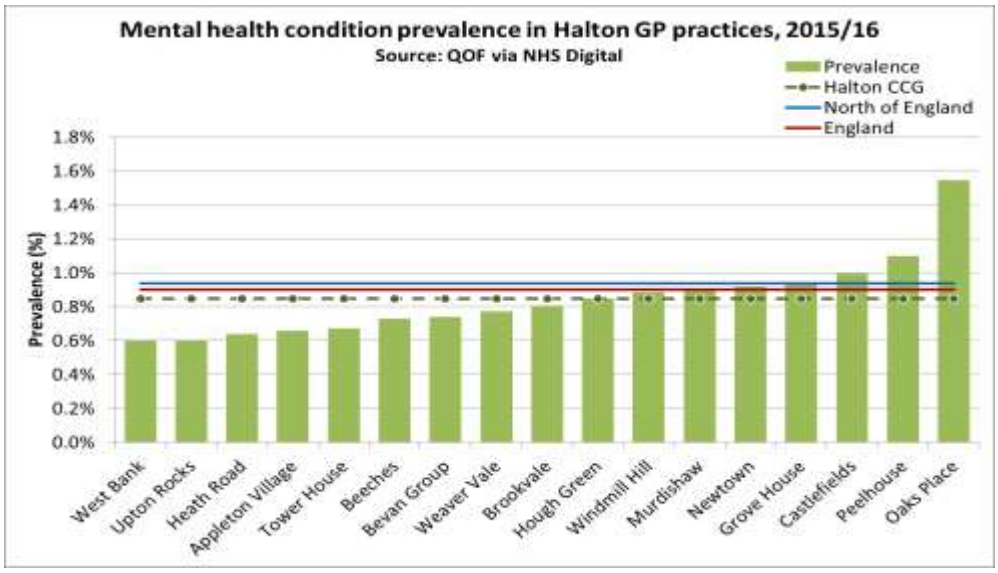
7.9. Mental Health

7.9.1. Level of Need

Mental Health is one of Halton's Health & Wellbeing Strategy priorities, with an emphasis on wellbeing as well as prevention and early detection of mental illness.

Since 2008-9 the Quality Outcomes Framework (QOF) has included that the GP register of mental health includes all people with a diagnosis of schizophrenia, bipolar affective disorder and other psychoses rather than a generic phrase that is open to variations in interpretation. This brings mental health in line with other areas of the QOF. Such patients should receive a review every 15 months which includes health promotion and prevention advice, have a care plan, the follow-up of those who do not attend for their annual review and monitoring of the use of lithium therapy.

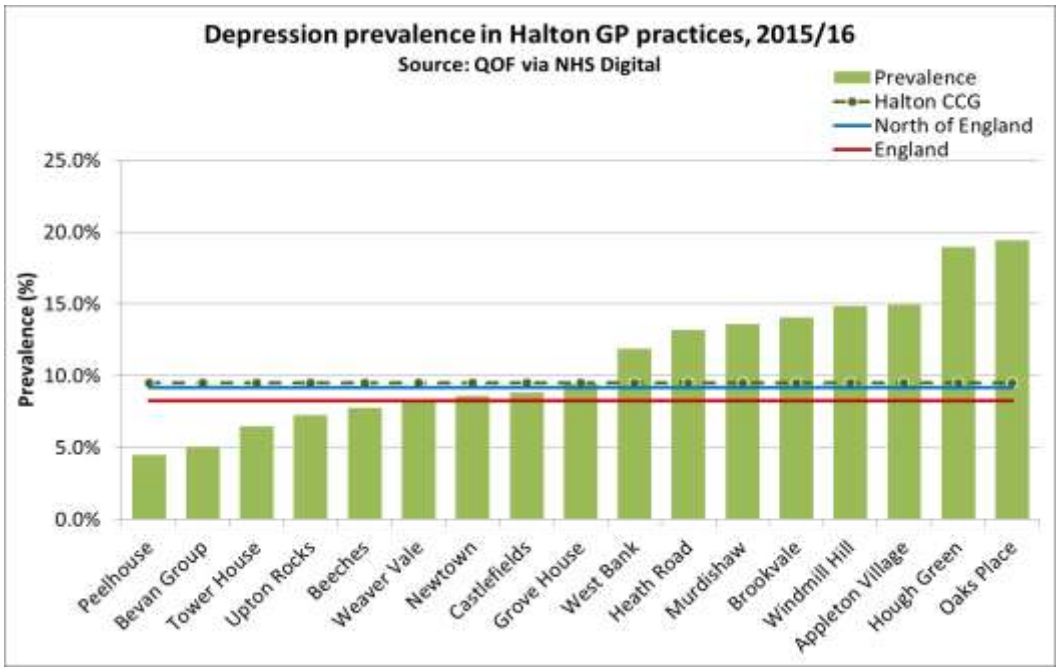
Figure 29: Prevalence of severe mental illness identified on GP registers in Halton, compared to Merseyside and England, 2015/16



Further changes to QOF for 2009-10 included the introduction of a register for those aged 18 and over who have been diagnosed with depression. Clinical management indicators include:

- the percentage of patients on the diabetes and/or CHD register who have been assessed for depression,
- for those newly diagnosed with depression, the percentage of whom have had an assessment of its severity at the onset of treatment and
- the percentage of those who receive an assessment who then receive a follow-up assessment 5-12 weeks after this.

Figure 30: Prevalence of depression identified on GP registers in Halton, compared to Merseyside and England, 2015/16



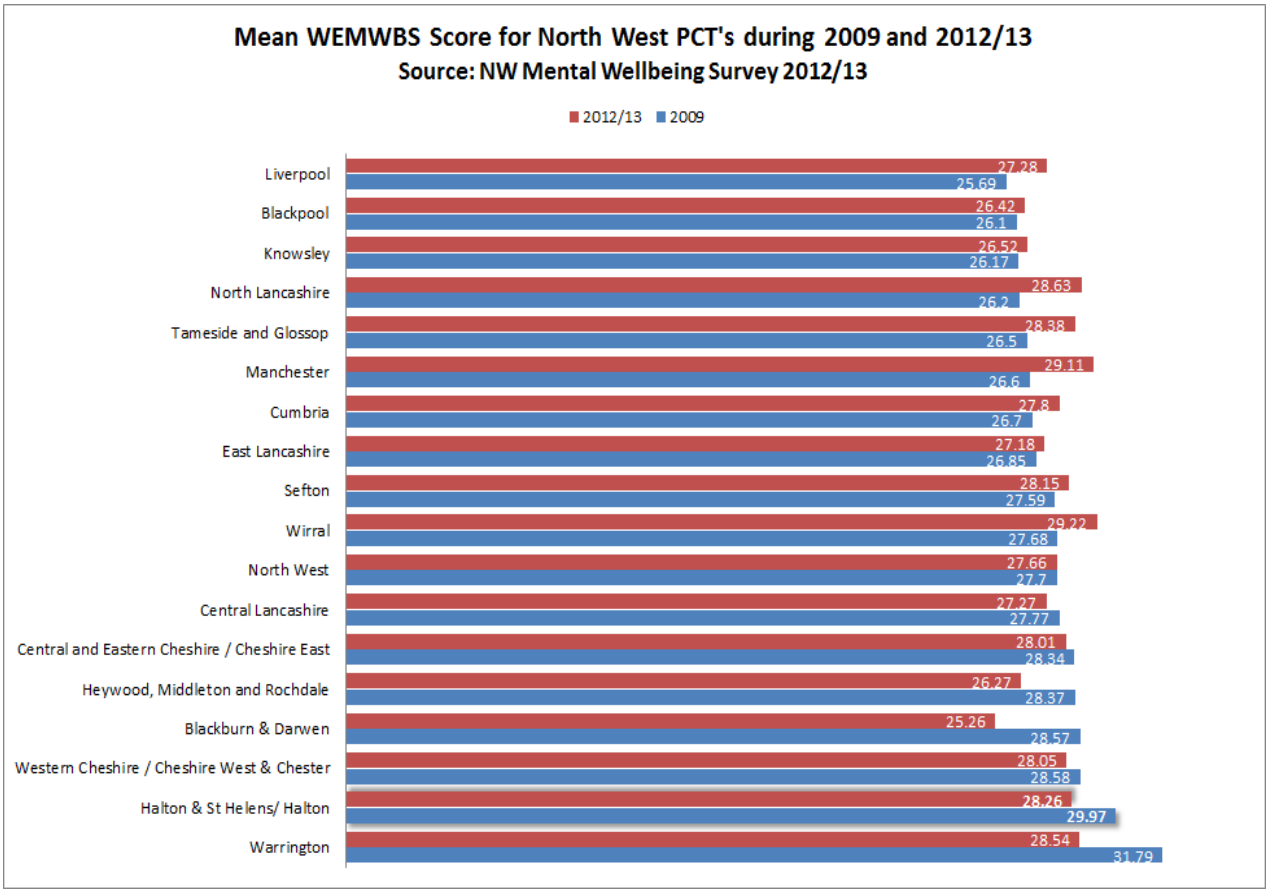
Much of the data available under the label mental health is in fact measuring a clinically diagnosed mental illness. There has been increasing interest nationally and locally in the concept of mental wellbeing. The Foresight report [159] defines mental wellbeing, or simply wellbeing, as:

> *"a dynamic state, in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others, and contribute to their economy. It is enhanced when an individual is able to fulfil their personal and social goals and achieve a sense of purpose in society."*

The North West Mental Wellbeing Survey points out that there is a clear distinction between mental wellbeing and mental illness. Mental health, or mental wellbeing, is something we all have and seek to improve. Mental illness or disorders affect up to one in four people. The determinants of one are not necessarily the same as the other.[160]

Results from the 2009 North West mental Wellbeing Survey and the more recent 2012/13 survey are shown in Figure 31. Using a composite score of 7 questions on a 5-point Likert scale, known as WEMWBS (Warrick and Edinburgh Mental Wellbeing Score), boroughs could easily be compared to the North West average and also to one another.

Figure 31: NW mental wellbeing survey results



Although the overall wellbeing score for Halton is slightly lower than the previous result for Halton & St Helens PCT, it is nevertheless above the North West average and higher than others in the Liverpool City Region, apart from Wirral.

7.9.2. Evidence of effective interventions in the community pharmacy setting

No relevant studies on the early detection or depression were found in the literature review undertaken. A report by the Department of Health on the public health role of pharmacists, acknowledges this lack of an evidence base, suggesting that it is not beyond the scope of community pharmacists to have a role in mild to moderate mental ill health. For example, customers purchasing products to reduce stress and anxiety, such as sleeping products, could be offered support and advice from appropriately training pharmacists such as signposting or referral to local services.[161] This role in detecting the early signs and symptoms of mental health problems and providing information on how to deal with them is supported by a joint pharmacy report in which they conclude that there is a potential role for pharmacy staff to offer support and advice in relation to mental health issues.[162] Studies have also shown that the community pharmacist can make a valuable contributions to community mental health teams.[163][164][165]

The stigma of mental illness can be a barrier to effective medication management in the community pharmacy setting. Self-stigma impeded consumers' community pharmacy engagement. Positive relationships with knowledgeable staff are fundamental to reducing stigma. Stigmatising views can also be held by health professionals resulting in the giving of biased/inaccurate advise and behaviours. Awareness raising training for pharmacy staff can improve communications and reduce

negative experiences.[166] This is not surprising given that mental health literacy -*'knowledge and beliefs about mental disorders which aid in their recognition, management or prevention'* - is poor, especially compared to physical health issues such as long-term conditions. Healthcare professionals, including community pharmacists, view education campaigns as important in addressing this.[167] The focus on products and business required of community pharmacies can inhibit a more patient-centred pharmacy culture, despite undergraduate training programmes espousing this.[168] Research is scarce on medication support interventions for people with mental health problems but broader medicines management for long-term conditions can inform the development of mental health focussed medication support services.[169]

7.9.3. Local provision

Mental Health is a local JHWBS priority. The focus of the JHWBS is one of wellbeing, prevention and early detection across the life course. This is in line with the national mental health strategy.

The community pharmacy is an ideal place for the public to obtain information on all forms of mental health conditions, in particular, ways in which they can access support and services to improve their wellbeing. As seen from the evidence, appropriately trained pharmacy staff can play a role in signposting and referral and there is the potential to link them to Health & Wellbeing Services and other provision of support. As such, and based on the evidence, it would be appropriate to include mental health and wellbeing as one of the six health education campaigns pharmacies should support each year as part of their essential services, national contract.

Conclusions

- Pharmacies are well placed to detect the early signs of mental health problems and could refer people in to the single point of access to mental health services and to participate in awareness raising campaigns
- Under the essential services contract pharmacies should support six health education campaigns per year. Community pharmacies are well placed to take part on local and national campaigns around mental health. As a local JHWBS priority this should be considered

7.10. Substance Misuse

7.10.1. Level of Need

Prevalence estimates of opiate and crack/cocaine use indicates a higher rate per 1,000 population in Halton than nationally. The estimated prevalence of injecting drug use is slightly below the national average.

The data below is taken from the National Drug Treatment Monitoring System, and includes people who are in structured drug treatment for:

- Alcohol and non-opiate
- Non-opiate
- Opiate

During 2015/16 there were 585 individuals in contact with structured drug treatment, which is slightly lower than the previous year when there were 646.

The balance of males and females has remained constant for a number of years in Halton. Of the total population of people in treatment during 2015/16, 26% were female and 74% male. This is very similar to the national (27% female and 73% male) and North West (28% female and 72% male) figures.

In Halton during 2015/16, 97% of people in treatment were retained for 12 weeks or more or completed treatment. Due to this high percentage, the Halton 2015/16 value was significantly higher (better) compared to the North West (93%) and England (93%).

The percentage of people successfully leaving treatment in Halton improved slightly between 2014/15 and 2015/16 – from 27.2% to 29.7%. During 2015/16, the Halton percentage was significantly higher (better) than both the England (15.2%) and North West (17.9%) averages.

7.10.2. Evidence of effective interventions in the community pharmacy setting

NICE guidance PH52 on the optimum provision of Needle & Syringe Programmes[170] places community pharmacies at the heart of the provision of these programmes.

Recommendation 8 Provide community pharmacy-based needle and syringe programmes
Community pharmacies, coordinators and local pharmaceutical should:

- Ensure staff who distribute needles and syringes are competent to deliver the level of service they offer. As a minimum, this should include awareness of the need for discretion and the need to respect the privacy and confidentiality of people who inject drugs. It should also include an understanding of how to treat people in a non-judgmental way.
- Ensure staff providing level 2 or 3 services (see recommendation 6) are competent to provide advice about the full range of drugs that people may be using. In particular, they should be able to advise on how to reduce the harm caused by injecting and how to prevent and manage an overdose.
- Ensure staff have received health and safety training, for example, in relation to blood-borne viruses, needlestick injuries and the safe disposal of needles, syringes and other injecting equipment.
- Ensure hepatitis B vaccination is available for staff directly involved in the needle and syringe programme.
- Ensure staff are aware of, encourage and can refer people to, other healthcare services including drug treatment services.
- Ensure pharmacy staff offer wider health promotion advice, as relevant, to individuals.

Recommendation 7 Provide people with the right type of equipment and advice
Needle and syringe programme providers should:

- Provide people who inject drugs with needles, syringes and other injecting equipment. The quantity provided should not be subject to a limit but, rather, should meet their needs. Where possible, make needles available in a range of lengths and gauges, provide syringes in a range of sizes and offer low dead-space equipment.
- Not discourage people from taking equipment for others (secondary distribution), but rather, ask them to encourage those people to use the service themselves.
- Ensure people who use the programmes are provided with sharps bins and advice on how to dispose of needles and syringes safely. In addition, provide a means for safe disposal of used bins and equipment.

- Provide advice relevant to the type of drug and injecting practices, especially higher risk practices such as injecting in the groin or neck.
- Encourage people who inject drugs to mark their syringes and other injecting equipment, or to use easily identifiable equipment, to reduce the risk of accidental sharing.
- Encourage people who inject drugs to use other services as well. This includes services that aim to: reduce the harm associated with this practice; encourage them to switch to safer methods, if these are available (for example, opioid substitution therapy), or to stop using drugs; and address their other health needs. Tell them where to find these services and refer them as needed.

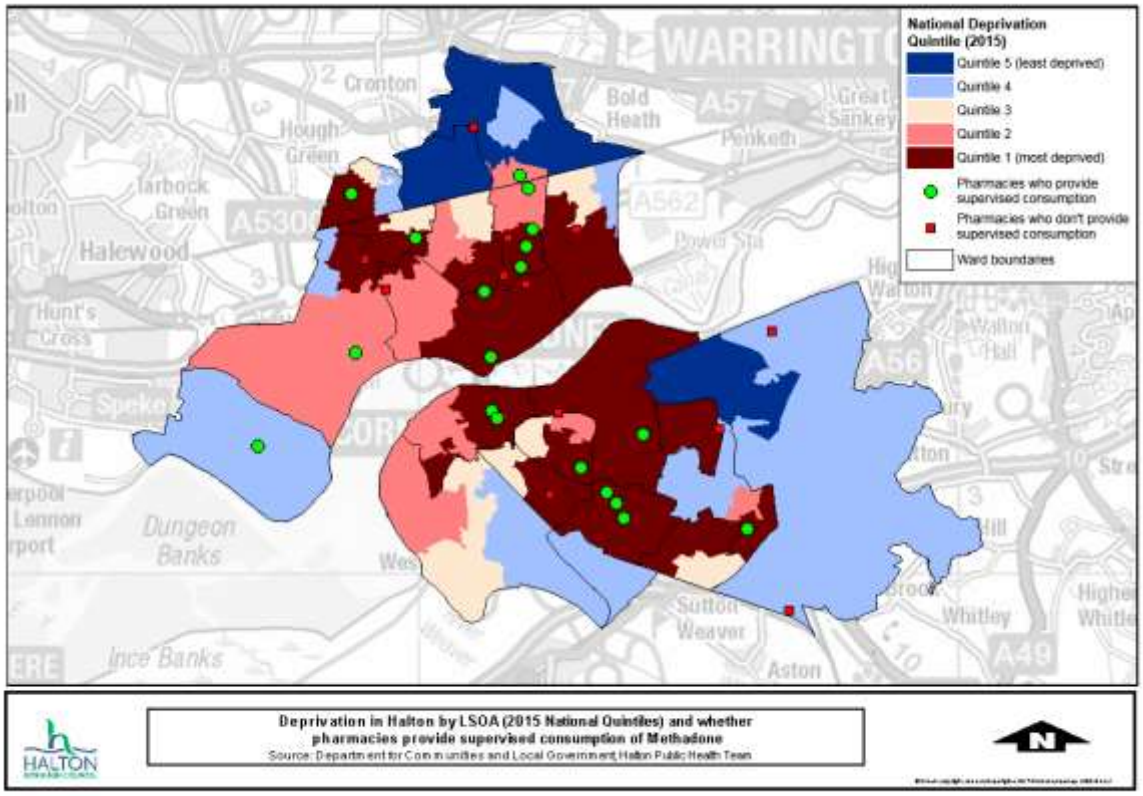
Research also demonstrates that community pharmacy-based supervised methadone administration services can achieve high attendance rates and are acceptable to clients.[171] NICE guidelines recommend that each new treatment of opiate dependence be subject to supervised administration for the first three months or a period considered appropriate by the prescriber. The rationale for this recommendation is to provide routine and structure for the client, helping to promote a move away from chaotic and risky behaviour. This service requires the pharmacist to supervise the consumption of prescribed medicines at the point of dispensing in the pharmacy – ideally within a private consultation room, and ensuring that the dose has been administered to the patient.[172]

7.10.3. Local provision

Currently commissioned pharmaceutical services available to substance misuse clients include supervised administration of methadone (or similar medication). This is a fundamental harm reduction service. Supervised administration is a service that can only be provided by a pharmacy following dispensing of an appropriate diamorphine substitute such as methadone. It minimises harm by reducing diversion of prescribed methadone onto an illicit market and protecting vulnerable individuals from overdose.

20 pharmacies are currently commissioned to provide supervised administration, and these are shown in Map 16. The service requires the pharmacist to supervise the consumption of prescribed medicines (methadone), at the point of dispensing in the pharmacy within a private consultation room, and ensuring that the dose has been administered to the patient.

Map 16: Supervised consumption provision



Pharmacy provision of needle and syringe exchange service is currently being redeveloped. The LAPHT and pharmacies are working on the revised provision and it is envisaged that this will recommence during the lifetime of this PNA.

The community pharmacy is also an ideal place for the public to obtain information on all forms of substance misuse, and in particular ways in which they can access support and services. This should include information on the misuse of prescription and non-prescription substances and also the misuse of steroids which is increasing locally.

However, only 43% of respondents to the local community pharmacy services survey stated that they think advice and treatment for drug problems should be available through community pharmacies. 35% stated they did not think these services should be available through the community pharmacy and 21% were unsure. This is a substantially lower 'Yes' response than for all other services apart from alcohol misuse services.

Conclusions

- Provision of needle & syringe exchange is through the community drugs service. This provision is adequate. However, there is an ambition to recommence the pharmacy provision of this service
- There is adequate provision of supervised administration services provided by community pharmacies across the borough

7.11. Older People

7.11.1. Level of Need

As people get older the chances of developing long-term conditions increase. As these worsen they are likely to impact on a person's ability to carry out all the daily activity they would like to. This is especially likely if the person has multiple conditions. Data from the last Census shows that Halton has a higher proportion of its population living with a long-term health problem or disability that limit their daily lives a lot or a little than both the North West and England.

Table 6: Percentage of the population with long-term health problem or disability, 2011 Census

	Population	Day-to-day activities limited a lot	Day-to-day activities limited a little	Day-to-day activities not limited
Halton	125,746	11.6%	9.8%	78.6%
North West	7,052,177	10.4%	10.0%	79.8%
England	53,012,456	8.3%	9.3%	82.4%

Source: Office of National Statistics, 2013

This data also shows that in Halton, as elsewhere the number of the population with such conditions increases with age

Table 7: Number of Halton residents with long-term health problem or disability, by age group, 2011 Census

	Age Group									
	All ages	0 to 15	16 to 24	25 to 34	35 to 49	50 to 64	65 to 74	75 to 84	85 and over	65+
limited a lot	13,970	417	340	615	1,978	4,302	2,911	2,396	1,011	6,318
limited a little	12,154	574	501	741	2,042	3,658	2,451	1,758	429	4,638
limited a little or a lot	26,124	991	841	1,356	4,020	7,960	5,362	4,154	1,440	10,956
not limited	98,750	23,930	13,551	14,424	22,526	17,372	4,926	1,758	263	6,947

Source: Census 2011, Office of National Statistics 2013.

The level of ill health in the borough means that Halton experiences a lower than average level of healthy life expectancy at 65 (Figure 32). The level is statistically significantly lower than the England average. Table 8 shows that Halton males and females spend a small proportion of their life from age 65 onwards in good health, compared to the North West and England averages.

Figure 32: Healthy Life expectancy, 2009/2011 to 2013/15

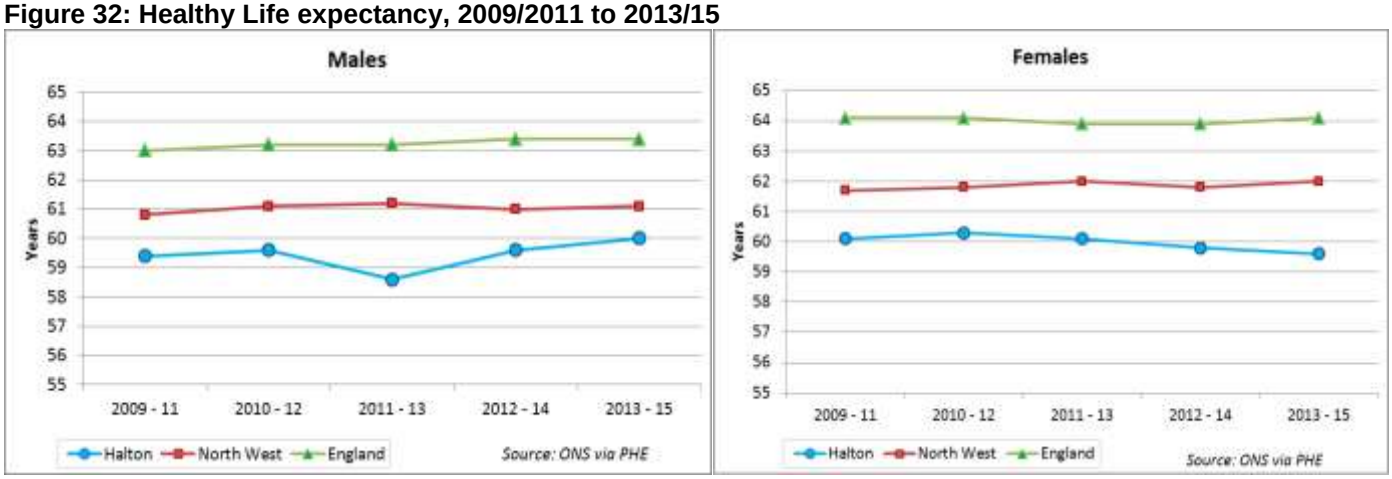


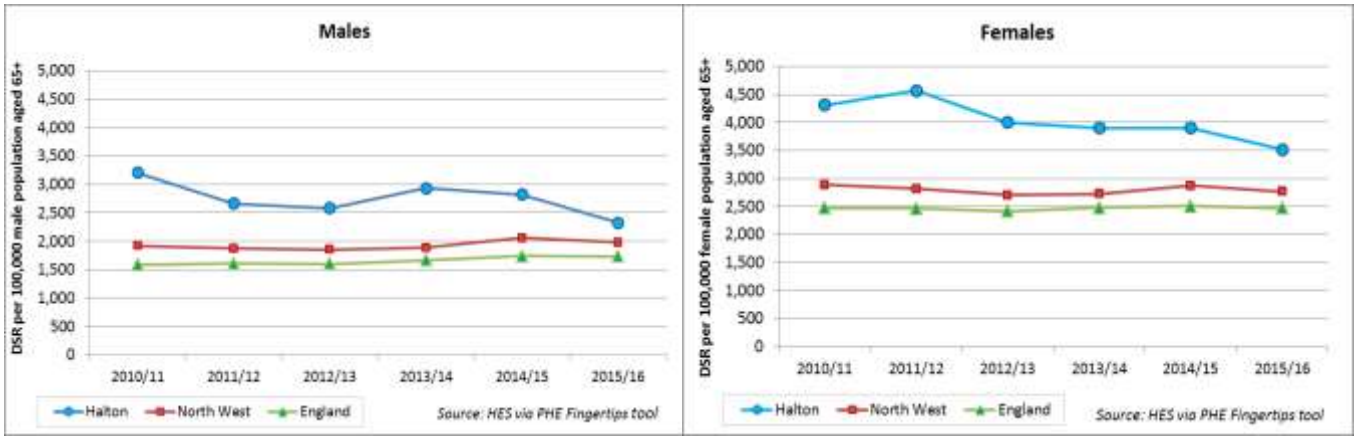
Table 8: Proportion of life spent in good health, at age 65

		2009/11	2010/12	2011/13	2012/14
Males	Halton	51.5	48.8	46.8	46.2
	North West	49.0	53.2	54.0	54.2
	England	56.2	56.3	56.2	56.3
Females	Halton	56.1	55.0	56.1	48.0
	North West	50.7	50.7	51.1	51.4
	England	53.7	53.7	53.4	52.4

Source: Office for National Statistics

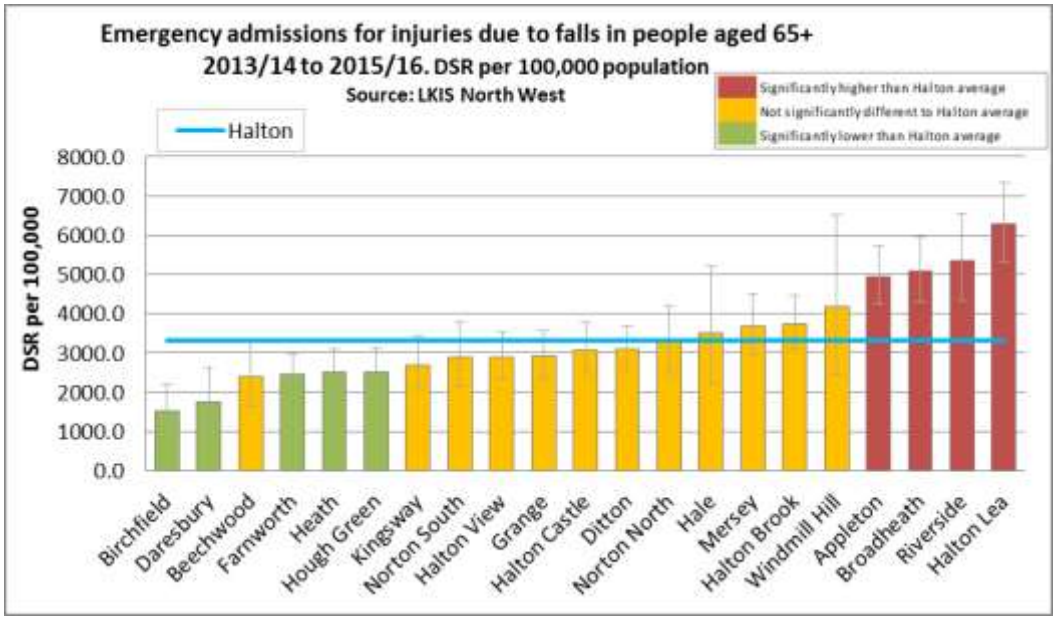
Falls amongst those aged 65+ was a 2013-2016 Health & Wellbeing Board priority due to the significant cause of infirmity and loss of independence they can cause in later life. Healthy Ageing remains a JHWBS priority for 2017-2022, with hospital admissions due to falls continuing to be a key indicator. Data from the last six years shows that whilst rates are slightly lower for men than women (in Halton and elsewhere), the rates in Halton for both genders is statistically significantly worse and despite reductions, has been so over the six year period.

Figure 33: Trend in hospital admissions due to injuries from falls (ICD-10 S00-T98 and W00-W19), Directly Standardised Rate per 1,000 population, males and females, 2010/11 to 2015/16



Local ward level data for 2013/14 to 2015/16 (Figure 33) shows that rates vary across the borough from around 1,500 per 100,000 population aged 65+ to over 6,000 per 100,000, with the borough average of 3,300 per 100,000.

Figure 34: Hospital admissions due to falls amongst Halton residents aged 65+, by electoral ward, 2013/14 to 2015/16



It is estimated that, if all older people were immunised against influenza, almost 5,000 additional lives might be saved each year in England. Studies show influenza immunisation among older people is cost-effective. Older people, as a vulnerable group, are eligible for NHS flu immunisation, and are included in groups that may be offered flu vaccine. The national targets are based on World Health Organisation (WHO) targets. The WHO target for influenza vaccination for those aged 65 years and over is 75%. Everyone aged 65 and over should be actively contacted and offered flu vaccine.[173]

A qualitative study by Evans et al 2007[174] shows that many older people do not feel vulnerable to influenza and this affects their likelihood of taking up the immunisation. Both refusers and defaulters overstated adverse effects from influenza vaccine so this is a potential target for an intervention. Individual prompts, particularly from GPs, seemed to be the most significant motivators to attend for immunisation. However, whilst influential, other research suggests that the messages healthcare workers give need to be sensitive to the reasons for non-uptake and people's views about their health.[175][176]

7.11.2. Evidence of effective interventions in the community pharmacy setting

Qualitative research shows that older people value continuity of personalised pharmaceutical care which enables them to build a trusting relationship over time. There can be a lack of awareness of services already available from community pharmacies. Ongoing disruption in the supply of medicines caused problems for this client group, and the complexity of prescription ordering, collection and delivery systems presented challenges for participants. Good communication from the community pharmacy helped to improve the experience.[177 Dexterity problems can affect a sizable proportion of older people. Whilst this is a manufacturing issue, community pharmacy staff are on hand and should check if this is an issue when dispensing.[178] Assisting patients with dementia (and their carers) in respect of medications is a particular problem. As prevalence of this condition rises, ways of addressing this will become more pressing.[179]

Community pharmacy-based services assessing older women's risk of osteoporosis were well received and were able to identify women at different levels of risk.[180] Those that followed women up post intervention found they had made lifestyle changes such as increased calcium in the diet, increased physical activity and relevant medication.[181][182][183].

Medicines reviews for the elderly are both perceived favourably by participants[184] and can help reduce prescribing costs.[185] However, it is unclear if such interventions are cost effective as the cost of the interventions was not detailed.

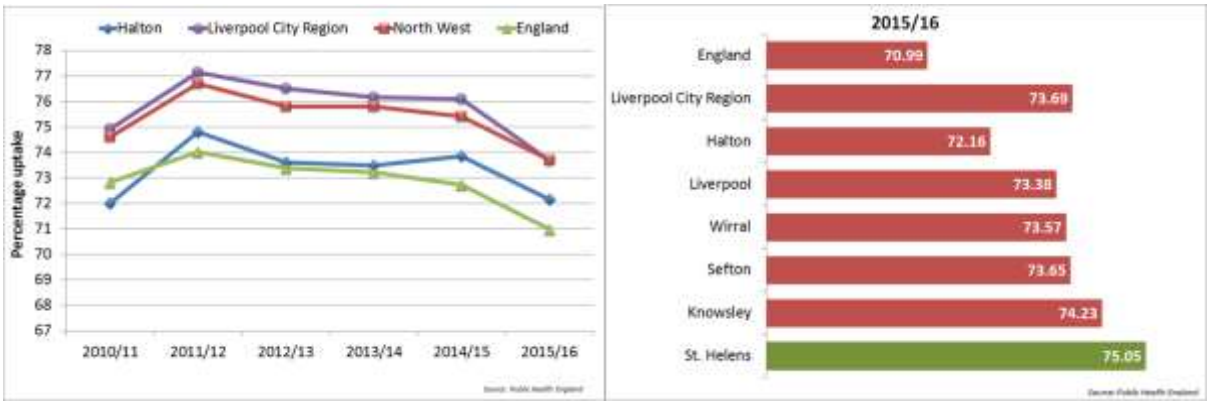
NICE guidance on medicines management in care homes was published March 2014.[186] It states that helping residents to help look after and take their medicines themselves is important in enabling residents to retain their independence. Care home staff should assume residents are able to look after and manage their own medicines when they move into a care home, unless indicated otherwise. An individual risk assessment should be undertaken to determine the level of support a resident needs to manage their own medicines.

The guideline considers all aspects of managing medicines in care homes and recommends that all care home providers have a care home medicines policy. The policy should ensure that processes are in place for safe and effective use of medicines in the care home. Sections of the guideline provide recommendations for different aspects of managing medicines covered by the care home medicines policy.

7.11.3. Local provision

As described in section 3.2.5 the NHS Influenza Vaccination Programme is now commissioned as part of the Advanced Services for both at risk adults under age 65 and all adults aged 65+. This annual, seasonal influenza vaccination programme continues to be implemented primarily through GP practices although pharmacies now offer patients another venue at which to have their vaccination. This increased access is especially important in Halton, as Figure 35 shows that, for those over the age of 65, Halton has not reached the 75% uptake target for the last 3 years. There has been a slightly but consistent decline in uptake across comparators as well as locally. In 2015/16 only one local authority in the Liverpool City Region achieved the 75% uptake target. Halton had the lowest uptake within the sub-region.

Figure 35: NHS Influenza Vaccination Programme uptake for those aged 65+



See also 7.4.3. Planned care: medicines use reviews.

Older people are more likely to be diagnosed with a long term condition and as such are more likely to be on a significant number of medications. Whilst this is often necessary, multiple medications are more likely to cause significant side effects such as falls and physiological as well as psychological and cognitive complications. It is important that older people, especially those resident in care homes have their medication regularly reviewed to ensure they are on the minimum effective and

efficient combination of drugs to meet their needs. The employment of a Care Homes Pharmacist and Pharmacy Technician has supported this aim by working with local GP practices and care homes as well as provider services to optimise medication for this group of patients. The Pharmacy Technician has also worked extensively with Halton care homes to improve medication processes for ordering, storage, administration and disposal. This work has supported the waste reduction agenda and helped share learning across all homes following incidents and issues.

The Care Homes Pharmacy technician also has a role working closely with Domiciliary Care providers to improve their processes for medication support and to improve safety and quality of care for Halton residents. This often involves liaison with local community pharmacies to support resolution of issues and to improve quality of care for service users.

Conclusions

- Influenza vaccination for at risk adults is now widely available through pharmacies across the borough and this has greatly increased accessibility. The primary provider of influenza vaccination remains General Practice

7.12 Antimicrobial Resistance (AMR)

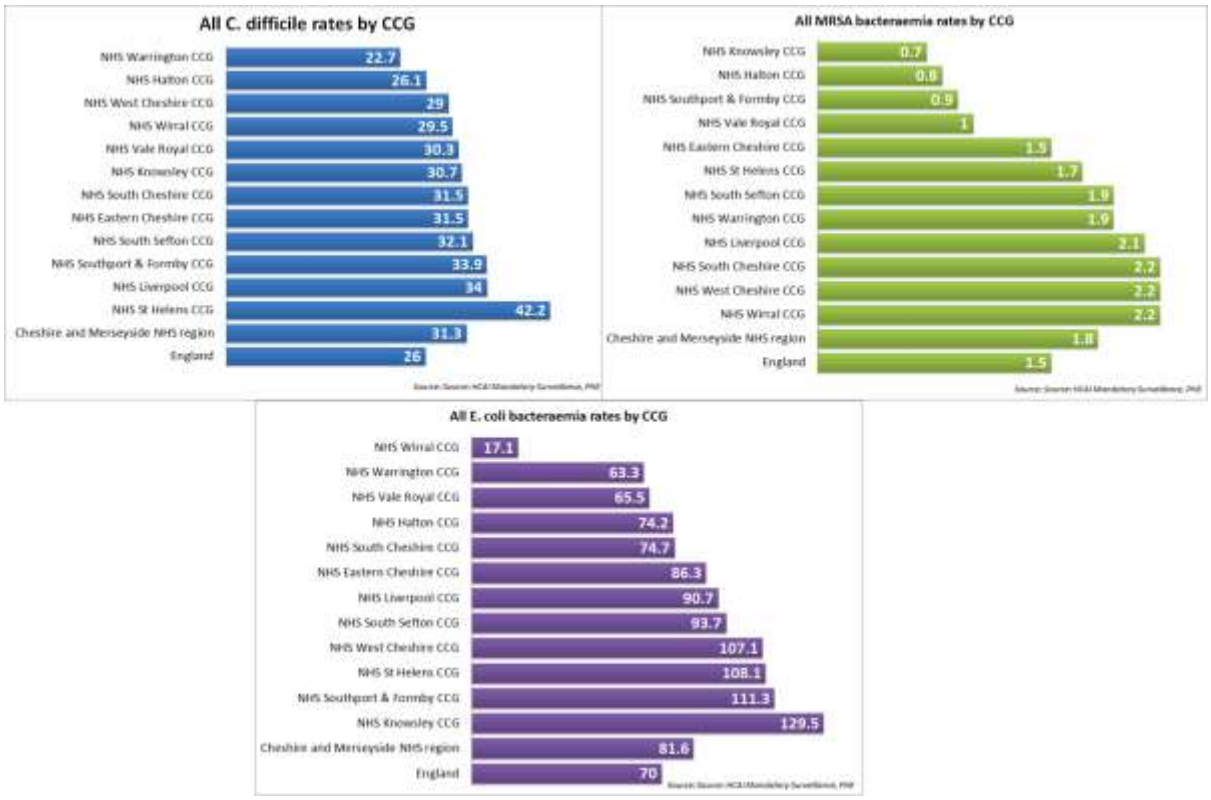
7.12.1 Level of Need

Modern medical practice relies on the widespread availability of effective antimicrobials to prevent and treat infections in humans and animals. Resistance to all antimicrobials, including antivirals and antifungals, is increasing, but of greatest concern is the rapid development of bacterial resistance to antibiotics. If the number of hard-to-treat infections continues to grow, then it will become increasingly difficult to control infection in a range of routine medical care settings and it will be more difficult to maintain animal health and protect animal welfare.[187]

Healthcare-associated infections became headline news in the 1990s, with concern about meticillin-resistant Staphylococcus aureus (MRSA) and C. difficile. More recently multi-drug resistant tuberculosis (TB) and 'extensively drug-resistant tuberculosis' have become a problem across Europe. The former resulted in mandatory reporting and targets, solidified in legislation. Focussed, consistent efforts across the country has led to a reduction in cases.[188] The 2013-2018 UK Strategy[189] set out actions to address the key challenges to AMR.

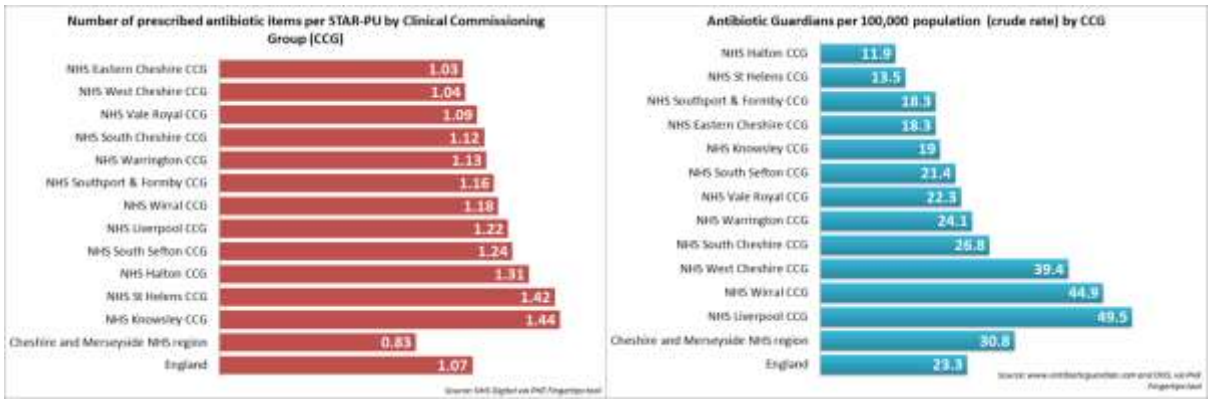
Cheshire and Merseyside has some of the highest healthcare acquired infections in the country. Fortunately reported levels in Halton are some of the lowest in the sub-region.

Figure 36: Levels of healthcare acquired infections (HCAI), crude rate per 100,000 population, 2015/16



Levels of antibiotic prescribing are higher than the national average, with levels of antibiotic guardianship lower in 7 CCGs and higher in 5, compared to the England average. Public Health England (PHE) has set up a national campaign to encourage members of the public and healthcare professionals to take action in helping to slow antibiotic resistance and ensure antibiotics work now and in the future. Organisations and individuals are asked to make a pledge to tackle this issue. The rate of antibiotic guardianship per 100,000 population is an indicator of the level of engagement within an area. Halton has the lowest level of antibiotic guardianship. Across Cheshire & Merseyside there is a relationship between CCG population size and levels of guardianship, with the larger areas having higher rates.

Figure 37: Antibiotic prescribing (12-month rolling year, September 2016, indirectly standardised ration per STAR_PU) and guardianship, 2016



7.12.2 Evidence of effective interventions in the community pharmacy setting

Cheshire and Merseyside has one of the highest rates of healthcare acquired infection and combined general practice and hospital antibiotic consumption in England. National[190] and local[191] strategies to reduce antimicrobial resistance take two main approaches.

1. The need to reduce antibiotic use
2. The need to increase antimicrobial stewardship[xiii]

The national strategy also seeks to stimulate the development of new antibiotics, diagnostics and novel therapies.

The first point requires action to change prescribing habits and public education. This will reduce public expectations about receiving antibiotics when it is not appropriate. Antibiotic stewardship needs concerted effort and support at a national level and from infection specialist staff. This will enable local areas to utilise healthcare staff including community pharmacists.[192] Such joint efforts, including active involvement of the public, have been shown to work.[193] Public knowledge and attitudes are key.[194][195] There is a relationship between income and education levels and awareness of inappropriate antibiotic use,[196] including their use for viral infections, hoarding and sharing. Regular campaigns are the cornerstone in efforts to educate the public including the use of social media. An understanding of health literacy needs to play and increasing role.[197] Consistent messages in all key healthcare settings are needed, especially during peak prescribing periods.[198]

Studies have shown that community pharmacists can have an educational role[199] providing information on correct usage and addressing barriers to adherence.[200] However, barriers to them doing this need to be better understood and addressed,[201][202] including barriers to inter-professional collaboration.

7.12.3. Local Provision

The local authority public health and health improvement teams, together with Halton CCG have supported the national Public Health England *Keep Antibiotics Working* campaign. Campaign materials were distributed to a wide variety of community venues, including to pharmacies. Pharmacies are a key location for the distribution and availability of information to the public to support the appropriate use of antibiotic, as well as wider health care usage campaigns. NHS Choices campaign also encourages individuals to seek the most appropriate health professional for a series of illnesses and highlights the key role of local pharmacists in advice on the treatment of minor ailments. Pharmacies can enhance their role in this function to ensure appropriate NHS usages, including reducing the demand from patients for the prescribing of antimicrobials.

There are four key messages for community pharmacists to help address the growing issues about Antimicrobial Resistance:

- Advise patients on appropriate antibiotic use when prescribed
- Advise patients on antibiotic resistance, as appropriate
- Advise patients on adverse effects
- Recommend appropriate symptomatic therapy for non-vulnerable patients

xiii. NICE guidance NG15 (2015) defines this as 'an organisational or healthcare-system-wide approach to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness'.

Conclusions

- Pharmacies have a key role to play in raising awareness of the importance of using antibiotics appropriately. As part of the essential services contract, the use of the six health education campaigns should include at least one on antibiotic use.

7.13. Palliative Care

7.13.1. Level of Need

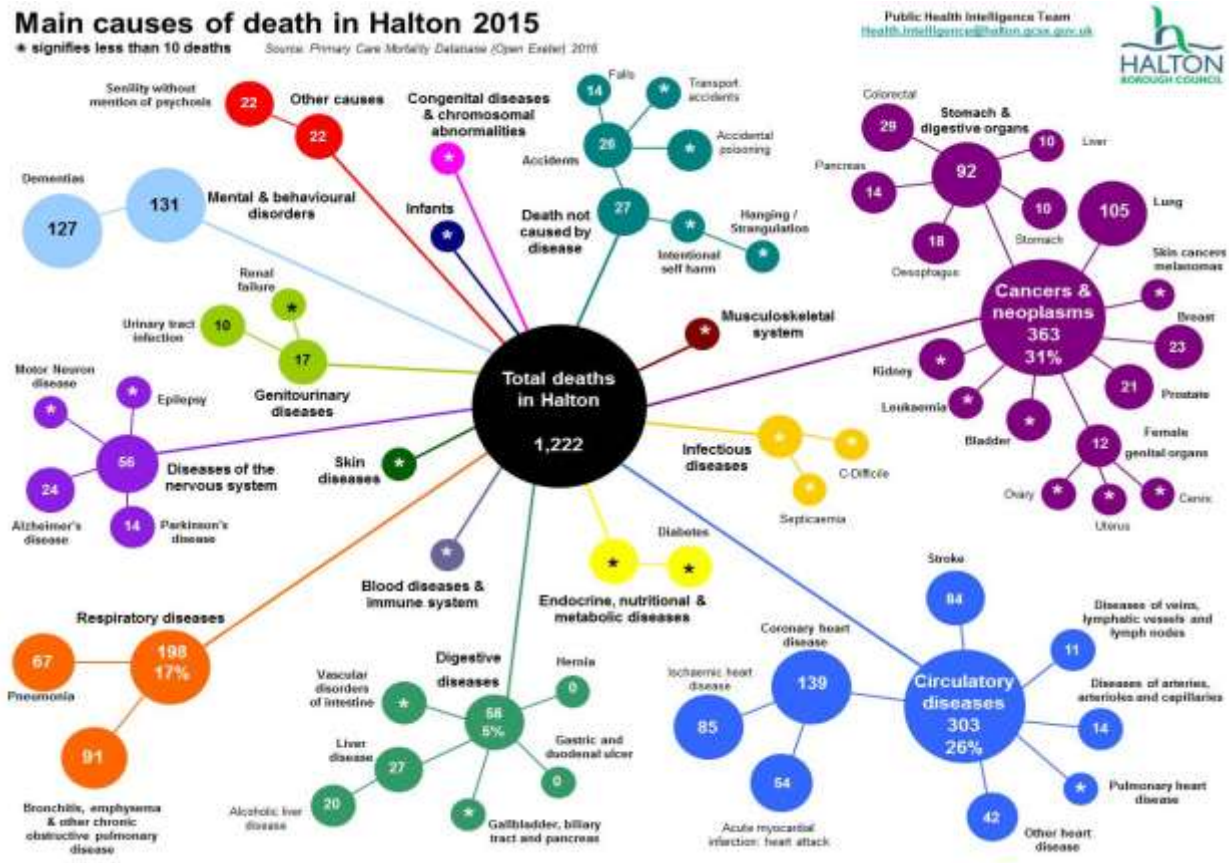
The Department of Health *End of Life Care Strategy*[203] states that patients should have access to:

- rapid specialist advice and clinical assessment-through 24/7 telephone helplines and rapid access to home care
- 9-5 access to specialist nurses – 7 days a week including bank holidays
- High quality care in the last days of life
- coordinated care and support, ensuring that patients' needs are met- in hospices and care home with palliative care beds

Coordinated care will be delivered through multi agency training including the 'gold standards framework' and the Six Steps programme. Pharmacists play a vital role for patients who have stipulated their preferred priorities of care and wish to die at home

In Halton, cancers account for the largest single cause of death in the borough, at 31%. The second highest cause is disease of the circulatory system at 26%, with a further 17% of people dying from a respiratory disease.

Figure 38: Main causes of death in Halton 2015



Most research into people's preference for place of death has been undertaken with cancer patients. This has found that 50-70% would like to die at home.[204] There has been slow but gradual increase in patients dying at home who request to do so. Deprivation, availability of appropriate home care and whether the individual is living with relatives or alone are all factors in determining the likelihood of a home death.[205][206]

Place of death has been determined by examination of local mortality files. Table 9 shows that the majority of Halton residents die in hospital. However, whilst more men die at home than in residential, nursing or care homes, the reverse is so for women.

Table 9: Place of death during 2015

	Halton		Region	England	England		Halton statistical significance compared to England
	Count	Value	Value	Value	Worst/ Lowest	Best/ Highest	
Hospital	589	48.4%	48.7%	46.7%	37.1%	68.1%	
Care home	221	18.2%	21.0%	22.6%	6.7%	34.4%	
Home	280	23.0%	22.6%	22.8%	18.2%	29.0%	
Other Places	23	1.9%	2.0%	2.2%	1.1%	5.5%	
Hospice	104	8.5%	5.7%	5.6%	0.0%	13.3%	

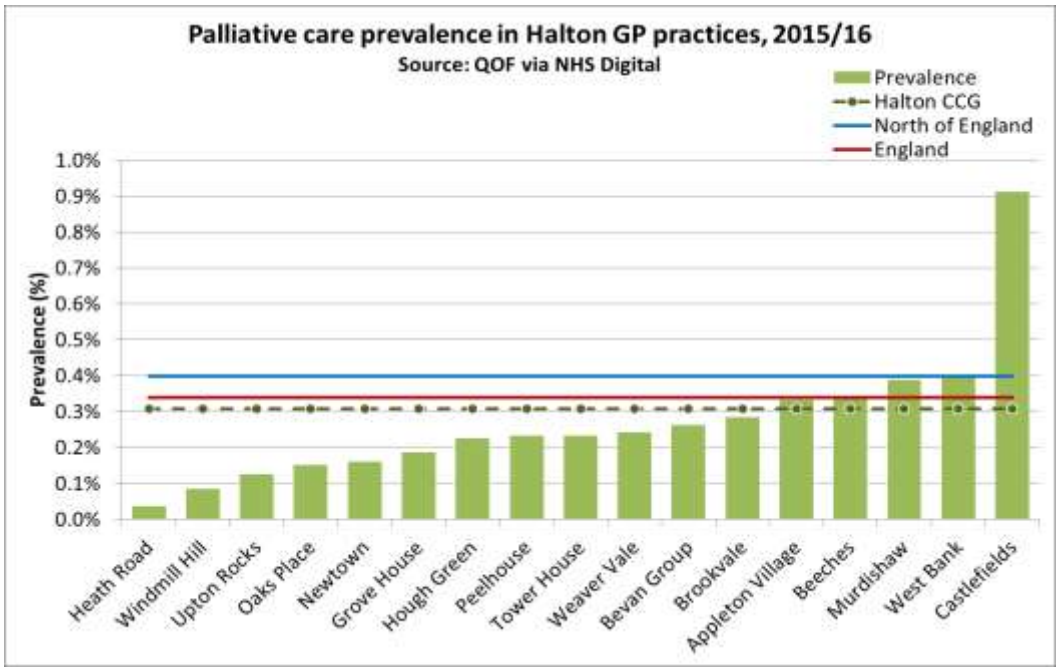
Key: Lower Similar Higher

Source: ONS via PHE Fingertips tool

GPs are required to keep a register of patients likely to die within the next 12 months and therefore in need of palliative care. Date for 2015/16 shows the percentage of patients in need of palliative

care identified on GP registers is lower in Halton than its comparators. The majority of GP practices have levels below the England average and all but one is lower than the North of England average.

Figure 39: QOF Palliative Care register, 2015/15, by GP practice



7.13.2. Evidence of effective interventions in the community pharmacy setting

Palliative care is designed to provide pain relief and improve the quality of life of patients with life-threatening illness. The number of patients with chronic, slowly debilitating conditions has risen. This means that even where patients die in a hospital or other care institution many will live in their own homes with the need to manage the condition for some time before this happens. NICE guidance on palliative care shows that, amongst other things, there was inadequate access to pharmacy services outside normal working hours[207] so local schemes should seek to address this issue. Pharmacists are a vital part of the multidisciplinary team supporting an individual and their family during this time, ensuring that medications are assessed and the effectiveness of medications is reviewed and needs change.[208] As timely access to medicines is vital, especially as the preferred place of care is the home environment, stock control can hinder effective provision. Knowing the level of need locally is an important part of this[209] Details about key patient groups such as those with end-stage cancer can be poor with opportunities to embed community pharmacists in to palliative care teams missed.[210] Community pharmacists are generally positive about providing services and support for palliative care patients. They may not have a full understanding of it however, as need training and support to facilitate their involvement.[211]

7.13.3. Local provision

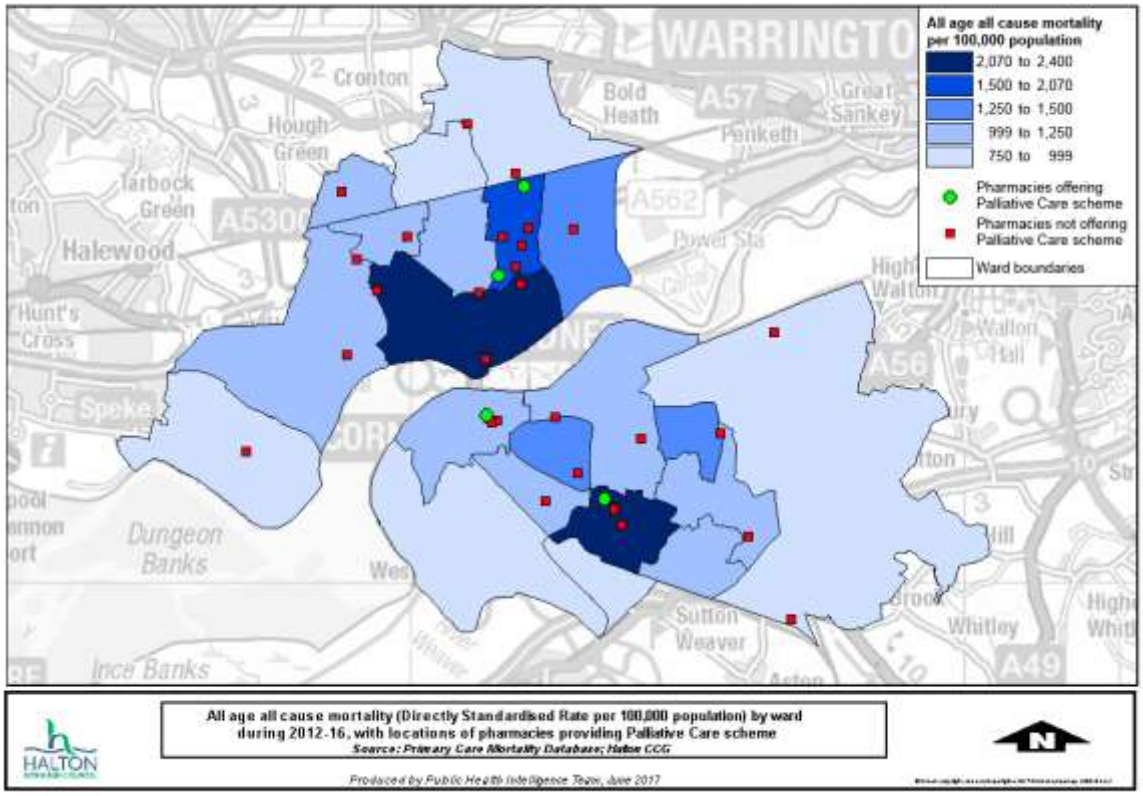
In April 2017 this pharmacy service was re-commissioned to improve access to the key medications often required to manage symptoms at the end of life. The formulary was rationalised and a more active role in ensuring stocks are available when needed has been adopted. There are now 4 pharmacies that provide the service with the aim of improving access to palliative care medicines when they are required. Requests for these medications can often be both unpredictable and urgent and as such it is necessary to ensure timely access to support effective patient care and to support families and carers at what is often a very stressful and emotional time. The pharmacies selected to deliver the service have been based on opening hours and geographical spread following a request

for expressions of interest from Halton pharmacies. Out of the four pharmacies providing the service, three are 100 hour pharmacies. Two of the pharmacies are based in Runcorn and two are based in Widnes.

Pharmacies that provide the service maintain a stock of a locally agreed range of palliative care medicines and commit to ensuring continuity of supply so that users of this service have prompt access to these medicines during the opening hours of the pharmacy. Pharmacists are able to support users, carers and clinicians by providing information and advice.

To help ensure patient care is joined-up and to improve accessibility, a list of participating pharmacies and the Pharmacy Palliative Care Drug Formulary is to be shared with providers of Out of Hours care, Walk-in-Centres, specialist palliative care nurses and district nursing teams.

Map 17: Community pharmacy palliative care drugs service provision



Conclusions
• This service provides convenient access and can only be provided by community pharmacy • This service is primarily designed to provide access to infrequent and unpredictably required specialist drugs • Given the changes that have taken place recently provision is adequate as it stands at the moment but the CCG will continue to review this on an ongoing basis

Appendix 1: Policy Context

'A Vision for Pharmacy in the New NHS'

In the last five years, the pace of change for NHS community pharmaceutical services has probably been more rapid than at any other time in the last 60 years. In that same period, community pharmacy has featured more prominently in how to improve services, how its potential can be more widely recognised by the NHS and by other health professionals, and how its ability to respond innovatively and creatively can be better utilised. That is what was intended when the Department of Health launched *A Vision for Pharmacy in the New NHS* in July 2003, that identified and aligned the ambitions for pharmacy alongside the wider ambitions for the NHS as a whole.

The current policy context shaping the direction of pharmacy services has its roots in the publication of '*Choosing Health'* published by the Government in 2004. This programme of action aimed to provide more of the opportunities, support and information people want to enable them to improve their health.

'Choosing Health Through Pharmacy'

As part of the *Choosing Health* programme, the Government made a commitment to publish a strategy for pharmaceutical public health which expanded the contribution that pharmacists, their staff and the premises in which they work can make to improving health and reducing health inequalities.

This strategy recognised that pharmacists work at the heart of the communities they serve and they enjoy the confidence of the public. Every day, they support self-care and provide health messages, advice and services in areas such as diet, physical activity, stop smoking and sexual health.

A New Contractual Framework

As part of the *Vision for Pharmacy* a new community pharmacy contractual framework was put in place in April 2005. It comprises three tiers of services – essential, advanced and local enhanced services.

- Essential services are those which every pharmacy must provide, including dispensing.

- Advanced services are those which, subject to accreditation requirements, a pharmacy contractor can choose to provide. At present, there are three advanced services, Medicines Use Reviews (MUR), Appliance Use Reviews (AURs) and Stoma Appliance Customisation (SAC). In MURs and AURs the pharmacist discusses with the patient their use of the medicines or appliances they are prescribed and whether there are any problems that the pharmacist can help resolve. For SAC the aim is to ensure proper use and comfortable fitting of the stoma appliance and to improve duration of usage thereby reducing waste.

- Local enhanced services, such as health and lifestyle advice or help for substance misusers, are commissioned locally by PCTs direct with contractors.

Community pharmacies are remunerated through this national contractual framework, the majority of the income to community pharmacy is made through fees, allowances and retained purchasing profit which is controlled at a national level to provide an agreed return on investment to pharmacy contractors. In return pharmacy contractors must provide certain specified services at agreed times. Around 85% of community pharmacy income nationally comes from NHS services. A growing source of income to community pharmacies comes from providing enhanced services commissioned by PCTs. Pharmacies provide both NHS funded care and services that are paid for directly by the

patient. Some community pharmacies provide these non-NHS services to our population. These include:

- Over the counter medication, including supply of emergency hormonal contraception and smoking cessation
- Measurements like blood pressure, weight and height
- Diagnostic tests like cholesterol and blood glucose

'Our health, our care, our say'

This White Paper in January 2006 set out a new strategic direction for improving the health and well-being of the population. It focused on a strategic shift to locate more services in local communities closer to people's homes. This recognised the vital role that community pharmacies provide in providing services which support patients with long term conditions and make treatment for minor illnesses accessible and convenient.

'NHS Next Stage Review'

The final report set out a vision of an NHS that gives patients and the public more information and choice, works in partnership and has quality of care at its heart – quality defined as clinically effective, personal and safe. The changes that are now being taken forward, locally and nationally, will see the NHS deliver high quality care for all users of services in all aspects, not just some. It will see services delivered closer to home, a much greater focus on helping people stay healthy and a stronger emphasis on the NHS working with local partners. Pharmacy has a key role to play in delivering this vision, particularly as a provider of services which prevent ill-health, promote better health for all and improve access to services within communities.

'Pharmacy in England - Building on strengths delivering the future'

In April 2008 the government set out its plans in this Pharmacy White Paper and subsequently a consultation was undertaken on the proposed changes to the regulations for pharmacy.

This White Paper sets out a vision for improved quality and effectiveness of pharmaceutical services, and a wider contribution to public health. Whilst acknowledging good overall provision and much good practice amongst providers, it revealed several areas of real concern about medicines usage across the country which it seeks to address through a work programme which will challenge and engage PCTs, pharmacists and the NHS.

It identifies practical, achievable ways in which pharmacists and their teams can improve patient care in the coming years. It sets out a reinvigorated vision of pharmacy's potential to contribute further to a fair, personalised, safe and effective NHS. This vision demonstrates how pharmacy can continue, and expand further, its role in an NHS that focuses as much on prevention as it does on treating sick people, helping to reduce health inequalities, supporting healthy choices, improving quality and promoting well-being for patients and public alike.

This White Paper has put forward a broad range of proposals to build on progress over the last three years which has succeeded in embedding community pharmacy's role in improving health and well-being and reducing health inequalities. An overview is set out below in Figure 34. This includes proposals for nationally commissioned additions to the contract in future years for how pharmacies will, over time:

- offer NHS funded treatment for many minor ailments (e.g. coughs, colds, stomach problems) for people who do not need to go to their local GP;
- provide specific support for people who are starting out on a new course of treatment for long term conditions such as high blood pressure or high cholesterol;
- be commissioned based on the range and quality of services they deliver.

Figure 40: Pharmacy White Paper – Summary

Building on strengths – delivering the future
The Aims of the White Paper, Pharmacy in England

Supporting healthy living and better care
Community pharmacies will become 'healthy living' centres providing a primary source of information for healthy living and health improvement.

Pharmacy will be integrated into public health initiatives such as stop smoking, sexual health services and weight management, or offer screening for those at risk of vascular disease – an area where there are significant variations in access to services and life expectancy around the country.

Better, safe use of medicines
Safe medication practices should be embedded in patient care by identifying, introducing and evaluating systems designed to reduce unintended hospital admissions related to medicines use.

Identifying specific patient groups for MURs, using MURs and repeat dispensing to identify and reduce the amount of unused medicines and including pharmacists in care pathways for longterm conditions are all examples of this.

Access and choice
Community pharmacies improve access and choice through more help with medicines. This will be realised by developing MURs, repeat dispensing, access to urgent medicines, emergency supply and working with hospitals on medicine reconciliation.

Integration and interfaces
Community based pharmaceutical care will be developed which will involve creating new alliances between hospital and community pharmacists as well as primary care pharmacists and pharmacy technicians.

Quality
Underpinning all of this in the White Paper and the other policy drivers mentioned earlier is continual improvement in quality. This is a recurring theme throughout all the policy drivers currently influencing the development of community pharmacy. This refers to staff, premises and services alike. PCTs have a responsibility to ensure continuous quality by monitoring the community pharmacy services against the strategic tests.

'Healthy lives, healthy people',

The public health strategy for England (2010) says:

> *"Community pharmacies are a valuable and trusted public health resource. With millions of contacts with the public each day, there is real potential to use community pharmacy teams more effectively to improve health and wellbeing and to reduce health inequalities."*

This will be relevant to local authorities as they take on responsibility for public health in their communities.

In addition, Community pharmacy is an important investor in local communities through employment, supporting neighbourhood and high street economies, as a health asset and long term partner.

Equity and excellence: Liberating the NHS (2010)

> *"Information, combined with the right support, is the key to better care, better outcomes and reduced costs. Patients need and should have far more information and data on all aspects of healthcare, to enable them to share in decisions made about their care and find out much more easily about services that are available. Our aim is to give people access to comprehensive, trustworthy and easy to understand information from a range of sources on conditions, treatments, lifestyle choices and how to look after their own and their family's health".*

Community pharmacy is at the forefront of self-care, health promotion and is ably qualified to assist people to manage long term conditions, the vast majority of which are managed via the use of medication. Advanced services under the contract should be maximized to ensure patients get access to the support that they need.

October 2011 - Market entry by means of pharmaceutical needs assessments and quality and performance (market exit)

The NHS Act 2006 required the Secretary of State for Health to make Regulations concerning the provision of NHS pharmaceutical services in England. The Health Act 2009 amended these provisions by providing that PCTs must develop and publish PNAs; and PCTs would then use their PNAs as the basis for determining entry to the NHS pharmaceutical services market.

The Health Act 2009 also introduced new provisions which allow the Secretary of State to make regulations about what remedial actions PCTs can take against pharmacy and dispensing appliance contractors who breach their terms of service or whose performance is poor or below standard.

The first set of Regulations dealing with the development and publication of PNAs, the NHS (Pharmaceutical Services and Local Pharmaceutical Services)(Amendment) Regulations 2010 (S.I. 2010/914) were laid on 26 March 2010 and came into force on 24 May 2010.

Later the National Health Service (Pharmaceutical Services) Regulations 2012 ("the 2012 Regulations") and draft guidance came into force concerning the remaining provision under the Health Act 2009.

Section 128A of NHS Act 2006, as amended by Health Act 2009 and Health and Social Care Act 2012

From 1st April 2013, every Health and Wellbeing Board (HWB) in England will have a statutory responsibility to publish and keep up to date a statement of the needs for pharmaceutical services of the population in its area, referred to as a pharmaceutical needs assessment (PNA). This is of particular relevance for local authorities and commissioning bodies. Guidance outlines the steps required to produce relevant, helpful and legally robust PNAs.

Consolidation Applications

On 5 December 2016, amendments to the 2013 Regulations come into effect.

NHS pharmacy businesses may apply to consolidate the services provided on two or more sites onto a single site. Applications to consolidate will be dealt with as "excepted applications" under the 2013 Regulations, which means they will not be assessed against the pharmaceutical needs assessment. Instead, consolidation applications will follow a simpler procedure, the key to which is whether or

not a gap in pharmaceutical service provision would be created by the consolidation. Some provision is also made in respect of continuity of services so, if NHS England commissions enhanced services from the contract the closing premises, then the applicant is required to give an undertaking to continue to provide those services following consolidation.

If NHS England is satisfied that the consolidation would create a gap in pharmaceutical services provision, it must refuse the application.

If NHS England grants the application, it must then refuse any further "unforeseen benefits applications" seeking inclusion in the pharmaceutical list, if the applicant is seeking to rely on the consolidation as a reason for saying there is now a gap in provision, at least until the next revision of the PNA.

Appendix 2: Abbreviations Used

AF	Atrial Fibrillation
AMR	Antimicrobial Resistance
AUR	Appliance Use Review
BI	Brief Intervention
BP	Blood pressure
CATC	Care at the Chemist
CCG	Clinical Commissioning Group
CPAF	Community Pharmacy Assurance Framework
COPD	Chronic Obstructive Pulmonary Disease
CVD	Cardio Vascular Disease
DSR	Directly Standardised Rate
EHC	Emergency Hormonal Contraception
GP	General Practice / General Practitioner
GUM	Genito-urinary Medicine
HBC	Halton Borough Council
HCAI	Healthcare Acquired Infections
HIV	Human Immunodeficiency Virus
HLE	Healthy Life Expectancy
HWB	Health and Wellbeing Board
ID	(English) Indices of Deprivation
IMD	Index of Multiple Deprivation
JHWBS	Joint Health and Wellbeing Strategy
JSNA	Joint Strategic Needs assessment
LAPHT	Local Authority Public Health Team
LARC	Long-acting reversible contraception
LMC	Local Medical Committee
LPC	Local Pharmaceutical Committee
LPS	Local Pharmaceutical Services
LSOA	Lower Super Output Area
MDS	Monitored Dosage Systems
MRSA	Methicillin-resistant Staphylococcus aureus
MUR	Medicines Use Review
NHS	National Health Service
NHSE	NHS England
NICE	National Institute for Health and Clinical Excellence
NMS	New Medicines Service
NRT	Nicotine Replacement Therapy
NUMSAS	NHS Urgent Medicines Supply Advanced Service
ONS	Office of National Statistics
PCDG	Pharmacy Contracts and Development Group
PCT	Primary Care Trust
PGD	Patient Group Direction
PHE	Public Health England
PNA	Pharmaceutical Needs Assessment
PSNC	Pharmaceutical Services Negotiating Committee
QOF	Quality Outcomes Framework
RCT	Randomised control trial
SAC	Stoma Appliance Customisation

SHLAA	Strategic Housing Land Availability Assessment
STI	Sexually Transmitted Infection
TB	Tuberculosis
TIA	Transient Ischaemic Attack
WEMWBS	Warrick and Edinburgh Mental Wellbeing Score
WHO	World Health Organisation

Appendix 3: Community Pharmacy addresses and opening hours

Name	Address 1	Address 2	Postcode	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	100 hour pharmacy
RUNCORN											
Asda Pharmacy	West Lane	Runcorn	WA7 2PY	**08:00 - 23:00**	**07:00 - 23:00**	**07:00 - 23:00**	**07:00 - 23:00**	**07:00 - 23:00**	**07:00 - 22:00**	**10:30 - 16:30**	**Y**
Boots the Chemist	90 Forest Walk	Halton Lea Shopping Centre	WA7 2GX	**09:00 - 17:30**	**09:00 - 17:30**	**09:00 - 17:30**	**09:00 - 17:30**	**09:00 - 17:30**	**09:00 - 17:30**	Closed	
Boots	Hallwood Health Centre	Hospital Way	WA7 2UT	**08:30 - 18:30**	**07:30 - 19:30**	**08:30 - 18:30**	**08:30 - 18:30**	**08:30 - 18:30**	Closed	Closed	
Boots Pharmacy	21 High Street	Runcorn	WA7 1AP	**09:00 - 17:30**	**09:00 - 17:30**	**09:00 - 17:30**	**09:00 - 17:30**	**09:00 - 17:30**	**09:00 - 13:00**	Closed	
Boots Castlefields	Castlefields Primary Care Centre	Runcorn	WA7 2ST	**08:00 - 19.00**	**08:00 - 19.00**	**08:00 - 19.00**	**08:00 - 18.30**	**08:00 - 18.30**	**08:00 - 12.30**	Closed	
Lloyds Pharmacy	5-6 Granville Street	Runcorn	WA7 1NE	**08:00 - 22:30**	**08:00 - 22:30**	**08:00 - 22:30**	**08:00 - 22:30**	**08:00 - 22:30**	**08:00 - 22:30**	**09:30 - 22:30**	**Y**
Murdishaw Pharmacy	Gorsewood Road	Murdishaw	WA7 6DA	**08:30 - 18:00**	**08:30 - 18:00**	**08:30 - 18:00**	**08:30 - 18:00**	**08:30 - 18:00**	Closed	Closed	
Peak Pharmacy	51-53 Church Street	Runcorn	WA7 1LQ	**09:00 - 17:30**	**09:00 - 17:30**	**09:00 - 17:30**	**09:00 - 17:30**	**09:00 - 17:30**	**09:00 - 13:00**	Closed	
Peak Pharmacy	49 High Street	Runcorn	WA7 1AH	**08:45 - 18:00**	**08:45 - 18:00**	**08:45 - 18:00**	**08:45 - 18:00**	**08:45 - 18:00**	Closed	Closed	
Superdrug Pharmacy	89 Forest Walk	Halton Lea	WA7 2GX	**09.00 - 17.30**	**09.00 - 17.30**	**09.00 - 17.30**	**09.00 - 17.30**	**09.00 - 17.30**	**09:00 - 17:30**	Closed	
Well Pharmacy	11 Grangeway	Runcorn	WA7 5LY	**09:00 - 18:00**	**09:00 - 18:00**	**09:00 - 18:00**	**09:00 - 18:00**	**09:00 - 18:00**	**09:00 - 12:30**	Closed	
Wise Pharmacy Ltd	27 Hillcrest	Runcorn	WA7 2DY	**09.00 - 17.30**	**09.00 - 17.30**	**09.00 - 17.30**	**09.00 - 17.30**	**09.00 - 17.30**	Closed	Closed	
Wise Pharmacy Ltd	Windmill Hill Shopping Centre	Windmill Hill Avenue West	WA7 6QZ	**09:00 - 18:00**	**09:00 - 18:00**	**09:00 - 18:00**	**09:00 - 18:00**	**09:00 - 18:00**	**09:00 - 12:00**	Closed	

Name	Address 1	Address 2	Postcode	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	100 hou pharma
WIDNES											
Appleton Village Pharmacy	Appleton village	Widnes	WA8 6EQ	07:00 - 23:00	07:00 - 23:00	07:00 - 23:00	07:00 - 23:00	07:00 - 23:00	08:00 - 22:00	10:00 - 16:00	Y
Asda Pharmacy	Widnes Road	Widnes	WA8 6AH	08:00 - 23:00	07:00 - 23:00	07:00 - 23:00	07:00 - 23:00	07:00 - 23:00	07:00 - 22:00	10:00 - 16:00	Y
Boots Pharmacy	Unit 7 Widnes Shopping Park	High Street	WA8 7TN	09:00 - 20:00	09:00 - 20:00	09:00 - 20:00	09:00 - 20:00	09:00 - 20:00	09:00 - 19:00	10:00 - 16:00	
Cohens Chemist	222a Liverpool Road	Ditton	WA8 7HY	09:00 - 17:30	09:00 - 17:30	09:00 - 17:30	09:00 - 17:30	09:00 - 17:30	Closed	Closed	
Cookes Ltd	76 Albert Road	Widnes	WA8 6JT	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	Closed	Closed	
Ditton Pharmacy	203 Hale Road	Widnes	WA8 8QB	08:30 - 18:30	08:30 - 18:30	08:30 - 18:30	08:30 - 18:30	08:30 - 18:30	Closed	Closed	
Hale Village Pharmacy	3 Ivy Farm Court	Hale Village	L24 4PG	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	09:00 - 12:30	Closed	
Lloyds Pharmacy	Hough Green Health Park	45-47 Hough Green Road	WA8 4NJ	08:45 - 19:30	08:45 - 18:00	08:45 - 18:00	08:45 - 18:00	08:45 - 18:00	09:00 - 13:00	Closed	
McDougalls's Pharmacy	Widnes Health Care Resource Centre	Oaks Place	WA8 7GD	09:00 - 19:00	09:00 - 19:00	09:00 - 19:00	09:00 - 13:00 14:00 - 17:00	09:00 - 19:00	09:00 - 17:00	Closed	
Nicholson's Pharmacy	17 Queens Avenue	Ditton	WA8 8HR	09:00 - 13:00 14:00 - 18:00	09:00 - 13:00 14:00 - 18:00	09:00 - 13:00 14:00 - 18:00	09:00 - 13:00 14:00 - 18:00	09:00 - 13:00 14:00 - 18:00	09:00 - 13:00 14:00 - 17:00	Closed	
Rowlands Pharmacy	11 Farnworth Street	Widnes	WA8 9LH	09:00 - 17:30	09:00 - 17:30	09:00 - 17:30	09:00 - 17:30	09:00 - 17:30	09:00 - 11:30	Closed	
Strachan's Chemist	445 Hale Road	Widnes	WA8 8UU	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	09:00 - 13:00	Closed	
Tesco In-store Pharmacy	Ashley Retail Park	Lugsdale Road	WA8 7YT	08:00 - 22:30	06:30 - 22:30	06:30 - 22:30	06:30 - 22:30	06:30 - 22:30	06:30 - 22:00	11:00 - 17:00	Y
Upton Rocks Pharmacy	12a Cronton Lane	Widnes	WA8 5AJ	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	09:00 - 13:00	Closed	
Well Pharmacy	Peel House Medical Plaza	Peel House Lane	WA8 6TN	08:30 - 18:30	08:30 - 18:30	08:30 - 18:30	08:30 - 18:30	08:30 - 18:30	Closed	Closed	
West Bank pharmacy	8a Mersey Road	West Bank	WA8 0DG	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	Closed	Closed	
Widnes Late Night Pharmacy	Peel House Lane	Widnes	WA8 6TE	08:00 - 23:00	08:00 - 23:00	08:00 - 23:00	08:00 - 23:00	08:00 - 23:00	08:00 - 23:00	08:00 - 23:00	Y
Wise Pharmacy Ltd	204 Warrington Road	Widnes	WA8 0AX	09:00 - 17:30	09:00 - 17:30	09:00 - 17:30	09:00 - 17:30	09:00 - 17:30	09:00 - 12:00	Closed	
DISTANCE SELLING 'INTERNET' PHARMACIES											
Calea UK Ltd	Cestrian Court	Eastgate Way	WA7 1NT	07:00 - 23:59	07:00 - 23:59	07:00 - 23:59	07:00 - 23:59	07:00 - 23:59	Closed	Closed	Y
L Rowland & Co	Whitehouse Industrial Estate	Rivington Road	WA7 3DJ	08:45 - 17:15	08:45 - 17:15	08:45 - 17:15	08:45 - 17:15	08:45 - 17:15	Closed	Closed	
Wise Pharmacy Ltd	Unit 7. Jenson Court	Runcorn	WA7 1SQ	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	09:00 - 18:00	Closed	Closed	

Appendix 4: Community Pharmacy services

Runcorn													
Name	100hrs	Ward Location	Post Code	CONSRM	MUR	NMS	Flu	EHC	CATC	IM-SCESS	NRT	Varen	SUPCON	PALL
Asda Pharmacy, West Lane, Runcorn	Y	Halton Lea	WA7 2PY	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Boots Pharmacy, Halton Lea Shopping Centre, Runcorn		Halton Lea	WA7 2GX	Yes	Yes	Yes	Yes		Yes					
Boots Pharmacy, Castlefields Primary Care Centre, Runcorn		Halton Castle	WA7 2ST	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Boots Pharmacy, Hallwood Health Centre, Runcorn		Halton Lea	WA7 2UT	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes	
Boots Pharmacy, 21 High Street, Runcorn		Mersey	WA7 1AP	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes		
Lloyds Pharmacy, 5-6 Granville Street, Runcorn	Y	Mersey	WA7 1NE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Murdishaw Pharmacy, Gorsewood Road, Runcorn		Norton South	WA7 6ES	Yes	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes	
Peak Pharmacy, 51-53 Church Street, Runcorn		Mersey	WA7 1LQ	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Peak Pharmacy, 49 High Street, Runcorn		Mersey	WA7 1AH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Superdrug Pharmacy, Halton Lea Shopping Centre		Halton Lea	WA7 2BX	Yes	Yes	Yes	Yes	Yes	Yes			Yes	Yes	
Well Pharmacy, 11 Grangeway, Runcorn		Grange	WA7 5LY	Yes	Yes	Yes	Yes		Yes					
Wise Pharmacy Ltd, 27 Hillcrest, Runcorn		Halton Brook	WA7 2DY	Yes			Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Wise Pharmacy Ltd, Windmill Hill Shopping Centre, Runcorn		Windmill Hill	WA7 6QZ	Yes	Yes		Yes		Yes					

Widnes														
Name	100hrs	Ward Location	Post Code	CONSRM	MUR	NMS	Flu	EHC	CATC	IM-SCESS	NRT	Varen	SUPCON	PALL
Appleton Village Pharmacy	Y	Appleton	WA8 6EQ	Yes	Yes	Yes		Yes	Yes	Yes	Yes	Yes		
Asda Pharmacy, Widnes Road, Widnes	Y	Kingsway	WA8 6AH	Yes	Yes	Yes	Yes	Yes	Yes	Yes				Yes
Boots Pharmacy, Unit 7, Widnes Shopping Centre		Appleton	WA8 7TN	Yes	Yes	Yes	Yes	Yes	Yes	Yes			Yes	
Cohens Chemist, 22a Liverpool Road, Widnes		Broadheath	WA8 7HY	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Cookes Ltd, 76 Albert Road, Widnes		Appleton	WA8 6JT	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Ditton Pharmacy, 203 Hale Road, Widnes		Ditton	WA8 8QB	Yes	Yes	Yes			Yes					
Hale Village Pharmacy, 3 Ivy Farm Court, Widnes		Hale	L24 4AG	Yes	Yes	Yes	Yes	Yes	Yes			Yes	Yes	
Lloyds Pharmacy, Hough Green Health Park, Widnes		Hough Green	WA8 4NJ	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
McDougalls's Pharmacy, Health Care Resource Centre, Widnes		Kingsway	WA8 7GD	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Nicholson's Pharmacy, 17 Queens Avenue, Widnes		Ditton	WA8 8HR	Yes										
Rowlands Pharmacy, 11 Farnworth Street, Widnes		Farnworth	WA8 9LX		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Strachan's Chemist, 445 Hale Road, Widnes		Ditton	WA8 8UU	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Tesco In-store Pharmacy, Ashley Retail Park, Widnes	Y	Riverside	WA8 7YT		Yes	Yes	Yes		Yes	Yes	Yes	Yes		
Upton Rocks Pharmacy, 12a Cronton Lane, Widnes		Farnworth	WA8 5AJ	Yes	Yes	Yes	Yes		Yes					
Well Pharmacy, Peel House Medical Plaza, Widnes		Appleton	WA8 6TN	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
West Bank pharmacy, 8a Mersey Road, Widnes		Riverside	WA8 0DG				Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Widnes Late Night Pharmacy, Peel House Lane, Widnes	Y	Appleton	WA8 6TR	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Wise Pharmacy Ltd, 204 Warrington Road, Widnes		Halton View	WA8 0AX		Yes	Yes	Yes		Yes					

KEY

CONSRM: Consulting room
MUR: Medicines Use Review
NMS: New Medicines Service
Flu: NHS Influeza Vaccination (all adults at risk)
EHC: Emergency Hormonal Contraception
CATC: Care at the Chemist (minor ailments)
IM-SCESS: Intermediate Smoking Cessation
NRT: Nictotine Replacement Therapy (NRT) Vouchers
Varen: Varenicline Initiation
SUPCON: Supervised Consumption - Methadone
PALL: Palliative Care Medicines Service

Appendix 5: Cross border Community Pharmacy service provision

Number on map	Pharmacy Name	Address	Postcode	MUR's	Care at the Chemist (Minor Ailments)	Open Hours	Open Hours - Weekends
			Liverpool				
1	Lloyds Pharmacy	109 East Millwood Road	L24 6TH	Yes	Yes	8:30 - 18:00 Mon - Fri	
2	Rowlands Pharmacy	15 Penketh Drive	L24 2WZ	Yes	Yes	9:00 - 18:00 Mon - Fri	9:00 - 17:00 Sat
3	Rowlands Pharmacy	New Neighbourhood Health Centre	L24 2XD	Yes	No	8:45 - 18:45 Mon - Fri	
4	Greencross Pharmacy	West Speke Health Centre	L24 3TY	Yes	Yes	9:00 - 18:00 Mon - Fri	9:00 - 13:00 Sat
5	Lloyds Pharmacy	4 Woodend Avenue	L25 0PA	Yes	Yes	8:30 - 18:00 Mon - Fri	9:00 - 13:00 Sat
6	Asda Pharmacy	Hunts Cross Shopping Park	L24 9GB	Yes	Yes	8:00 - 20:00 Mon - Fri	8:00 - 20:00 Sat 10:00 - 16:00 Sun
7	Woolton Late Night Chemist	267 Hunts Cross Avenue	L25 9ND	Yes	Yes	7:30 - 22:30 Mon - Fri	9:00 - 21:30 Sat & Sun
			Knowsley				
8	Daveys Chemist	43-45 Manor Farm Road	L36 0UB	Yes	Yes	9:00 - 18:15 Mon - Fri	
9	Lloyds pharmacy	5 Tarbock Road	L36 5XN	Yes	Yes	8:30 - 18:30 Mon - Fri	9:00 - 17:30 Sat
10	Superdrug	Derby Road	L36 9UJ	Yes	Yes	9:00 - 17:30 Mon - Fri	9:00 - 17:30 Sat
11	Asda Pharmacy	Huyton Lane	L36 7TX	Yes	Yes	8:00 - 23:00 Mon 7:00 - 23:00 Tues - Fri	7:00 - 22:00 Sat 10:30 - 16:30 Sun
12	Sedem Pharmacy	The Long View Primary Care Centre	L36 6EB	Yes	Yes	9:00 - 18:30 Mon - Fri	
13	Boots Whiston	Old Colliery Road	L35 3SX	Yes	Yes	8:00 - 19:00 Mon - Fri	8:30 - 12:00 Sat
14	Neil's Pharmacy	32 Molyneux Drive	L35 5DY	Yes	Yes	9:00 - 18:00 Mon - Fri	
			St Helens				
15	Lloyds Pharmacy	473 Warrington Road	L35 4LL	Yes	Yes	9:00 - 18:00 Mon - Fri	9:00 - 13:00 Sat
16	Longsters Pharmacy	578 Warrington Road	L35 4LZ	Yes	Yes	9:00 - 18:00 Mon - Fri	
17	Rowlands Pharmacy	Four Acre Health Centre	WA9 4QB	Yes	Yes	9:00 - 18:00 Mon - Fri	9:00 - 17:00 Sat
			Warrington				
18	Barrow Hall Pharmacy	103 Barrow Hall Lane	WA5 3AE	Yes	No	8:30 - 18:00 Mon - Fri	
19	Aston Pharmacy	2 Station Road	WA5 1RQ	Yes	No	9:00 - 18:00 Mon - Fri	
20	Hood Manor Pharmacy	Hood Manor Centre	WA5 1UH	Yes	No	9:00 - 18:00 Mon - Fri	9:00 - 13:00 Sat
21	Lloyds Pharmacy	Honiton Way	WA5 2EY	Yes	No	8:30 - 18:15 Mon - Fri	9:00 - 17:30 Sat
22	Stockton Heath Pharmacy	The Forge, London Road	WA4 6HJ	Yes	No	7:30 - 22:30 Mon - Fri	7:00 - 22:30 Sat 10:00 - 17:00 Sun
23	Boots Pharmacy	19 London Road	WA4 6SG	Yes	No	8:30 - 18:00 Mon - Fri	9:00 - 17:00 Sat
24	Thomas Brown Pharmacy	51 London Road	WA4 6SG	Yes	No	9:00 - 18:00 Mon - Fri	9:00 - 13:00 Sat
25	Lloyds Pharmacy	The Forge, London Road	WA4 6HW	Yes	No	8:45 - 18:00 Mon - Fri	9:00 - 17:00 Sat
26	Well Pharmacy	45 Dudlow Green Road	WA4 5EQ	Yes	No	8:45 - 18:00 Mon - Fri	
			Cheshire West & Chester				
27	Boots Pharmacy	7 Church Street, Frodsham	WA6 7DN	Yes	Yes	8:45 - 17:45 Mon - Fri	9:00 - 17:00 Sat
28	Boots Pharmacy	Princeway, Frodsham	WA6 6RX	Yes	No	9:00 - 18:00 Mon - Fri	9:00 - 12:00 Sat

Appendix 6: Healthy Living Pharmacies

Background

The Healthy Living Pharmacy (HLP) framework[212] is a tiered commissioning framework aimed at achieving consistent delivery of a broad range of high quality services through community pharmacies to meet local need, improving the health and wellbeing of the local population and helping to reduce health inequalities. It is a nationally agreed accreditation or 'kite mark' for community pharmacies which deliver proactive health and wellbeing advice as part of their day to day role.

Quality Criteria needed to demonstrate that a pharmacy is either working towards Healthy Living Pharmacy status or actually achieving this quality mark. Once progressed to the next level the pharmacy must ensure that the standards of the previous level are maintained:

- Level 1: Promotion – Promoting health, wellbeing and self-care (in July 2016, Level 1 changed from a commissioner-led process to a profession-led self-assessment process)
- Level 2: Prevention – Providing services (commissioner-led)
- Level 3: Protection – Providing treatment (commissioner-led)

The HLP framework is underpinned by three enablers:

- workforce development – a skilled team to pro-actively support and promote behaviour change, improving health and wellbeing
- premises that are fit for purpose
- engagement with the local community, other health professionals (especially GPs), social care and public health professionals and local authorities

Key findings from the evaluation of the HLP pathfinder sites:[213][214][215]

- increased service delivery and improved quality measures and outcomes
- 60% of peopled surveyed would have otherwise gone to a GP
- 99% of the public surveyed were comfortable to receive the service in the pharmacy
- More people successfully quit smoking in HLPs than non-HLPs
- More sexual health advice given than in non-HLPs
- HLPs were effective at delivering increased support for people taking medicines for long term conditions, through both Medicines Use Reviews and the New Medicine Service
- 70% of the contractors surveyed saying it had been worthwhile for their business
- Health promotion zones within pharmacies play a vital part in supporting the public health role of the pharmacy

The Healthy Living Pharmacy Quality Mark

Healthy living pharmacies will have a healthy living pharmacy logo that is easily identified by members of the public, healthcare professionals and commissioners. This will require marketing and publicity to ensure that people recognise what this means. A national logo exists but a local variant could be agreed if this is thought more locally acceptable.

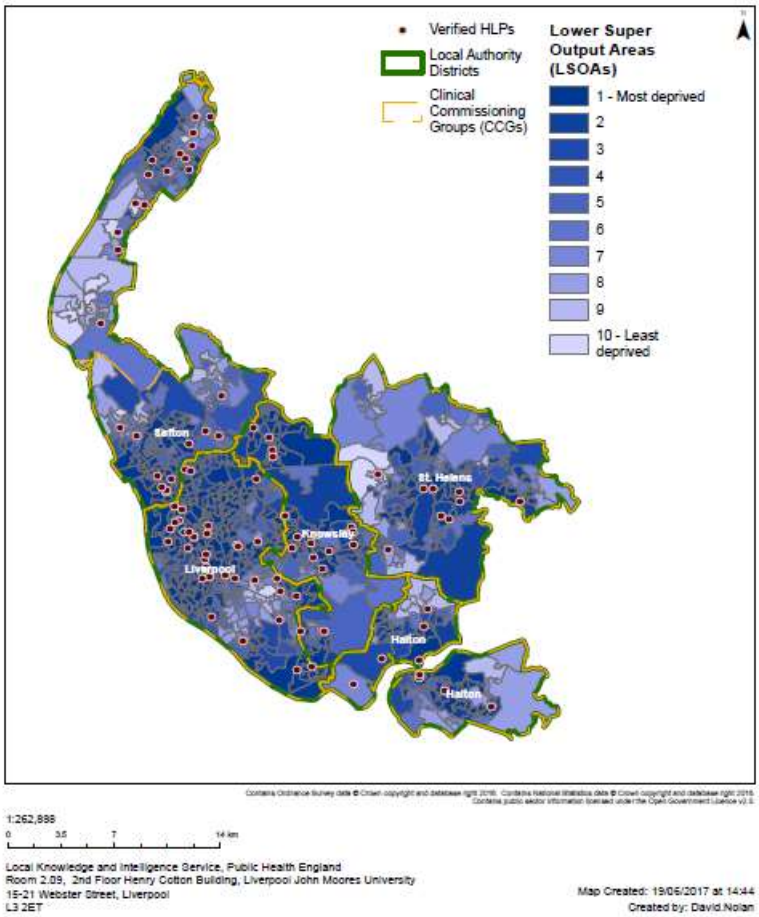
What is a Healthy Living Pharmacy?

Figure 41: Healthy Living Pharmacy

The approach illustrated above shows that there is an ethos within a HLP to proactively promote health and wellbeing throughout the whole pharmacy team. Additionally, a HLP[216] has at least one Healthy Living Champion trained to level 2 qualification in '*Understanding Health Improvement*' accredited by the Royal Society of Public Health. A HLP will achieve defined quality criteria requirements and meets productivity targets linked to local health needs e.g. number of stop smoking quits at 4 weeks; number of targeted MURs completed, tailored to local need. It builds on all existing core pharmacy services (Essential and Advanced) with a series of locally commissioned services.

A number of pharmacies in Halton (and across Cheshire & Merseyside) already have HLP status or are working towards it.

Map 18: Verified HLPs in Merseyside (NHS Area Team) at end of May 2017



Source: North West Local Knowledge and Intelligence Service, PHE

Appendix 7: Pharmacy Premises and Services Questionnaire

A questionnaire to gather information from all pharmacies was devised as a collaborative exercise with Cheshire & Merseyside local authority PNA leads, Local Pharmaceutical Committee (LPC) representatives and NHSE. It was conducted online via Pharm Outcomes. Both the LPCs and NHSE sent communications to pharmacies to encourage completion.

1: Premises Details

Contractor Code (ODS Code)	
Name of contractor (i.e. name of individual, partnership or company owning the pharmacy business)	
Trading Name	
Address of pharmacy	
Pharmacy postcode	
Is this pharmacy entitled to Pharmacy Access Scheme payments?	☐ Yes ☐ No ☐ Under review
Is this pharmacy a 100-hour pharmacy?	☐ Yes ☐ No
Does this pharmacy hold a Local Pharmaceutical Services (LPS) contract? (i.e. it is not the 'standard' Pharmaceutical Services contract)	☐ Yes ☐ No
Is this pharmacy a Distance Selling Pharmacy? (i.e. it cannot provide Essential Services to persons present at or in the vicinity of the pharmacy)	☐ Yes ☐ No
Pharmacy email address	
Pharmacy telephone	
Pharmacy fax (if applicable)	
Pharmacy website address (if applicable)	
Can we share the above information with the LPC and use it to contact you?	☐ Yes ☐ No

2: Contact Details

Contact details of person completing questionnaire, if questions arise		
Name:	Phone:	Email:
Contact details for head office (if different/appropriate)		
Name:	Phone:	Email:

3: In which Local Authority are you based?

Cheshire East ☐	Cheshire West & Chester ☐	Halton ☐	Knowsley ☐	Liverpool ☐
Sefton ☐	St. Helens ☐	Warrington ☐	Wirral ☐	

4: Total opening hours (what hours are you open?)

Day	Open from	To	Lunchtime (From – To)
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

5: Consultation facilities

Is there a consultation area on premises (meeting the criteria for the Medicines Use Review service) (tick one)	None, or	☐
	Available (including wheelchair access), or	☐
	Available (without wheelchair access), or	☐
	Planned within the next 12 months, or	☐
	Other (specify)	
Where there is a consultation area, is it a closed room?		☐ Yes ☐ No
During consultations are there hand-washing facilities?	In the consultation area, or	☐
	Close to the consultation area, or	☐
	None	☐
How many closed consultation rooms have you got?		Drop down 0,1,2,3+
Do patients attending for consultations have access to toilet facilities?		☐ Yes ☐ No
Off-site	Does the pharmacy have access to an off-site consultation area (i.e. one which the former PCT or NHS England local team has given consent for use)?	☐ Yes ☐ No
	Is the pharmacy willing to undertake consultations in patient's home / other suitable site?	☐ Yes ☐ No

6: Healthy Living Pharmacies (HLP) Yes/No.

The pharmacy has achieved HLP status	☐ Yes ☐ No
The pharmacy is working toward HLP status	☐ Yes ☐ No
Expected completion by 24th Nov 2017?	☐ Yes ☐ No
The pharmacy is not currently working toward HLP status but would be interested in becoming a HLP in the future	☐ Yes ☐ No
The pharmacy would not be interested in becoming a HLP	☐ Yes ☐ No

7.1: Services

Does the pharmacy dispense the following:

	Yes	No
Stoma appliances	☐	☐
Incontinence appliances	☐	☐
Dressings	☐	☐
Other (please specify)	☐	☐

7.2: Advanced services

Does the pharmacy provide the following services?

	Yes	Intending to begin within next 12 months	No - not intending to provide
Medicines Use Review service	☐	☐	☐
New Medicine Service	☐	☐	☐
Appliance Use Review service	☐	☐	☐
Stoma Appliance Customisation service	☐	☐	☐
NHS Flu Vaccination Service	☐	☐	☐
NHS Urgent Medicine Supply Advanced Service	☐	☐	☐

7.3: Enhanced[xiv] and Other Locally Commissioned Services[xv]

Which of the following services does the pharmacy provide, or would be willing to provide?

	Currently commissioned to provide	Company led service[xvi]	Potentially willing to provide in future if commissioned[xvii]	Not able or willing to provide
Anticoagulant Monitoring Service	☐	☐	☐	☐
Anti-viral Distribution Service	☐	☐	☐	☐
Care Home Service	☐	☐	☐	☐
Chlamydia Testing Service	☐	☐	☐	☐
Chlamydia Treatment Service	☐	☐	☐	☐
Contraceptive service (not EC)	☐			
Disease specific medicines management service				
Allergies	☐	☐	☐	☐
Alzheimer's/dementia	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
CHD	☐	☐	☐	☐
COPD	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Diabetes type I	☐	☐	☐	☐
Diabetes type II	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐
Heart Failure	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐
Parkinson's disease	☐	☐	☐	☐

[xiv] 'Enhanced Services' are those commissioned by the local NHS England Team. CCGs and Local Authorities can commission Other Locally Commissioned Services that are equivalent to the Enhanced Services, but for the purpose of developing the PNA are called 'Other Locally Commissioned Services' not 'Enhanced Services'

[xv] These services are not listed in the Advanced and Enhanced Services Directions, and so are not 'Enhanced Services' if commissioned by the local NHS England Team. The local NHS England Team may commission them on behalf of the CCG or Local Authority, but when identified in the PNA they will be described as 'Other Locally Commissioned Services' or 'Other NHS Services'

[xvi] This is a private service either paid for by the patient or free to the patient, that is available through your organisation/company

[xvii] Depending on local need and funding

	Currently commissioned to provide	Company led service[xvi]	Potentially willing to provide in future if commissioned[xvii]	Not able or willing to provide
Other (please state)				
Emergency Contraception Service	☐	☐	☐	☐
Quick Start Contraception Service	☐	☐	☐	☐
Emergency Supply Service	☐	☐	☐	☐
Gluten Free Food Supply Service (i.e. not via FP10)	☐	☐	☐	☐
Home Delivery Service (not appliances)	☐	☐	☐	☐
Independent Prescribing Service	☐	☐	☐	☐
If currently providing an Independent Prescribing Service, what therapeutic areas are covered?				
Language Access Service	☐	☐	☐	☐
Medicines Assessment and Compliance Support Service	☐	☐	☐	☐
Minor Ailment Scheme (Care at the Chemist)	☐	☐	☐	☐
MUR Plus/Medicines Optimisation Service	☐	☐	☐	☐
If currently providing an MUR Plus/ Medicines Optimisation Service, what therapeutic areas are covered?		Free text field		
Needle and Syringe Exchange Service	☐	☐	☐	☐
Sharps Disposal Service	☐	☐	☐	☐
Obesity/weight management (adults and children)	☐	☐	☐	☐
Not Dispensed Scheme	☐	☐	☐	☐
On Demand Availability of Specialist Drugs Service	☐	☐	☐	☐
Out of Hours Services	☐	☐	☐	☐
Patient Group Direction Service (name the medicines covered by the Patient Group Direction)	Free text field			
Phlebotomy Service	☐	☐	☐	☐
Prescriber Support Service	☐	☐	☐	☐
Schools Service	☐	☐	☐	☐
Screening Service				
Alcohol	☐	☐	☐	☐
Atrial Fibrillation service	☐	☐	☐	☐
Cholesterol	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Gonorrhoea	☐	☐	☐	☐
H. pylori	☐	☐	☐	☐
HbA1C	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐
HIV	☐	☐	☐	☐
Other (please state)				
Seasonal Influenza Vaccination Service	☐	☐	☐	☐
Other vaccinations				
Childhood vaccinations	☐	☐	☐	☐

	Currently commissioned to provide	Company led service[xvi]	Potentially willing to provide in future if commissioned[xvii]	Not able or willing to provide
Hepatitis (at risk workers or patients)	☐	☐	☐	☐
HPV	☐	☐	☐	☐
Travel vaccines	☐	☐	☐	☐
Other – (please state)				
NRT Voucher Dispensing	☐	☐	☐	☐
Intermediate Stop Smoking Service	☐	☐	☐	☐
Varenicline PDG Service	☐	☐	☐	☐
Supervised Administration Service	☐	☐	☐	☐
If you provide supervised administration service, is this done in a separate private room?				
Supplementary Prescribing Service (what therapeutic areas are covered?)			☐	☐
Vascular Risk Assessment Service (NHS Health Check)	☐	☐	☐	☐
Palliative care service	☐	☐	☐	☐
IV Antibiotics supply	☐	☐	☐	☐
Domiciliary Medicine Administration Records (MAR)	☐	☐	☐	☐
Locally Commissioned Domiciliary MUR Service[xviii]	☐	☐	☐	☐

7.4: Non-commissioned services

Does the pharmacy provide any of the following?

Collection of prescriptions from GP practices	☐ Yes ☐ No
Delivery of dispensed medicines – Free of charge on request	☐ Yes ☐ No
Delivery of dispensed medicines - Chargeable	☐ Yes ☐ No
Monitored/Community Dosage Systems – Free of charge on request if not covered by Equality Act (DDA)	☐ Yes ☐ No
Monitored/Community Dosage Systems – chargeable if not covered by Equality Act (DDA)	☐ Yes ☐ No
Is there a particular need for a locally commissioned service in your area? If so, what is the service requirement and why.	Free text field

8: Accessibility

Can customers legally park within 50 metres of the pharmacy?	☐ Yes ☐ No
How far is the nearest bus stop/train station?	☐ Within 100m ☐ 100m to 500m ☐ 500m to 1km ☐ Other ☐ None
Do pharmacy customers have access to a designated disabled parking?	☐ Yes ☐ No
Is the entrance to the pharmacy suitable for wheelchair access unaided?	☐ Yes ☐ No

[xviii] Currently commissioned by Warrington LA

Are all areas of the pharmacy floor accessible by wheelchair?		☐ Yes ☐ No
Do you have any other facilities in the pharmacy aimed at supporting disabled people access your service?	Automatic door assistance	☐ Yes ☐ No
	Bell at front door	☐ Yes ☐ No
	Toilet facilities accessible by wheelchair users	☐ Yes ☐ No
	Hearing loop	☐ Yes ☐ No
	Sign language	☐ Yes ☐ No
	Large print labels	☐ Yes ☐ No
	Large print leaflets	☐ Yes ☐ No
	Wheelchair ramp access	☐ Yes ☐ No
	Other, please state	Free text field
Are you able to offer support to people whose first language is not English? If so how?	Use of interpreter/language line	☐ Yes ☐ No
	Staff at pharmacy speak languages other than English (please indicate which languages)	Free text field
Are you able to provide advice and support if a customer wishes to speak to a person of the same sex?	At all times	☐ Yes ☐ No
	By arrangement	☐ Yes ☐ No

Are you aware of any gaps in access or pharmaceutical need for any of the following groups, relating to their:

		If yes, please specify:
Age	☐ Yes ☐ No	
Disability	☐ Yes ☐ No	
Gender	☐ Yes ☐ No	
People who have had or about to have a reassignment of gender	☐ Yes ☐ No	
Marriage and civil partnership	☐ Yes ☐ No	
Pregnancy and maternity	☐ Yes ☐ No	
Race	☐ Yes ☐ No	
Religion or belief	☐ Yes ☐ No	
Sexual orientation	☐ Yes ☐ No	
Other, (please state)		Free text field

9: IT Facilities Select any that apply

Electronic Prescription Service Release 2 enabled	☐
Registered for NHS mail	☐
NHS Summary Care Record enabled	☐
Up to date NHS Choice entry	☐

Appendix 8: Public Local Pharmacy Services Questionnaire

During June 2017 the public health team conducted a survey at a local health & wellbeing event and online. It asked local residents to give their feedback on their local pharmacy. The online version of the survey was sent out via a wide range of networks including Halton & St Helens Voluntary Action, Healthwatch, Halton Local Strategic Partnership groups and networks, Halton Children's Trust, Halton Clinical Commissioning Group engagement network, Halton OPEN (Older People's Network) and others. **216** responses were received. A press release was also issued to the local paper. The online survey was open for four weeks. The following is the communication sent out and questionnaire.

Pharmacy Services in Halton - Have your say
Halton Borough Council are seeking your views about your local pharmacy.

Please help us to make sure that your local pharmacy is providing the right services and support for you and your family by completing a short survey.

Your responses will help Halton's Health and Wellbeing Board to produce its local Pharmaceutical Needs Assessment (PNA). This document will help to ensure that your local pharmacy provides the service you need both now and in the future.

Director of Public Health, Eileen O'Meara said:
"The local pharmacy is often the first place residents will turn to when they have a concern about their health or that of their family. It is for this reason that it is important we look into the needs of Halton's population and how pharmacies can meet these needs. I would ask everyone to get involved and respond to this important survey, to help us shape the future of the service."

The questionnaire is anonymous and should only take a few minutes to complete.

How to get involved
To give us your views complete this questionnaire or go to https://www.surveymonkey.co.uk/r/pnapatient2017 and fill in the on-line questionnaire.
Paper versions of the survey are available by calling 0151 511 6855 (Monday to Friday between 9:00 and 4:00pm) and providing your name and postal address

LOCAL SURVEY OF COMMUNITY PHARMACY SERVICES

Thank you for agreeing to complete this questionnaire which is asking for your views on the current provision of pharmacy services in your local area

A pharmacy or Chemist is a place you would use to get a prescription dispensed or buy medicines or ask a pharmacist for advice. A pharmacist is the most qualified person in the pharmacy to dispense and sell medicines and give advice

1. In which Local Authority do you live?

☐ Cheshire East ☐ Cheshire West & Chester ☐ Halton ☐ Knowsley

☐ Liverpool ☐ Sefton ☐ St. Helens ☐ Warrington ☐ Wirral

The following questions are about the last time you used a pharmacy

2. Why did you visit the pharmacy? (Please tick all that apply)

☐ To collect a prescription for yourself ☐ To collect a prescription for someone else To get advice from the pharmacist ☐ To buy other medications I cannot buy elsewhere ☐ Other

3. When did you last use a pharmacy to get a prescription, buy medicines or to get advice?

(Please tick one answer only)

☐ In the last week ☐ In the last two weeks ☐ In the last month

☐ In the last three months ☐ In the last six months ☐ Not in the last six months

4. How did you get to the pharmacy? Please tick all that apply

☐ Walking ☐ Public transport ☐ Car ☐ Taxi ☐ Bicycle ☐ Other (please specify)

5. Thinking about the location of the pharmacy, which of the following is most important to you?

☐ It is close to my doctor's surgery
☐ It is close to my home
☐ It is close to other shops I use
☐ It is close to my children's school or nursery
☐ It is easy to park nearby
☐ It is near to the bus stop / train station
☐ It is close to where I work
☐ It is close to/in my local supermarket
☐ None of these
☐ Other (please specify)

6. How easy is to get to your usual pharmacy? (*Please tick one answer only)*

☐ It is very easy
☐ It is quite easy
☐ It is not easy
☐ It is not easy at all
☐ It is very difficult
☐ It is very inconvenient for me to get to a pharmacy and can cause a problem for me

7. If you have a condition that affects your mobility, are you able to park close enough to your pharmacy?

☐Yes ☐ No ☐ Don't know ☐ Not applicable

8. Does your pharmacy deliver medication to your home if you are unable to collect it yourself?

☐Yes ☐ No ☐ Don't know/ I have never used this service

9. In the last 12 months have you had any problems finding a pharmacy to get a medicine dispensed, to get advice or to buy medicines?
☐ Yes ☐ No (Go to Q12)

10. If Yes, what was your main reason for going to the pharmacy?(*Please tick one answer only)*

☐ To get medicine(s) on a prescription ☐ To buy medicine(s) from the pharmacy
☐ To get advice at the pharmacy ☐ Other (please specify)

11. Please tell us what was the problem in finding a pharmacy?

12. Are you satisfied with the opening hours of your pharmacy?
☐ Yes ☐ No (please specify why below)

About the last time you found your usual pharmacy, or the one closest to you, closed

13. In the last 12 months how many times have you needed to use your usual pharmacy (or the pharmacy closest to you) when it was closed?

☐ Once or twice ☐ Three or four times ☐ Four or more times
☐ I haven't needed to use the pharmacy when it was closed (Go to Question 17)

14.. What day of the week was it?

☐ Monday to Friday ☐ Saturday ☐ Sunday ☐ Bank Holiday ☐ Can't remember

15. What time of the day was it?

☐ Morning ☐ Lunchtime (between 12pm and 2pm) ☐ Afternoon ☐ Evening (after 7pm)
☐ Can't remember

16. What did you do when your pharmacy was closed?

☐ Went to another pharmacy ☐ Waited until the pharmacy was open ☐ Went to a hospital
☐ Went to a Walk in Centre ☐ Other (please specify)

About any medicines you receive on prescription and dispensed by your usual, or local pharmacy

17. Did you get a prescription the last time you used a pharmacy?

☐ Yes ☐ No (Go to Q20) ☐ Can't remember (Go to Q20)

18. Did the staff at the pharmacy tell you how long you would have to wait for your prescription to be prepared?

☐ Yes ☐ No, but I would have liked to have been told ☐ No, but I did not mind
☐ Can't remember

19. If 'yes' was this a reasonable period of time?

☐ Yes ☐ No

20. Did you get all the medicines that you needed on this occasion?

☐ Yes (Go to Q24) ☐ No ☐ Can't remember (Go to Q24)

21. What was the main reason for not getting all your medicines on this occasion? (*Please tick one answer only)*

☐ The pharmacy had run out of my medicine
☐ My GP had not prescribed something I wanted
☐ My prescription had not arrived at the pharmacy
☐ Some other reason

22. How long did you have to wait to get the rest of your medicines?

☐ Later the same day ☐ The next day ☐ Two or more days ☐ More than a week

23. Did the pharmacist offer to deliver the remainder of your prescription to your home?

☐ Yes☐ No

24. If you have needed to use a hospital pharmacy (e.g. as an outpatient or on discharge following a stay in hospital), would you like to have the option to have the prescription dispensed as your local pharmacy?

☐ Yes☐ No ☐ I have never used a hospital pharmacy

About times when you needed a consultation, or wished to talk to the pharmacist in the pharmacy

25. Have you had a consultation with the pharmacist in the last 12 months for any health related purpose?

☐ Yes ☐ No (Go to Q29) ☐ Can't remember (Go to Q29)

26. What advice were you given during your consultation?

☐ Lifestyle advice (e.g. stop smoking, diet and nutrition, physical activity etc.)
☐ Advice about a minor ailment (e.g. using Care at the Chemist service)
☐ Medicine advice
☐ Emergency contraception advice
☐ Other (please specify)

27. Where did you have your consultation with the pharmacist?

Please tick one

☐ At the pharmacy counter
☐ In the dispensary or a quiet part of the shop
☐ In a separate room
☐ Over the telephone (Go to Q29)
☐ Other (please specify)

28. How do you rate the level of privacy you have in the consultation with the pharmacist?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Very Poor

About what you feel pharmacies should be able to offer you

29. Please tell us how you would describe your feelings about pharmacies.

☐ I wish pharmacies could provide more services for me
☐ I am satisfied with the range of services pharmacies provide
☐ Don't know

30. Which if any of the services below do you think should be available locally through pharmacies? (Please tick one box in each row)

To get treatment of a minor illness such as a cold instead of my doctor (Known as Care at the Chemist this is free of charge if you don't pay for prescriptions)	Yes ☐	No ☐	Not sure ☐
Advice on stopping smoking and/or vouchers for nicotine patches/gum etc.	Yes ☐	No ☐	Not sure ☐
Advice on contraception and supply of "morning after" pill free of charge	Yes ☐	No ☐	Not sure ☐
Weight management services and advice on diet/exercise for weight management	Yes ☐	No ☐	Not sure ☐
Tests to check blood pressure, cholesterol, whether I might get diabetes or other conditions	Yes ☐	No ☐	Not sure ☐
Advice and treatment for alcohol misuse	Yes ☐	No ☐	Not sure ☐
Advice and treatment for drug misuse	Yes ☐	No ☐	Not sure ☐
Review of medicines on repeat prescription with advice on when it is best to take them, what they are for and side-effects to expect	Yes ☐	No ☐	Not sure ☐
Provision of the "Flu" vaccination	Yes ☐	No ☐	Not sure ☐

31. Is there anything you particularly value as a service from pharmacies?

32. Is there anything else, or any service that you feel could be provided by local pharmacies?

Finally please provide some details about yourself

24.Are you? ☐Male ☐Female

25. How old are you?
☐ 16-20 years ☐ 21-30 years ☐ 31-40 years ☐ 41-50 years ☐ 51-59 years
☐ 60- 69 years ☐ 70 years or over

26. Please tell us your postcode

36. Disability: Do you have any of the following (Please tick all that apply)

☐ Physical impairment
☐ Visual impairment
☐ Hearing impairment/ Deaf
☐ Mental health impairment/ Mental distress
☐ Learning difficulty
☐ Long term illness that affects your daily activity
☐ Other (please specify)

37. If you have ticked any of the boxes above, or you have cancer, diabetes or HIV this would be classed as 'disability' under the legislation. Do you consider yourself to be 'disabled'?
☐ Yes☐ No

38. Which ethnic group do you belong to? (Please tick the appropriate box)
☐ Asian - Bangladeshi ☐ Asian - Indian ☐ Asian - Pakistani ☐ Asian – Other Background
☐ Black - African ☐ Black - British ☐Black - Caribbean ☐ Black – other background
☐ Chinese ☐ Other Chinese Background
☐ Mixed Ethnic Background – Asian & White ☐ Mixed Ethnic Background – Black African & White
☐ Mixed Ethnic Background – Caribbean & White ☐ Mixed Ethnic Background – Other
☐ White - British ☐ White - English ☐ White - Irish ☐ White - Scottish
☐ White - Welsh ☐ White – Gypsy/ Traveller ☐ White – Other

The following questions are a little more personal and you can choose to stop here if you wish. However, it would be helpful if you would consent to complete these questions

39. Do you have a religion or belief?

☐ Yes☐ No

40. If "Yes" please tick one of the options below:

☐ Buddhist ☐ Christian ☐ Hindu ☐ Jewish
☐ Muslim ☐ Sikh ☐ No Religion
☐ Other (please specify)

41. How would you describe your sexual orientation?

☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Rather not say

42. Do you live in the gender you were given at birth?

☐ Yes☐ No

Thank you for taking the time to complete this survey. The findings will help inform the development of pharmacy services in your local area.
The data you have provided is private and confidential and will not be shared. Only overall anonymised results of this consultation will form part of the final report which will be used to improve the delivery of local services.

Appendix 9: 60-day statutory Consultation Letter and Questionnaire

Dear Sir / Madam

Pharmaceutical Needs Assessment (PNA) Consultation

Our Ref	EOM/lw
If you telephone please ask for	Eileen O'Meara
Date	7 August 2017
E-mail address	eileen.omeara@halton.gov.uk

Invitation to Participate

During the reorganisation of the NHS the responsibility for production of the Pharmaceutical Needs Assessments (PNAs) transferred to the Health and Wellbeing Boards (HWB) which are hosted by local authorities.

Halton Health and Wellbeing Board (HWB) is developing a new PNA. This is a statutory HWB responsibility, as set out under the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013(SI 2013 No. 349).

A PNA is a document which records the assessment of the need for pharmaceutical services within a specific area. As such, it sets out a statement of the pharmaceutical services which are currently provided, together with when and where these are available to a given population. The same Regulations require NHS England to use the PNA to consider applications to open a new pharmacy, move an existing pharmacy or to commission additional services from pharmacy.

The HWB has established a PNA Task & Finish Group to oversee the development of the new PNA. This group includes membership from our partner organisations, Healthwatch and the Local Pharmaceutical Committee.

As part of the development process, the Regulations require that the HWB undertakes a formal consultation on a draft of its PNA. The key outcomes for this consultation are:

- To encourage constructive feedback from a variety of stakeholders
- To ensure a wide range of primary care health professionals provide opinions and views on what is contained within the PNA

Taking this into account, we would like to invite you to participate in this consultation, which will run from Wednesday 9 August to Wednesday 11 October 2017:

- The draft PNA can be found on our website by via the following link

https://webapp.halton.gov.uk/survey_snap/pna.htm

All responses must be in writing.

- Submitting responses: You may choose one of the following options to submit your response:

  - Complete the survey online at

    https://webapp.halton.gov.uk/survey_snap/pna.htm

  - Complete the form sent with this letter and return it electronically via email to: Lynne.Woods3@halton.gov.uk

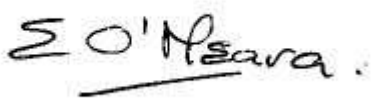
  - complete the form and return it by post to the following address: **Public Health and Public Protection Department, Halton Borough Council, Runcorn Town Hall, Heath Road, Runcorn, Cheshire, WA7 5TD**

Halton Borough Council has decided to run this consultation electronically in order to limit the environmental impact of this consultation. However, if you require a paper version of the PNA, please contact Lynne Woods on 0151 511 6855 who will arrange to provide this within 14 days of your request.

All feedback received by 11 October 2017 will be collated and presented to the PNA Task & Finish Group, for consideration on behalf of the HWB. A consultation report will be included within the final PNA document. This will provide an overview of the feedback received and set out how the comments have been acted upon. An updated PNA including consultation process and responses will be presented to the HWB in January 2018 and published by 31 March 2018.

We look forward to receiving your feedback on the draft PNA.

Yours faithfully



Eileen O'Meara
Director of Public Health
PNA Sponsor, Halton Health & Wellbeing Board
Halton Borough Council

Halton Pharmaceutical Needs Assessment
Consultation Response Form

1. Has the purpose of the PNA been explained sufficiently within section 2 of the draft PNA document?

Yes ☐ No ☐ Not sure ☐

If "No", please explain why in the box below:

2. Does Section 3 clearly set out the scope of the PNA?

Yes ☐ No ☐ Not sure ☐

If "No", please explain why in the box below:

3. Does Section 4 and 6 clearly set out the local context and the implications for the PNA?

Yes ☐ No ☐ Not sure ☐

If "No", please explain why in the box below:

4. Does the information in Sections 5 & 7 provide a reasonable description of the services which are provided by pharmacies in Halton?

Yes ☐ No ☐ Not sure ☐

If "No", please explain why in the box below:

5. Are you aware of any pharmaceutical services currently provided which have not been included within the PNA?

Yes ☐ No ☐ Not sure ☐

If "Yes", please explain why in the box below:

6. Do you think the pharmaceutical needs of the population have been accurately reflected in the PNA?

Yes ☐ No ☐ Not sure ☐

If "Yes", please let us know which service(s) in the box below:

7. Do you agree with the key findings about pharmaceutical services in Halton?

Yes ☐ No ☐ Not sure ☐

If "No" please explain why in the box below:

8. Do you agree with the assessment of future pharmaceutical services as set out in sections 7?

Yes ☐ No ☐ Not sure ☐

If "No", please explain why in the box below:

9. ***Community pharmacies & Dispensing Appliance Contractor only.*** Please can you review the information in Appendix B (Opening Hours) and Appendix C (Service Provision) for accuracy? If you identify any issues please provide details

	Is the information Accurate?				If "No", please provide details:
Opening Hours	Yes	☐	No	☐	
Service Provision	Yes	☐	No	☐	

10. If you have any further comments, please enter them in the box below (question applies to all):

11. About you - please can you provide the following information:

Name	
Job Title	
Pharmacy Name Or Organisation	
Address	
Telephone No.	
Please confirm that you are happy for us to store these details in case we need to contact you about your feedback?	Yes ☐ No ☐

Please return this feedback form:

- Via email to: Lynne.Woods3@halton.gov.uk
- Via post to the following address: **Public Health and Public Protection Department, Halton Borough Council, Runcorn Town Hall, Heath Road, Runcorn, Cheshire, WA7 5TD**

Appendix 10: 60-day statutory Consultation Response

1 response was received

Questions	Responses	Response to comments
Q1: Has the purpose of the PNA been explained sufficiently within section 2 of the draft PNA document?	Yes	Noted
Q2: Does Section 3 clearly set out the scope of the PNA?	Yes	Noted
Q3: Does Section 4 & 6 clearly set out the local context and the implications for the PNA?	Yes	Noted
Q4: Does the information in Sections 5 & 7 provide a reasonable description of the services which are provided by pharmacies in Halton?	Yes	Noted
Q5: Are you aware of any pharmaceutical services currently provided which have not been included within the PNA?	No	Noted
Q6: Do you think the pharmaceutical needs of the population have been accurately reflected in the PNA?	Yes	Noted
Q7: Do you agree with the key findings about pharmaceutical services in Halton?	Yes	Noted
Q8: Do you agree with the assessment of future pharmaceutical services as set out in sections 7?	Yes	Noted
Q9: ***Community pharmacies & Dispensing Appliance Contractor only.*** Please can you review the information in Appendix B (Opening Hours) and Appendix C (Service Provision) for accuracy? If you identify any issues please provide details	….	Noted

Q10: Further comments	
Comments	**Response from Steering group**
No further comments included	Noted

Appendix 11: References

1. NHS Digital (2016) *Prescriptions Dispensed in the Community England 2005-15* http://content.digital.nhs.uk/catalogue/PUB20664/pres-disp-com-eng-2005-15-rep.pdf Accessed 13 June 2017

2. NHS Digital (2016) *Prescriptions Dispensed in the Community England 2005-15* http://content.digital.nhs.uk/catalogue/PUB20664/pres-disp-com-eng-2005-15-rep.pdf Accessed 13 June 2017

3. Department of Health (2008) *High Quality Care For All - NHS Next Stage Review Final Report*

4. Chapman N (2011) *When and how to use using Monitored Dosage Systems: Careful consideration of the costs and benefits*. Dispensing Doctors' Association, Guidance, 13th of April 2011.

5 YHEC (2010) *Evaluation of the scale, causes and costs of waste medicines. Final report of DH funded national project*. York Health Economics Consortium and the School of Pharmacy, University of London.

6. Oboh L (2013) *Supporting older people in the community to optimise their medicines including the use of multi compartment compliance aids (MCAs) Vs3*. NHS East and South East England Specialist Pharmacy Services http://www.medicinesresources.nhs.uk/en/Communities/NHS/SPS-E-and-SE-England/Meds-use-and-safety/Service-deliv-and-devel/Older-people-care-homes/MCA-Toolkit-Vs3-Jun13/

7. Chapman N (2011) *When and how to use using Monitored Dosage Systems: Careful consideration of the costs and benefits*. Dispensing Doctors' Association, Guidance, 13th of April 2011.

8. Halton Borough Council (2016) Strategic Housing Land Availability Assessment. http://www3.halton.gov.uk/Pages/planning/policyguidance/pdf/evidencebase/Monitoring%20Documents/Strategic%20Housing%20Land%20Availability%20Assessment%20(SHLAA)%202015.pdf Accessed 12 June 2017

9. http://www3.halton.gov.uk/Pages/planning/policyguidance/local-Plan.aspx

10. http://www4.halton.gov.uk/Pages/planning/policyguidance/pdf/MidMerseySHMA.pdf

11. Department of Health 2008 *Health Inequalities: progress and next steps* The Stationary Office

12.http://www.apho.org.uk/resource/view.aspx?RID=50215&SEARCH=H* Accessed 11 July 2014

13. NICE(2006). *Brief Interventions and referral for smoking cessation in primary care and other settings*. London: National Institute of Health and Clinical Excellence.

14. NICE (2007). *Smoking cessation services, including the use of pharmacotherapies, in primary care, pharmacies, local authorities and workplaces, with particular reference to manual working groups, pregnant women who smoke and hard to reach communities*. London: NICE.

15. Halapy H., MacCallum L. (2006) Perspectives in practice. A pharmacist-run smoking cessation program. *Canadian Journal of Diabetes* 30(4); 406-410.

16. Patwardhan P.D.,Chewning B.A. (2012) Effectiveness of intervention to implement tobacco cessation counseling in community chain pharmacies. *Journal of the American Pharmacists Association: JAPhA*, 52(4); 507-14

17. Carson K.; King C.; Smith B.; To-A-Nan R.; Robertson M. (2015) Community pharmacy personnel interventions for smoking cessation: A cochrane systematic review and meta-analysis *Respirology*; Mar 2015; vol. 20 ; p. 16

18. Condinho M.; Figueiredo I.V.; Fernandez-Llimos F.; Sinogas C. (2015) Cesacion tabaquica en farmacia comunitaria: Resultados preliminares de un programa de atencion farmaceutica Smoking cessation in a community pharmacy: Preliminary results of a pharmaceutical care programme *Vitae*; Aug 2015; vol. 22 (no. 1); p. 42-46

19. Armstrong M. (2007) *Towards a Smoke-free England: Brief interventions for stopping smoking by pharmacists and their staff* London: Pharmacy HealthLink & Department of Health

20. Corelli R.L., Fenlon C.M., Kroon L.A., Prokhorov A.V., Hudmon K.S. (2007) Evaluation of a train-the-trainer program for tobacco cessation. *American Journal of Pharmaceutical Education* 71(6); 109

21. Williams D.M. (2009) Preparing pharmacy students and pharmacists to provide tobacco cessation counselling. *Drug & Alcohol Review* 28(5); 533-40.

22. Sohanpal R; Rivas C; Steed L; MacNeill V; Kuan V et al. Sohanpal R; Rivas C; Steed L; MacNeill V; Kuan V; Edwards E; Griffiths C; Eldridge S; Taylor S; Walton R (2016) Understanding recruitment and retention in the NHS community pharmacy stop smoking service: perceptions of smoking cessation advisers. *BMJ open*; Jul 2016; vol. 6 (no. 7); p. e010921

23. Saba M.; Diep J.; Saini B.; Dhippayom T. (2014) Meta-analysis of the effectiveness of smoking cessation interventions in community pharmacy *Journal of Clinical Pharmacy and Therapeutics*; Jun 2014; vol. 39 (no. 3); p. 240-247

24. Anderson C, Blenkinsopp A. and Armstrong A. (2009) *The contribution of community pharmacy to improving the public's health: Summary report of the literature review 1990–2007* London: Pharmacy HealthLink

25. Saba M.; Diep J.; Saini B.; Dhippayom T. (2014) Meta-analysis of the effectiveness of smoking cessation interventions in community pharmacy *Journal of Clinical Pharmacy and Therapeutics*; Jun 2014; vol. 39 (no. 3); p. 240-247

26. Mortensen K.; Kinnear M.; Muir A (2013) What factors may influence success of Community Pharmacy Stop Smoking Services? *International Journal of Clinical Pharmacy*; Dec 2013; vol. 35 (no. 6); p. 1280-1281

27. Bauld L., Boyd K.A., Briggs A.H., Chesterman J., Ferguson J., Judge K., Hiscock R. (2011) One-year outcomes and a cost-effectiveness analysis for smokers accessing group-based and pharmacy-led cessation services. *Nicotine & Tobacco Research*, 13(2); 135-45

28. Csikar JI; Douglas GV; Pavitt S; Hulme C (2016) The cost-effectiveness of smoking cessation services provided by general dental practice, general medical practice, pharmacy and NHS Stop Smoking Services in the North of England. *Community dentistry and oral epidemiology*; Apr 2016; vol. 44 (no. 2); p. 119-127

29. Costello M.J., Sproule B., Victor J.C.,Leatherdale S.T., Zawertailo L., Selby P. (2011) Effectiveness of pharmacist counseling combined with nicotine replacement therapy: a pragmatic randomized trial with 6,987 smokers. *Cancer Causes & Control*, 22(2); 167-80

30. Brown D., PortlockJ.,PortlockJ.,Rutter P. (2012) Review of services provided by pharmacies that promote healthy living. *International Journal of Clinical Pharmacy*, 34(3); 399-409

31. Brown TJ; Todd A; O'Malley C; Moore HJ; Husband AK et al. Brown TJ; Todd A; O'Malley C; Moore HJ; Husband AK; Bambra C; Kasim A; Sniehotta FF; Steed L; Smith S; Nield L; Summerbell CD (2016) Community pharmacy-delivered interventions for public health priorities: a systematic review of interventions for alcohol reduction, smoking cessation and weight management, including meta-analysis for smoking cessation. *BMJ open*; Feb 2016; vol. 6 (no. 2); p. e009828

32. Rakestraw K.; Lovett A. (2013) A systematic review of community pharmacy-based interventions for smoking cessation *Journal of the American Pharmacists Association*; 2013; vol. 53 (no. 2)

33. http://fingertipsreports.phe.org.uk/health-profiles/2016/e06000006.pdf

34 Halton JSNA (2015) *Lifestyles: Healthy Eating, Physical Activity and Healthy Weight*

35. Anderson C, Blenkinsopp A. and Armstrong A. (2009) *The contribution of community pharmacy to improving the public's health: Summary report of the literature review 1990–2007* London: Pharmacy HealthLink

36. NICE (2006) *Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children*

37. Brown TJ; Todd A; O'Malley C; Moore HJ; Husband AK et al. Brown TJ; Todd A; O'Malley C; Moore HJ; Husband AK; Bambra C; Kasim A; Sniehotta FF; Steed L; Smith S; Nield L; Summerbell CD (2016) Community pharmacy-delivered interventions for public health priorities: a systematic review of interventions for alcohol reduction, smoking cessation and weight management, including meta-analysis for smoking cessation. *BMJ open*; Feb 2016; vol. 6 (no. 2); p. e009828

38. Gordon J; Watson M; Avenell A (2011) Lightening the load? A systematic review of community pharmacy-based weight management interventions. *Obesity reviews : an official journal of the International Association for the Study of Obesity*; 12 (11); p. 897-911

39. Phimarn W; Pianchana P; Limpikanchakovit P; Suranart K; Supapanichsakul S et al. Phimarn W; Pianchana P; Limpikanchakovit P; Suranart K; Supapanichsakul S; Narkgoen A; Saramunee K (2013) Thai community pharmacist involvement in weight management in primary care to improve patient's outcomes. *International journal of clinical pharmacy*; 35 (6); p. 1208-1217

40. Um IS; Armour C; Krass I; Gill T; Chaar BB (2014) Consumer perspectives about weight management services in a community pharmacy setting in NSW, Australia. *Health expectations : an international journal of public participation in health care and health policy*; 17 (4); p. 579-592

41. Fakih, Souhiela; Marriott, Jennifer L; Hussainy, Safeera Y Employing the nominal group technique to explore the views of pharmacists, pharmacy assistants and women on community pharmacy weight management services and educational resources. *The International journal of pharmacy practice*; Apr 2016; vol. 24 (no. 2); p. 86-96

42. Boardman, Helen F; Avery, Anthony J (2014) Effectiveness of a community pharmacy weight management programme. *International journal of clinical pharmacy*; 36 (4); p. 800-806

43. Bush J; Langley C; Mills S; Hindle L (2014) A comparison of the provision of the My Choice Weight Management Programme via general practitioner practices and community pharmacies in the United Kingdom. *Clinical obesity*; 4 (2); p. 91-100

44 Morrison D; McLoone P; Brosnahan N; McCombie L; Smith A; Gordon J (2013) A community pharmacy weight management programme: an evaluation of effectiveness. *BMC public health*; 13 ; p. 282

45. Um IS; Krass I; Armour C; Gill T; Chaar BB (2015) Developing and testing evidence-based weight management in Australian pharmacies: A Healthier Life Program. *International journal of clinical pharmacy*; 37 (5); p. 822-833

46. Brown TJ; Todd A; O'Malley C; Moore HJ; Husband AK et al. Brown TJ; Todd A; O'Malley C; Moore HJ; Husband AK; Bambra C; Kasim A; Sniehotta FF; Steed L; Smith S; Nield L; Summerbell CD (2016) Community pharmacy-delivered interventions for public health priorities: a systematic review of interventions for alcohol reduction, smoking cessation and weight management, including meta-analysis for smoking cessation. *BMJ open*; Feb 2016; vol. 6 (no. 2); p. e009828

47. Fakih S; Marriott JL; Hussainy SY (2014) Exploring weight management recommendations across Australian community pharmacies using case vignettes. *Health education research*; 29 (6); p. 953-965

48. Fakih S; Marriott JL; Hussainy SY (2015) A national mailed survey exploring weight management services across Australian community pharmacies. *Australian journal of primary health*; 21 (2); p. 197-204

49 Newlands RS; Watson MC; Lee AJ (2011) The provision of current and future Healthy Weight Management (HWM) services from community pharmacies: a survey of community pharmacists' attitudes, practice and future possibilities. *The International journal of pharmacy practice*; 19 (2); p. 106-114

50. Um IS; Armour C; Krass I; Gill T; Chaar BB (2013) Weight management in community pharmacy: what do the experts think? *International journal of clinical pharmacy*;35 (3); p. 447-454

51. NICE (2006) *Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children*

[52]. http://www.nice.org.uk/Guidance/PH53/chapter/recommendations#recommendation-9-commission-programmes-that-include-the-core-components-for-effective-weight-loss

[53]. Department of Health (2013) *Developing a specification for lifestyle weight management services. Best practice guidance for tier 2 services*

54. Policy Development Unit (2008) *Community pharmacy and alcohol-misuse services: a review of policy and practice* London: Royal Pharmaceutical Society of Great Britain

55. Watson M.C., Blenkinsopp A. (2009) The feasibility of providing community pharmacy-based services for alcohol misuse: a literature review. *International Journal of Pharmacy Practice* 17(4); 199-205.

56. Gray N.J., Wilson S.E., Cook P.A., Mackridge A.J., Blenkinsopp A., Prescott J., Stokes L.C., Morleo M.J., Heim D., Krska J., Stafford L. (2012) Understanding and optimising an identification/brief advice (IBA) service about alcohol in the community pharmacy setting. Final report. Liverpool PCT .

57. Krska J.; Mackridge A.J. (2014) Involving the public and other stakeholders in development and evaluation of a community pharmacy alcohol screening and brief advice service *Public Health*; Apr 2014; vol. 128 (no. 4); p. 309-316

58. Dhital R., Norman I., Whittlesea C., McCambridge J. (2013) Effectiveness of alcohol brief intervention delivered by community pharmacists: study protocol of a two-arm randomised controlled trial. *BMC Public Health*, 13;152

59. Brown TJ; Todd A; O'Malley C; Moore HJ; Husband AK et al. Brown TJ; Todd A; O'Malley C; Moore HJ; Husband AK; Bambra C; Kasim A; Sniehotta FF; Steed L; Smith S; Nield L; Summerbell CD (2016) Community pharmacy-delivered interventions for public health priorities: a systematic review of interventions for alcohol reduction, smoking cessation and weight management, including meta-analysis for smoking cessation. *BMJ open*; Feb 2016; vol. 6 (no. 2); p. e009828

60. NICE. (2011) *Services for the identification and treatment of hazardous drinking, harmful drinking and alcohol dependence in children, young people and adults. Commissioning Guide. 2011.*

61. Buchan R.; Hughes N.; Urban R.; Turner R. (2014) Can community pharmacy target the male population to provide alcohol intervention and brief advice? *International Journal of Pharmacy Practice*; Oct 2014; vol. 22 ; p. 19-20

62. Brown S; Henderson E; Sullivan C (2014)The feasibility and acceptability of the provision of alcohol screening and brief advice in pharmacies for women accessing emergency contraception: an evaluation study. *BMC public health*; Nov 2014; vol. 14 ; p. 1139

63. Aslani P., Krass I. (2009) Adherence: A review of education, research, practice and policy in Australia *Pharmacy Practice* 7(1); 1-10.

64. Boardman H., Lewis M., Trinder P., Rajaratnam G., Croft P. (2005) Use of community pharmacies: a population-based survey. *Journal of Public Health* 27(3); 254-262.

65. Pilling M. (n/d) *Pharmacy in Action case study: Men's health checks in Knowsley in Merseyside* London: RPSGB

66. Wong I.C.K., Siew S.C., Edmondson H. (2007) Children's over-the-counter medicines pharmacoepidemiological (COPE) study.*International Journal of Pharmacy Practice* 15(1); 17-22.

67. Broekmans S., Dobbels F., Milisen K., Morlion B., Vanderschueren S. (2010) Pharmacologic pain treatment in a multidisciplinary pain center: do patients adhere to the prescription of the physician? *Clinical Journal of Pain* 26(2); 81-86.

68. Gazmararian J., Jacobson K.L., Pan Y., Schmotzer B., Kripalani S. (2010) Effect of a pharmacy-based health literacy intervention and patient characteristics on medication refill adherence in an urban health system. *Annals of Pharmacotherapy* 44(1); 80-7.

69. Scott TL, Gazmararian JA, Williams MV, Baker DW. (2002) Health literacy and preventive health care use among Medicare enrolees in a managed care organization.*Med Care* 40(5); 395-404.

70. Jesson J., Pocock R., Wilson, K. (2005) Reducing medicines waste in the community. *Primary Health Care Research and Development* 6(2); 117-124.

71. Koster ES, Philbert D, Blom L, Bouvy ML (2016) "These patients look lost" – Community pharmacy staff's identification and support of patients with limited health literacy *International Journal of Pharmacy Practice*; 24(6), p403–410

72. NHS England (2014) Better Care Fund – Revised Planning Guidance
http://www.england.nhs.uk/wp-content/uploads/2014/07/bcf-rev-plan-guid.pdf

73. Ponniah A., Anderson B., Shakib S., Doecke C.J., Angley M. (2007) Pharmacists' role in the post-discharge management of patients with heart failure: a literature review.*Journal of Clinical Pharmacy Therapeutics* 32(4); 343-352.

74. Lenaghan E., Holland R., Brooks A. (2007) Home-based medication review in a high risk elderly population in primary care -- the POLYMED randomised controlled trial. *Age & Ageing* 36(3); 292-297.

75. Walker P.C., Bernstein S.J., Jones J.N., Piersma J., Kim H.W., Regal R.E., Kuhn L., Flanders S.A. (2009) Impact of a pharmacist-facilitated hospital discharge program: a quasi-experimental study. *Archives of Internal Medicine* 169(21); 2003-2010.

76. Department of Health (2008) *Pharmacy in England Building on strengths – delivering the future* London: TSO

77. Lewis H. & Ledger-Scott M. (n/d) Pharmacy in Action case Study: Patient hospital discharge services London: RPSGB

78. Hodson K., Blenkinsopp A., Cohen D., Longley M., Alam M.F., Davies P., Hughes L., James D., O'Brein C., Smith M., Turnbull L. (2014) *Evaluation of the Medicines Discharge Review Service* Pontypridd, University of South Wales

79. http://www.pharmaceutical-journal.com/news-and-analysis/news/welsh-dmr-service-to-continue-as-new-initiative-provides-pharmacies-with-access-to-discharge-information/11137901.article

80. Wong I.C.K., Siew S.C., Edmondson H. (2007) Children's over-the-counter medicines pharmacoepidemiological (COPE) study. *International Journal of Pharmacy Practice* 15(1); 17-22.

81. Department of Health (2008) *Pharmacy in England Building on strengths – delivering the future* London: TSO

82. Loader J. (2013) *Community Pharmacy -helping with winter pressures* London: NHS England

83. Parmentier H; Golding S; Ashworth M; Rowlands G (2004) Community pharmacy treatment of minor ailments in refugees *Journal of clinical pharmacy and therapeutics*; 29(5); p. 465-469

84. Rafferty E; Yaghoubi M; Taylor J; Farag M (2017) Costs and savings associated with a pharmacists prescribing for minor ailments program in Saskatchewan. Source Cost effectiveness and resource allocation; 15: p. 3

85. Watson MC; Ferguson J; Barton GR; Maskrey V; Blyth A, Paudya V, Bond CM, Holland R, Porteous T, Sach TH, Wright D, Fielding S (2015) *BMJ open*; 5(2); p. e006261

86. Tucker R, Stewart D (2015) Why people seek advice from community pharmacies about skin conditions *International Journal of Pharmacy Practice*; 23(2): p.150-153

87. Porteous T; Ryan M; Bond C; Watson M; Watson V (2016) Managing Minor Ailments; The Public's Preferences for Attributes of Community Pharmacies. A Discrete Choice Experiment *PloS one*; 11(3); p. e0152257

88. Weitzel KW, Goode JVR (2000). Implementation of a pharmacy based immunisation programme in a supermarket chain. *Journal of the American Pharmaceutical Association* 40: 252–26

89. Davidse W, Perenboom RJ (1995). Increase of degree of vaccination against influenza in at-risk patients by directed primary care invitation. *Ned. TijdschrGeneeskd*139: 2149–52.

90. Hind C, Peterkin G, Downie G, Michie C, Chisholm E. (2004) Successful provision of influenza vaccine from a community pharmacy in Aberdeen. *Pharm J*. 273; 194-6.

91. Machado M., Bajcar J., Guzzo G.C., Einarson T.R. (2007) Sensitivity of patient outcomes to pharmacist interventions. Part II: Systematic review and meta-analysis in hypertension management. *Annals of Pharmacotherapy* 41(11); 1770-81.

92. Fikri-Benbrahim N., Faus M.J., Martinez-Martinez F., Alsina D.G., Sabater-Hernandez D. (2012) Effect of a pharmacist intervention in Spanish community pharmacies on blood pressure control in hypertensive patients. *American Journal of Health-System Pharmacy*, 69(15); 1311-8

93. Amariles P., Sabater-Hernandez D., Garcia-Jimenez E., Rodriguez-Chamorro M.A., Prats-Mas R., Marin-Magan F., Galan-Ceballos J.A., Jimenez-Martin J., Faus M.J. (2012) Effectiveness of Dader Method for pharmaceutical care on control of blood pressure and total cholesterol in outpatients with cardiovascular disease or cardiovascular risk: EMDADER-CV randomized controlled trial. *Journal of Managed Care Pharmacy* 18(4); 311-23

94. Mangum, Stacy A; Kraenow, Kim R; Narducci, Warren A (2003) Identifying at-risk patients through community pharmacy-based hypertension and stroke prevention screening projects. *Journal of the American Pharmaceutical Association*; 43 (1); p. 50-55

95. Pongwecharak, Juraporn; Treeranurat, Tarakamon (2010) Screening for pre-hypertension and elevated cardiovascular risk factors in a Thai community pharmacy. *Pharmacy world & science : PWS*; Jun 2010; 32(3); p. 329-333

96. Bajorek B; Lemay KS; Magin P; Roberts C; Krass I et al. Bajorek B; Lemay KS; Magin P; Roberts C; Krass I; Armour CL (2016) Implementation and evaluation of a pharmacist-led hypertension management service in primary care: outcomes and methodological challenges. *Pharmacy practice*; 14 (2); p. 723

97. Bex SD; Boldt AS; Needham SB; Bolf SM; Walston CM; Ramsey DC; Schmelz AN; Zillich AJ (2011) Effectiveness of a hypertension care management program provided by clinical pharmacists for veterans. *Pharmacotherapy*; 31 (1); p. 31-38

98. Cheema E; Sutcliffe P; Singer DR (2014) The impact of interventions by pharmacists in community pharmacies on control of hypertension: a systematic review and meta-analysis of randomized controlled trials. *British Journal of Clinical Pharmacology*; 78 (6); p. 1238-1247

99. Fikri-Benbrahim N; Faus MJ; Martínez-Martínez F; Sabater-Hernández D (2013) Impact of a community pharmacists' hypertension-care service on medication adherence. The AFenPA study. *Research in social & administrative pharmacy : RSAP*; 2013; 9 (6); p. 797-805

100. Houle SK; Chuck AW; McAlister FA; Tsuyuki RT (2012) Effect of a pharmacist-managed hypertension program on health system costs: an evaluation of the Study of Cardiovascular Risk Intervention by Pharmacists-Hypertension (SCRIP-HTN). *Pharmacotherapy*; 32 (6); p. 527-537

101. Parker CP; Cunningham CL; Carter BL; Vander Weg MW; Richardson KK; Rosenthal GE (2014) A mixed-method approach to evaluate a pharmacist intervention for veterans with hypertension. *Journal of clinical hypertension*; 16 (2); p. 133-140

102. Skowron A; Polak S; Brandys J (2011) The impact of pharmaceutical care on patients with hypertension and their pharmacists. *Pharmacy practice*; 9 (2); p. 110-115

103. Kulchaitanaroaj P; Brooks JM; Chaiyakunapruk N; Goedken AM; Chrischilles EA et al. Kulchaitanaroaj P; Brooks JM; Chaiyakunapruk N; Goedken AM; Chrischilles EA; Carter BL (2017) Cost-utility analysis of physician-pharmacist collaborative intervention for treating hypertension compared with usual care. *Journal of hypertension*; 35 (1); p. 178-187

104. Smith SM; Carris NW; Dietrich E; Gums JG; Uribe L; Coffey CS; Gums TH; Carter BL (2016) Physician-pharmacist collaboration versus usual care for treatment-resistant hypertension. *Journal of the American Society of Hypertension : JASH*; 10 (4); p. 307-317

105. West R; Isom M (2014) Management of patients with hypertension: general practice and community pharmacy working together. *The British journal of general practice : the journal of the Royal College of General Practitioners*; 64 (626); p. 477-478

106. Smith SM; Carris NW; Dietrich E; Gums JG; Uribe L; Coffey CS; Gums TH; Carter BL (2016) Physician-pharmacist collaboration versus usual care for treatment-resistant hypertension. *Journal of the American Society of Hypertension : JASH*; 10 (4); p. 307-317

107. McLean DL; McAlister FA; Johnson JA; King KM; Makowsky MJ; Jones CA; Tsuyuki RT (2008) A randomized trial of the effect of community pharmacist and nurse care on improving blood pressure management in patients with diabetes mellitus: study of cardiovascular risk intervention by pharmacists-hypertension (SCRIP-HTN). *Archives of internal medicine*; 168 (21); p. 2355-2361

108. Kulchaitanaroaj P; Brooks JM; Chaiyakunapruk N; Goedken AM; Chrischilles EA et al. Kulchaitanaroaj P; Brooks JM; Chaiyakunapruk N; Goedken AM; Chrischilles EA; Carter BL (2017) Cost-utility analysis of physician-pharmacist collaborative intervention for treating hypertension compared with usual care. *Journal of hypertension*; 35 (1); p. 178-187

109. Bajorek, Beata V; LeMay, Kate S; Magin, Parker J; Roberts, Christopher; Krass, Ines; Armour, Carol L (2016) Management of hypertension in an Australian community pharmacy setting - patients' beliefs and perspectives. *The International journal of pharmacy practice*; Sep 2016 doi:10.1111/ijpp.12301

110. Noble K; Brown K; Medina M; Alvarez F; Young J; Leadley S; Kim Y; DiCarlo L (2016) Medication adherence and activity patterns underlying uncontrolled hypertension: Assessment and recommendations by practicing pharmacists using digital health care. *Journal of the American Pharmacists Association : JAPhA*; 56 (3); p. 310-315

111. Parker CP; Cunningham CL; Carter BL; Vander Weg MW; Richardson KK; Rosenthal GE (2016) A mixed-method approach to evaluate a pharmacist intervention for veterans with hypertension. *Journal of clinical hypertension (Greenwich, Conn.)*; 16 (2); p. 133-140

112. Bajorek B; Lemay KS; Magin P; Roberts C; Krass I; Armour CL (2016) Implementation and evaluation of a pharmacist-led hypertension management service in primary care: outcomes and methodological challenges. *Pharmacy practice*; 14 (2); p. 723

113. Earl GL; Henstenburg JA (2012) Dietary approaches to hypertension: a call to pharmacists to promote lifestyle changes. *Journal of the American Pharmacists Association : JAPhA*; 52 (5); p. 637-645

114. Yamada C., Johnson J.A., Robertson P., Pearson G., Tsuyuki R.T. (2005) Long-term impact of a community pharmacist intervention on cholesterol levels in patients at high risk for cardiovascular events: extended follow-up of the second study of cardiovascular risk intervention by pharmacists (SCRIP-plus). *Pharmacotherapy* 25(1); 110-5.

115. Armour C.L., Smith L., Krass I. (2008) Community pharmacy, disease state management, and adherence to medication: a review. *Disease Management & Health Outcomes* 16(4); 245-254.

116. Community Pharmacy Medicines Management Project Evaluation Team (2007) The MEDMAN study: a randomized controlled trial of community pharmacy-led medicines management for patients with coronary heart disease. *Family Practice* 24(2) 189-200.

117. Scott A., Tinelli M., Bond C., Community Pharmacy Medicines Management Evaluation Team. (2007) Costs of a community pharmacist-led medicines management service for patients with coronary heart disease in England: healthcare system and patient perspectives. *Pharmacoeconomics*25(5); 397-411.

118. National Institute for Health & Clinical Excellence (2008) *Reducing the rate of premature deaths from cardiovascular disease and other smoking-related diseases: finding and supporting those most at risk and improving access to services'.* London: NICE

119. McNaughton R.J., Oswald N.T., Shucksmith J.S., Heywood P.J., Watson P.S. (2011) Making a success of providing NHS Health Checks in community pharmacies across the Tees Valley: a qualitative study. *BMC Health Services Research*, 11(222); 1472-6963

120. Kassam R., Meneilly G.S. (2007) Role of the pharmacist on a multidisciplinary diabetes team. *Canadian Journal of Diabetes* 31(3); 215-222.

121. Brooks A., Rihani R.S., Derus C.L. (2007) Pharmacist membership in a medical group's diabetes health management program [corrected]. American *Journal of Health-System Pharmacy* 64(6); 617-621. [published erratum appears in AM J HEALTH SYST PHARM 2007;64(8):803]

122. Anaya J.P., Rivera J.O., Lawson K., Garcia J., Luna J. Jr., Ortiz M. (2008) Evaluation of pharmacist-managed diabetes mellitus under a collaborative drug therapy agreement.*American Journal of Health-System Pharmacy* 65(19); 1841-1845.

123. Krass I., Taylor S.J., McInman A.D., Armour C.L. (2006) The pharmacist's role in continuity of care in type 2 diabetes: an evaluation of a model. *Journal of Pharmacy Technology* 22(1); 3-8.

124. Scott D.M., Boyd S.T., Stephan M., Augustine S.C., Reardon T.P. (2006) Outcomes of pharmacist-managed diabetes care services in a community health center. *American Journal of Health-System;* 63(21); 2116-2122.

125. Paulós C.P., Nygren C.E.A., Celedón C., Cárcamo C.A. (2005) Impact of a pharmaceutical care program in a community pharmacy on patients with dyslipidemia.*Annals of Pharmacotherapy* 39(5); 939-943.

126. Planas L.G., Crosby K.M., Farmer K.C., Harrison D.L. (2012) Evaluation of a diabetes management program using selected HEDIS measures.*Journal of the American Pharmacists Association: JAPhA*52(6); 130-8

127. Choe H.M., Mitrovich S., Dubay D., Hayward R.A., Krein S.L., Vijan S. (2005) Proactive case management of high-risk patients with type 2 diabetes mellitus by a clinical pharmacist: a randomized controlled trial. *American Journal of Managed Care* 11(4); 253-260.

128. Mehuys E., Van Bortel L., De Bolle L., Van Tongelen I., Annemans L., Remon J.P., Giri M. (2011) Effectiveness of a community pharmacist intervention in diabetes care: a randomized controlled trial. *Journal of Clinical Pharmacy & Therapeutics* 36(5); 602-13

129. Mitchell B., Armour C., Lee M., Song Y.J., Stewart K., Peterson G., Hughes J., Smith L., Krass I. (2011) Diabetes Medication Assistance Service: the pharmacist's role in supporting patient self-management of type 2 diabetes (T2DM) in Australia. *Patient Education &Counseling*, 83(3); 288-94

130. Ali M., Schifano F., Robinson P., Phillips G., Doherty L., Melnick P., Laming L., Sinclair A., Dhillon S. (2012) Impact of community pharmacy diabetes monitoring and education programme on diabetes management: a randomized controlled study. *Diabetic Medicine,* 29(9); 326-33

131. Dobesh P.P. (2006) Managing hypertension in patients with type 2 diabetes mellitus.*American Journal of Health-System Pharmacy* 63(12); 1140-1149.

132. Hersberger K.E., Botomino A., Mancini M., Bruppacher R. (2006) Sequential screening for diabetes - Evaluation of a campaign in Swiss community pharmacies *Pharmacy World and Science*: 28(3); 171-179.

133. Krass I., Taylor S.J., McInman A.D., Armour C.L. (2006) The pharmacist's role in continuity of care in type 2 diabetes: an evaluation of a model. *Journal of Pharmacy Technology*, 22(1); 3-8.

134. Veg A., Rosenqvist U., Sarkadi A. (2006) Self-management profiles and metabolic outcomes in type 2 Diabetes. *Journal of Advanced Nursing* 56(1); 44-54.

135. Kaczorowski J, Chambers LW, Karwalajtys T, Dolovich L, Farrell B, McDonough B, Sebaldt R, Levitt C, Hogg W, Thabane L, Tu K, Goeree R, Paterson JM, Shubair M, Gierman T, Sullivan S, Carter M. (2008) Cardiovascular Health Awareness Program (CHAP): a community cluster-randomised trial among elderly Canadians. *Preventative Medicine* 46(6); 537-44.

136. Ogunbayo OJ; Schafheutle EI; Cutts C; Noyce PR (2017) How do community pharmacists conceptualise and operationalise self-care support of long-term conditions (LTCs)? An English cross-sectional survey. *The International journal of pharmacy practice*; 25 (2); p. 121-132

137. Ogunbayo O.J.; Schafheutle E.I.; Noyce P.R.; Cutts C. (2015) 'You just forget that the pharmacist is actually there ...': views of people with long-term conditions (LTCs) on using community pharmacy for self-care support International Journal of Pharmacy Practice; 23 ; p. 26

138. Ogunbayo OJ; Schafheutle EI; Cutts C; Noyce PR (2015) A qualitative study exploring community pharmacists' awareness of, and contribution to, self-care support in the management of long-term conditions in the United Kingdom. Research in social & administrative pharmacy : RSAP; 11 (6); p. 859-879

139. Ogunbayo OJ; Schafheutle EI; Cutts C; Noyce PR (2017) Self-care of long-term conditions: patients' perspectives and their (limited) use of community pharmacies. International journal of clinical pharmacy; Apr 39 (2); p. 433-442

140. Department of Health (2008) *Putting Prevention First Vascular Checks: risk assessment and management*

141 Champs (2016) Saving lives: Reducing the pressure
http://www.champspublichealth.com/sites/default/files/FINAL%20BP%20Strategy%2017.5.16_0.pdf

142. Anderson C, Blenkinsopp A, Armstrong M. (2004) *Evidence relating to community pharmacy involvement in health development: A critical review of the literature 1990-2001.*RPSGB /PHLink.

143. Pearce S, Evans A, Phelps C, Matthews M, Hughes G, Lewis I (2016) The case for targeting community pharmacy-led health improvement: Findings from a skin cancer campaign in Wales *International Journal of Pharmacy Practice*; 24 (5); p. 333-340

144. Newman J., Pandya A. and Wood N. (2010) *Promoting Cancer Awareness and Early Detection Within Community Pharmacies Essex Cancer Network and Essex LPC*

145. Yeoh T.T., Si P., Chew L. (2013) The impact of medication therapy management in older oncology patients. *Supportive Care in Cancer*, 21(5); 1287-93

146. Holle, LM (2016) The role of the community pharmacy team in assisting patients receiving oral anticancer medications *Drug Topics*; 160 (9); p. 59-6

147. Butt F, Ream E (2016) Implementing oral chemotherapy services in community pharmacies: a qualitative study of chemotherapy nurses' and pharmacists' views *International Journal of Pharmacy Practice*; 24 (3); p. 149-159

148. Department for Health and cross Government (2013) *A Framework for Sexual Health Improvement in England*

149. Department of Health (2010) *Healthy Lives, Healthy People: our strategy for public health in England*

150. NICE (2014) *Contraceptive services with a focus on young people up to the age of 25* http://publications.nice.org.uk/contraceptive-services-with-a-focus-on-young-people-up-to-the-age-of-25-ph51

151. Anderson C, Blenkinsopp A. and Armstrong A. (2009) *The contribution of community pharmacy to improving the public's health: Summary report of the literature review 1990–2007* London: Pharmacy HealthLink

152. Michie L, Cameron ST, Glasier A, Greed E (2014) Contraceptive use among women presenting to pharmacies for emergency contraception: an opportunity for intervention *Journal of Family Planning and Reproductive Health Care*; 40 (3); p. 190-195

153. Michie, L; Cameron, S T; Glasier, A; Chen, Z E; Milne, D; Wilson, S (2016) Provision of contraception after emergency contraception from the pharmacy: evaluating the acceptability of pharmacy for providing sexual and reproductive health services *Public Health*; 135 ; p. 97-103

154. Heller R, Cameron ST (2016) Evaluating the attractiveness of the availability of injectable progestogen contraceptives at the community pharmacy setting in the United *Kingdom The International journal of pharmacy practice*; 24 (4); p. 247-252

155. Gudka S, Afuwape FE, Wong B, Yow XL, Anderson C, Clifford RM (2013) Chlamydia screening interventions from community pharmacies: a systematic review *Sexual Health*; 10 (3); p. 229-239

156. Gudka S, Bourdin A, Watkins K, Eshghabadi A, Everett A, Clifford RM (2014) Self-reported risk factors for chlamydia: a survey of pharmacy-based emergency contraception *consumers International Journal of Pharmacy Practice*; 22 (1); p. 13-19

157. Michie, L; Cameron, S T; Glasier, A; Larke, N; Muir, A; Lorimer, A (2014) Pharmacy-based interventions for initiating effective contraception following the use of emergency contraception: a pilot study *Contraception*; 90 (4); p. 447-453

158. NICE (2017) *NG68: Sexually transmitted infections: condom distribution schemes*

159. Foresight project (2008) Mental Capital and Wellbeing: Making the most of ourselves in the 21st century

160. http://www.nwph.net/nwpho/publications/northwestmentalwellbeing%20surveysummary.pdf

161. Department of Health (2005) *Choosing Health through pharmacy – a programme for pharmaceutical public health 2005–2015*

162. Pharmaceutical Services Negotiating Committee, National Pharmaceutical Association, Royal Pharmaceutical Society of Great Britain and PharmacyHealthLink (2005) *Public Health: a practical guide for community pharmacists*

163. Engova (2000).Community pharmacists as contributors to care of people with mental health problems *Pharmacy Journal* 265(supplemental): R7.

164. Harris (2001). Compliance, concordance and the revolving door of care: caring for elderly peoplewith mental health problems. *International Journal of Pharmacy Practice* 9(supplemental): R67.

165. Ewan (2001).Evaluation of mental health care interventions made by 3 community pharmacists. *International Journal of Pharmacy Practice* 9; 225.

166. Knox K, Fejzic J, Mey A, L Fowler JL, Kelly F, McConnell D, Hattingh L, Wheeler AJ (2013) Mental health consumer and caregiver perceptions of stigma in Australian community pharmacies *International Journal of Social Psychiatry* ; 60(6), p. 533 - 543

167 Pawluk SA and Zolezzi M (2017) Healthcare professionals' perspectives on a mental health educational campaign for the public *Health Education Journal* Online First 24 March 2017

168. Murphy A, Szumilas M, Rowe D, Landry K, Martin-Misener R, Kutcher S, Gardner D (2014) Pharmacy students' experiences in provision of community pharmacy mental health services *Canadian Pharmacists Journal / Revue des Pharmaciens du Canada*; 147(1): p. 55-65

169. Scahill S, Fowler JL, Hattingh HL, Kelly F, Wheeler AJ (2015) Mapping the terrain: A conceptual schema for a mental health medication support service in community pharmacy *SAGE Open Medicine*, vol. 3, First Published September 30, 2015.

170. NICE (2014) *Needle and syringe programmes: providing people who inject drugs with injecting equipment*

171. Anderson C, Blenkinsopp A. and Armstrong A. (2009) *The contribution of community pharmacy to improving the public's health: Summary report of the literature review 1990–2007* London: Pharmacy HealthLink

172. NICE (2007) *Methadone and buprenorphine for the management of opioid dependence* London: NICE

173. Department of Health 2001, *National Service Framework for Older People*.

174. Evans M.R. et al (2007) A qualitative study of lay beliefs about influenza immunisation in older people *British Journal of General Practice* 57; 352–358.

175. Telford R. & Rogers A. (2003) What influences elderly peoples' decisions about whether to accept the influenza vaccination? A qualitative study *Health Education Research* 18(6); 743-753

176. Mangtani P. et al (2006) Cross-sectional survey of older peoples' views related to influenza vaccine uptake *BMC Public Health* 6; 249.

177. Wood, K., Gibson, F., Radley, A. and Williams, B. (2015), Pharmaceutical care of older people: what do older people want from community pharmacy?. *International Journal of Pharmacy Practice*; 23: 121–130

178. Philbert, D., Notenboom, K., Bouvy, M. L. and van Geffen, E. C.G. (2014), Problems experienced by older people when opening medicine packaging. *International Journal of Pharmacy Practice*, 22: 200–204

179. Smith, F., Grijseels, M. S., Ryan, P. and Tobiansky, R. (2015), Assisting people with dementia with their medicines: experiences of family carers. *International Journal of Pharmacy Practice*, 23: 44–51

180. MacLaughlin EJ, MacLaughlin AA, Snella KA, Winston TS, Fike DS, Raehl CR. (2005) Osteoporosis Screening and Education in Community Pharmacies Using a Team Approach. *Pharmacotherapy* 25(3); 379–3

181. MacLaughlin EJ, MacLaughlin AA, Snella KA, Winston TS, Fike DS, Raehl CR. (2005) Osteoporosis Screening and Education in Community Pharmacies Using a Team Approach. *Pharmacotherapy* 25(3); 379–386.

182. Naunton M, Peterson GM, Jones G. (2006) Pharmacist-provided quantitative heel ultrasound screening for rural women at risk of osteoporosis. *Annals of Pharmacotherarapy*40(1):38-44

183. Summers KM, Brock TP. (2005) Impact of Pharmacist-Led Community Bone Mineral Density Screenings. *Annals of Pharmacotherapy* 39; 243-8.

184. Moultry A.M., Poon I.O. (2008) Perceived value of a home-based medication therapy management program for the elderly. *Consultant Pharmacist* 23(11); 877-85.

185. Lenaghan E., Holland R., Brooks A. (2007) Home-based medication review in a high risk elderly population in primary care -- the POLYMED randomised controlled trial. *Age & Ageing* 36(3); 292-297

186. NICE (2014) *Managing medicines in care homes* https://www.nice.org.uk/Guidance/sc1

187 Annual Report of the Chief Medical Officer, 2011' (2013) *Volume Two, 2011 Infections and the rise of antimicrobial resistance*

188 Annual Report of the Chief Medical Officer, 2011' (2013) *Volume Two, 2011 Infections and the rise of antimicrobial resistance*

189 Department of Health (2013) *UK Five Year Antimicrobial Resistance Strategy 2013 to 2018*

190. Department of Health and Department for Environment, Food and Rural Affairs (Defra) (2013) *UK Five Year Antimicrobial Resistance Strategy 2013 to 2018* London: Department of Health

191. Champs (2014) *Cheshire and Merseyside Antimicrobial Resistance Strategy and Action Plan*

192. Goff DA; Kullar R; Goldstein EJ; Gilchrist M; Nathwani D; Cheng AC; Cairns KA; Escandón-Vargas K; Villegas MV; Brink A; van den Bergh D; Mendelson M (2017) A global call from five countries to collaborate in antibiotic stewardship: united we succeed, divided we might fail *The Lancet. Infectious diseases*; 17 (2); p. e56-e63

193. Roque F; Teixeira-Rodrigues A; Breitenfeld L; Piñeiro-Lamas M; Figueiras A; Herdeiro MT (2016) Decreasing antibiotic use through a joint intervention targeting physicians and pharmacists *Future microbiology*; Jul 2016; vol. 11 ; p. 877-88

194. Abu Taha A; Abu-Zaydeh AH; Ardah RA; Al-Jabi SW; Sweileh WM; Awang R; Zyoud SH (2016) Public Knowledge and Attitudes Regarding the Use of Antibiotics and Resistance: Findings from a Cross-Sectional Study Among Palestinian Adults *Zoonoses and public health*; 63 (6); p. 449-457

195. Res R; Hoti K; Charrois TL (2016) Pharmacists' Perceptions Regarding Optimization of Antibiotic Prescribing in the Community *Journal of pharmacy practice*; Jan 2016

196. Moienzadeh A; Massoud T; Black E (2017) Evaluation of the general public's knowledge, views and practices relating to appropriate antibiotic use in Qatar *The International journal of pharmacy practice*; 25 (2); p. 133-139

197. Fredericks I; Hollingworth S; Pudmenzky A; Rossato L; Syed S; Kairuz T (2015) Consumer knowledge and perceptions about antibiotics and upper respiratory tract infections in a community pharmacy *International journal of clinical pharmacy*; 37 (6); p. 1213-1221

198. McNulty CA; Francis NA (2010) Optimizing antibiotic prescribing in primary care settings in the UK: findings of a BSAC multi-disciplinary workshop 2009.*The Journal of antimicrobial chemotherapy*; 65 (11); p. 2278-2284

199. Black E; Cartwright A; Bakharaiba S; Al-Mekaty E; Alsahan D (2014) A qualitative study of pharmacists' perceptions of, and recommendations for improvement of antibiotic use in Qatar *International journal of clinical pharmacy*; 36 (4); p. 787-794

200. Fernandes M; Leite A; Basto M; Nobre MA; Vieira N; Fernandes R; Nogueira P; Nicola PJ; Jorge P (2014) Non-adherence to antibiotic therapy in patients visiting community pharmacies *International journal of clinical pharmacy*; 36 (1); p. 86-91

201. Black E; Cartwright A; Bakharaiba S; Al-Mekaty E; Alsahan D (2014) A qualitative study of pharmacists' perceptions of, and recommendations for improvement of antibiotic use in Qatar *International journal of clinical pharmacy*; 36 (4); p. 787-794

202. Ghiga I; Stålsby Lundborg C (2016) 'Struggling to be a defender of health' -a qualitative study on the pharmacists' perceptions of their role in antibiotic consumption and antibiotic resistance in Romania *Journal of pharmaceutical policy and practice*; 2016; vol. 9 ; p. 10

203. Department of Health (2008) *End of Life Care Strategy - promoting high quality care for all adults at the end of life*

204. Higginson, I. J., Astin, P., & Dolan, S. (1998) Where do cancer patients die? Ten-year trends in the place of death of cancer patients in England *Palliative Medicine* 12(5); 353-363

205. Higginson, I. J., Jarman, B., Astin, P., & Dolan, S. (1999) Do social factors affect where patients die: an analysis of 10 years of cancer deaths in England *Journal of Public Health Medicine* 21(1); 22-28.

206. Gomes, B. & Higginson, I. J. 2006, "Factors influencing death at home in terminally ill patients with cancer: systematic review", *British Medical Journal* 332(7540); 515-521.

207. NICE (2004) *Improving Supportive and Palliative Care for Adults with Cancer*

208. Hill R.R. (2007) Clinical pharmacy services in a home-based palliative care program. *American Journal of Health System Pharmacy* 64(8); 806-810.

209. Tait PA; Gray J; Hakendorf P; Morris B; Currow DC Rowett DS (2013) Community pharmacists: a forgotten resource for palliative care. *BMJ supportive & palliative care*; 3 (4); p. 436-443

210. Savage, I., Blenkinsopp, A., Closs, S. J. and Bennett, M. I. (2013), 'Like doing a jigsaw with half the parts missing': community pharmacists and the management of cancer pain in the community. *International Journal of Pharmacy Practice*, 21: 151–160

211. O'Connor M; Hewitt LY; Tuffin PH (2013) Community pharmacists' attitudes toward palliative care: an Australian nationwide survey. *Journal of palliative medicine*; 16 (12); p. 1575-1581

212.. http://psnc.org.uk/services-commissioning/locally-commissioned-services/healthy-living-pharmacies/

213. HLP Pathfinder Work Programme Report Executive Summary April 2013
http://psnc.org.uk/wp-content/uploads/2013/08/HLP-evaluation.pdf

214.. http://www.instituteofhealthequity.org/projects/evaluation-of-the-healthy-living-pharmacy-pathfinder-work-programme-2011-2012

215. Evaluation of the Tees healthy living pharmacy project
https://www.npa.co.uk/Documents/HLP/Healthy-Living-Pharmacy-Evaluation-Tees.pdf

216. NPA Health Living Pharmacies
http://www.npa.co.uk/Business-Management/Service-Development-Opportunities/Healthy-Living-Pharmacy/

REPORT TO:	Health Policy & Performance Board
DATE:	17th January, 2018
REPORTING OFFICER:	Strategic Director, People
PORTFOLIO:	Health & Wellbeing
SUBJECT:	Halton Safeguarding Adults Board Annual Report 2016-2017
WARD(S)	Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To present to the Board, the Halton Safeguarding Adults Board (HSAB) Annual Report 2016-2017.

2.0 **RECOMMENDATION: That the Board note the contents of the report and associated appendix.**

3.0 **SUPPORTING INFORMATION**

3.1 This report fulfils one of Safeguarding Adults Boards three core statutory duties:

1. Develop and publish a strategic plan setting out how they will meet their objectives and how their member and partner agencies will contribute;
2. Publish an annual report detailing how effective their work has been; and
3. Commission safeguarding adults reviews (SARs) for any cases which meet the criteria for these.

3.2 The Annual Report (attached at ***Appendix A***) covers the period from 1st April 2016-31st March 2017.

3.3 All members of HSAB, HSAB sub-group chairs and the Safeguarding Adults Partnership Forum members were invited to submit an annual summary of their work activity. The focus of work activity addresses HSAB's priorities as identified from 2015-2016 Annual Report, Performance Framework and Strategic Plan (2016-2018) in addition to acknowledging local and national safeguarding adults emerging issues/trends/policies throughout the year.

3.4 The report provides a summary analysis of the data gathered from both CCG and HBC Safeguarding Adults Collection and highlights what this information tells us for informing the work priorities for 2017-2018.

There top three forms of abuse, neglect and acts of omission, physical and financial abuse remain consistent with previous years with slight variation in prevalence. Females continue to experience a higher percentage of abuse than males.

The data found adults at most risk of harm are older adults (75 years plus), who live in their own home and are most at risk of neglect or acts of omission.

4.0 **POLICY IMPLICATIONS**

4.1 There are no policy implications 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**
None identified.

6.4 **A Safer Halton**
The Annual Report contributes to the work of HBC's Safer Halton priority.

The overarching purpose of a Safeguarding Adults Board is to help and safeguard adults with care and support needs. The Annual report is a public document that enables the work of the SAB and it's member organisations to be scrutinised to help achieve a safer Halton.

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.

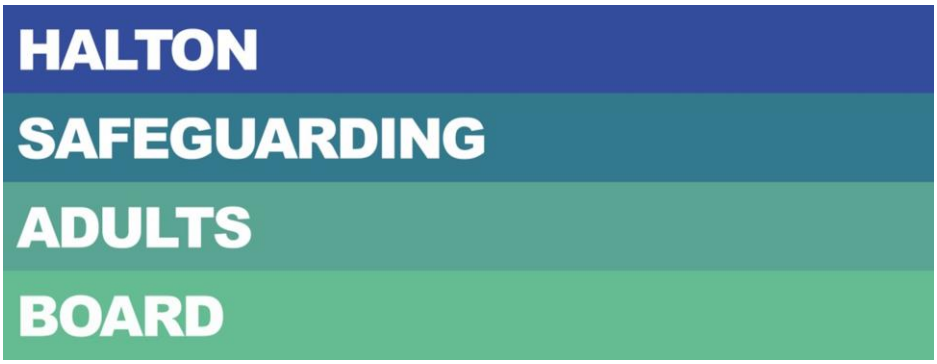
9.0 **LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972**

9.1 None under the meaning of the Act.

HALTON
SAFEGUARDING
ADULTS
BOARD

Halton Safeguarding Adults Board

Annual Report 2016-17



HALTON
SAFEGUARDING
ADULTS
BOARD

ANNUAL REPORT CONTENTS PAGE

HALTON
SAFEGUARDING
ADULTS
BOARD

FOREWORD

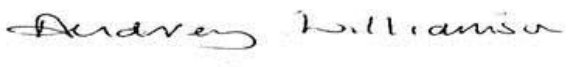
I am pleased to present Halton Safeguarding Adult Board's Annual Report April 2016 to March 2017. This report provides a picture of how agencies and organisations safeguard adults who may be at risk of harm in Halton. It describes the work of the partnership responsible for safeguarding, identifies those areas of work we need to strengthen and how we plan to do this. I hope you find it informative.

During the period this report covers we have worked hard to ensure that safeguarding remains a priority for all key agencies in Halton. The Safeguarding Adults Board is responsible for ensuring all partners and agencies fulfil their responsibilities in working together both to prevent adults being potentially placed at risk of abuse and to work closely and effectively when adults are seen to be vulnerable and abuse may have taken place. The Board is now stronger with good representation at senior level from the three key agencies responsible for safeguarding services; Cheshire Police, Halton Clinical Commissioning Group and Halton Borough Local Authority. The Board is supported by a range of working groups but particularly the Partnership Forum made up of the voluntary and faith sector. The Partnership Forum has been critical in developing our Preventive Strategy and we know that the Forum will work hard this year to ensure its success; not least in raising awareness in our communities of the need to be aware of what to do if abuse in whatever form is suspected.

There have been some positive developments this year; for example, the establishment of a panel led by the local police on supporting those who self-neglect in the community. This is a complex area of work but one that we are beginning to understand better. It will remain an area of focus for the coming year. Work on identifying financial scams has been strong and we know we all have a responsibility to prevent these taking place.

There is still much to do in Halton but I am confident that with the support of all partners, we can continue to improve and meet the needs of those adults who may be at risk or vulnerable in our locality. Through our work we have identified priorities for the coming year including mental health.

Finally, I would like to thank all Board members for their support this year. I would also like to thank both our administrator and our new Board Manager who joined us early this year and who has made a real difference to our work. Finally on behalf of the Board I would like to thank all those who work on a daily basis in what can be a complex and challenging arena.



Audrey Williamson – Independent Chair

HALTON
SAFEGUARDING
ADULTS
BOARD

EXECUTIVE SUMMARY

Halton Safeguarding Adults Board (HSAB) has undergone some changes during 2016-2017, strengthening HSAB and sub-groups, and establishing Halton Safeguarding Adults Partnership Forum. The work of these sub groups are fundamental to helping HSAB achieve it's strategic aims:

- Strengthening the Board
- Early Intervention and Prevention
- Awareness Raising and Engagement with the Community
- Performance and Quality Assurance of Providers and Services
- Making Safeguarding Personal – listen to and do when adults tell us about their experiences of abuse and neglect, and the services and support they receive

A business plan was produced which set out objectives for achieving these aims and this report will give a snapshot of some of this work. The Safeguarding Adults Board through the restructure and defined terms of reference for the sub groups has helped to strengthen the HSAB. There has been a strong focus on developing safeguarding prevention, with an update of the Safeguarding Adult Review Policy in line with the Care Act 2014. The Care Act 2014 also makes explicit a model of Coproduction for local Safeguarding Adults Board, and the establishment of the Safeguarding Adults Partnership Forum now provides more opportunity for this coproduction approach with more effective links with the wider community for the ongoing development of HSAB. The membership of this forum consists of safeguarding leads from a vast range of local services working with adults aiding greater awareness and improved engagement with the community of Halton. Assurance was received via a number of mechanisms, for example:

- Quarterly reporting from HSAB sub-groups to the board
- Monthly case file audits reported to HSAB to help with identifying themes trends and opportunities for improvement.
- Making Safeguarding Personal is a requirement locally for all adult safeguarding initial assessments. This information is recorded and then collected by Halton Borough Local Authority Performance Team.

In addition HSAB arranged a Safeguarding Adult Review to be conducted, which resulted in a number of key agencies coming together with an idependant chair/author. An action plan from the SAR follows and HSAB will ensure these actions are completed and reported in next year's annual report.

HALTON
SAFEGUARDING
ADULTS
BOARD

SECTION 3: INTRODUCTION

As stated in the Care Act 2014 (chapter 14), the main objective of a Safeguarding Adult Board is to assure itself that local safeguarding arrangements and partners act to help and protect adults in it's area who meet the criteria set out; ie. the safeguarding duties apply to an adult who:

- Has needs for care and support (whether or not the local authority is meeting any of those needs)
- Is experiencing, or at risk of, abuse or neglect
- As a result of those care and support needs is unable to protect themselves from either the risk of, or experience of abuse or neglect.

The Care Act states that Safeguarding Adults Boards have three core duties:

- Develop and publish a Strategic Plan setting out how they will meet their objectives and how member and partner agencies will contribute
- Publish an Annual Report detailing how effective their work has been
- Commission Safeguarding Adults Reviews for any cases which meet the criteria

The current membership of the Board includes representatives from each of the following:

Halton Borough Local Authority

NHS Halton Clinical Commissioning Group

Cheshire Constabulary

Cheshire Fire and Rescue

North West Ambulance Service

National Probation Services

Healthwatch

Elected member responsible for adult health and social care

SECTION 4: FINANCIAL SUMMARY

Halton Safeguarding Adults Board is resourced by three key agencies, Halton Borough Local Authority Halton Clinical Commisiong Group and Cheshire Police. Income and expenditure is set out in appendix 1. During this financial year HSAB recruited a Safeguarding Adults Board Officer, who came in to post January 2017.

SECTION 5: PERFORMANCE

Summary

The population of Halton is just under 127,000 with approx 54,000 households and an adult population of approx 97,400. Halton has an increasingly ageing population with a projected 27% increase of adults aged 65+ by 2024. In comparison to national and North-West regional figures Halton has a higher reported rate of safeguarding concerns and concerns leading to a Section 42 Enquiry. Halton reflects the national trend of distribution rates for safeguarding alerts per adult age group.

The most prevalent type of alleged abuse in Halton for 2016/2017 is neglect and acts of omission, then physical abuse followed by financial/material abuse. In 2015/2016 physical abuse was the most prevelant form of abuse in adults followed by neglect and acts of omission and financial abuse.

The alleged abuse is most likely to occur in the person's own home and perpetrated by someone who is known to the individual, for example, a care worker or family member. There has a been a decrease in the percentage of female to male reports of abuse. This year has also seen an increase in the number of completed enquiries in response to a concern of abuse or neglect. Additionally there has been a marked increase in the number of Deprivation of Liberty Safeguards (DoLS), there follows an overview of this years data and the key findings within the ody of the annual report.

Safeguarding Adults Collection

The Safeguarding Adults Collection (SAC) is a mandatory performance return to be completed for the Health and Social Care Information Centre, to provide statistics from local authorities across the

country regarding their safeguarding adult activity during the period 1st April 2016 to 31st March 2017.

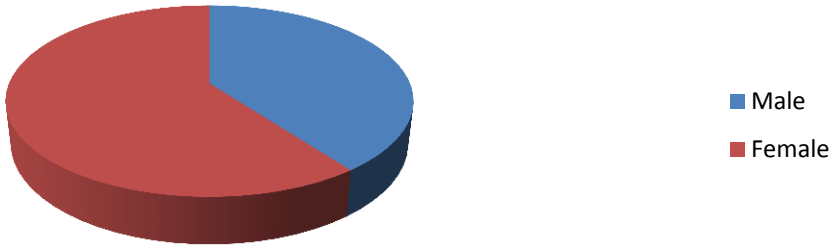
The statutory Safeguarding Adults Collection (SAC) records details of safeguarding activity for adults aged 18 and over in England. It is reported to and identified by Local Authoritys with adult social services responsibilities. The collection includes demographic information about the adults at risk and details of the incidents that have been alleged. It is helpful to note that the following data relates only to those adults who have been identified as at risk of harm. Whilst this is extremely important, these alerts account for a small number of the adult population in Halton. The current percentage of adults involved in a safeguarding concern locally (approx numbers, based on current available information 2016 Halton population profile) which are:

- 0.3% at 18-64 years,
- 0.6% between age 65-74 years,
- 2.4% from 75-84 years and
- 8% from the age of 85 years plus This information, in combination with a range of intelligence gathering locally, helps to inform the work of HSAB and of the local service provision. It enables targetted work, increases appropriate commissioning, training and awareness campaigns, and specific pieces of work that addresses those most at risk of harm within our community.

Key Findings:

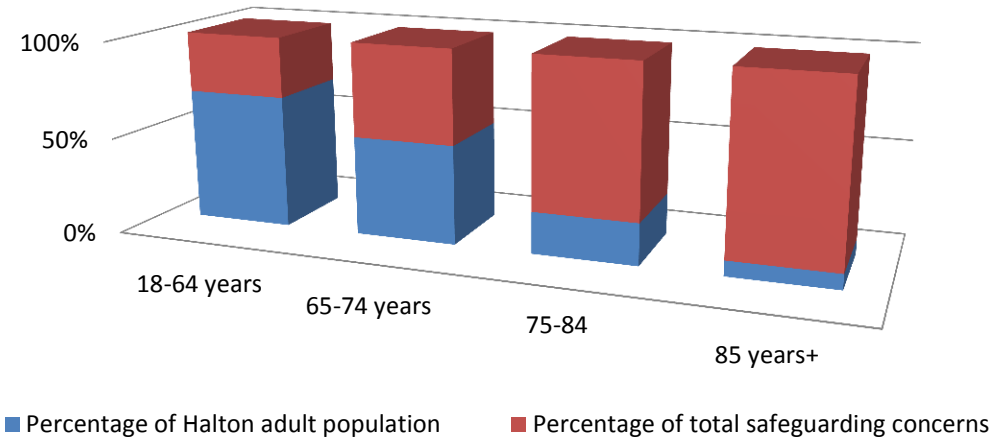
In 2016/17 the data shows reports of concerns then leading to a section 42 have reduced. There has been an increase in concerns received for males from 35% 2015/16 to 40% 2016/17 and a reduction for females from 2015/16 of 65% to 60% this reporting year. The performance data indicates that neglect and acts of omission was the highest reported type of abuse and the most common location where abuse/neglect takes place is in the person's own home. It is further highlighted when reviewing rates per age group it is evident that as we grow older there is increasing risk of safeguarding issues arising. Adults at most risk of harm are older adults (75 years plus), who live in their own home and are most at risk of neglect or acts of omission.

Distribution of male/females in safeguarding concerns



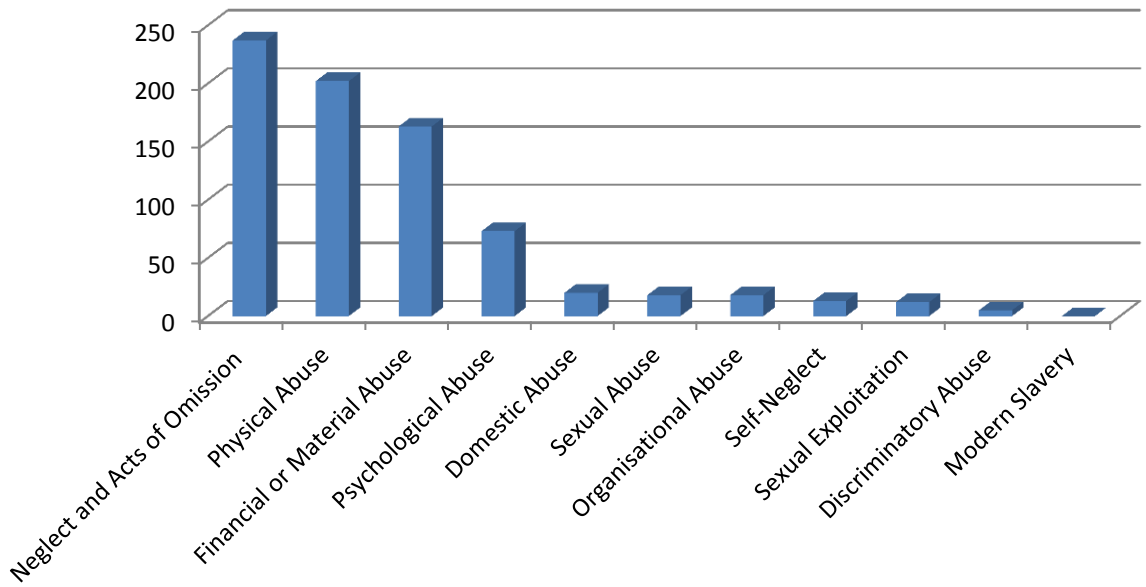
There has been an increase in completed enquiries in response to a concern of abuse or neglect that may have taken place. An enquiry could entail a conversation with the adult to a more formal multi-agency plan or action. 2015/16 recorded 611 completed cases rising to 694 completed cases during 2016/17.

Prevalance of safeguarding concerns per adult population group



The prevalance of safeguarding concerns per age group can be identified as increasing risk for the older population. That as people get older the risk continues to rise with over half the alerts relating to adults aged 75 years and older.

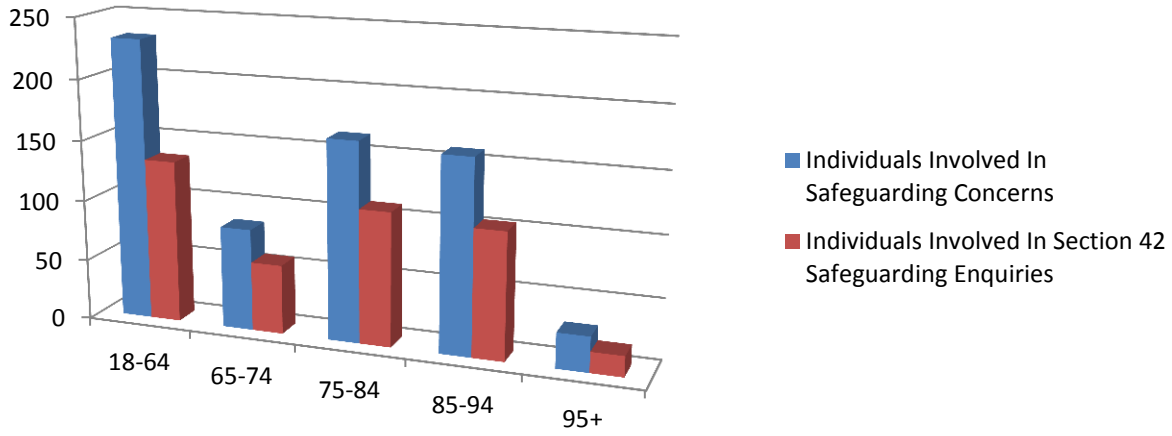
Total Section 42



Counts of enquiries by type and source of risk indicate the top three most prevalent types of abuse remain the same as 2015/2016 i.e. neglect and acts of omission, physical and financial/ material.

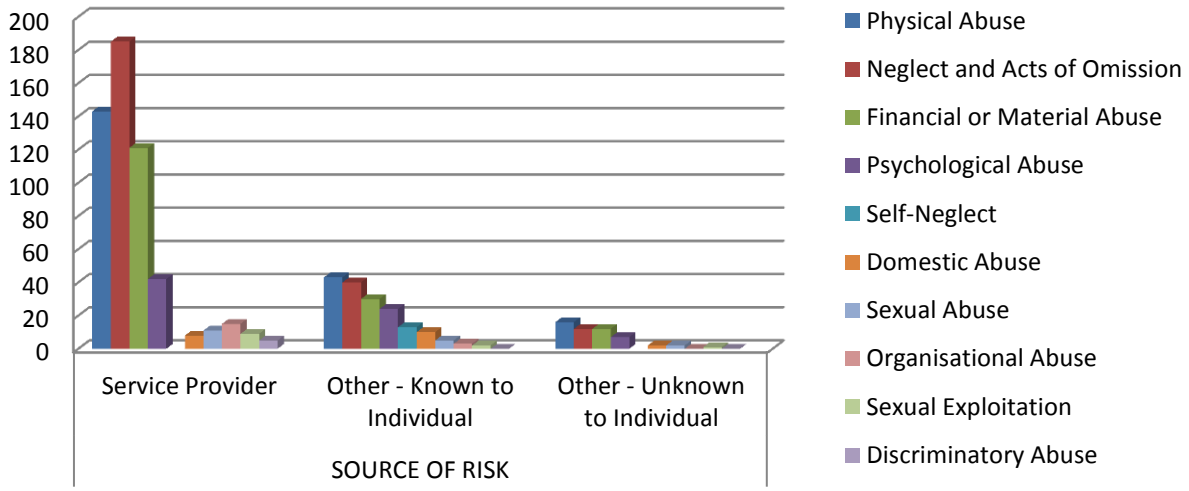
There are differences in the rate of types of abuse being reported during 2016/17 compared to 2015/16; for example, rates of physical and sexual abuse have declined and neglect and acts of omission, financial/material and discrimination increased.

Safeguarding concerns leading to Section 42 enquiry



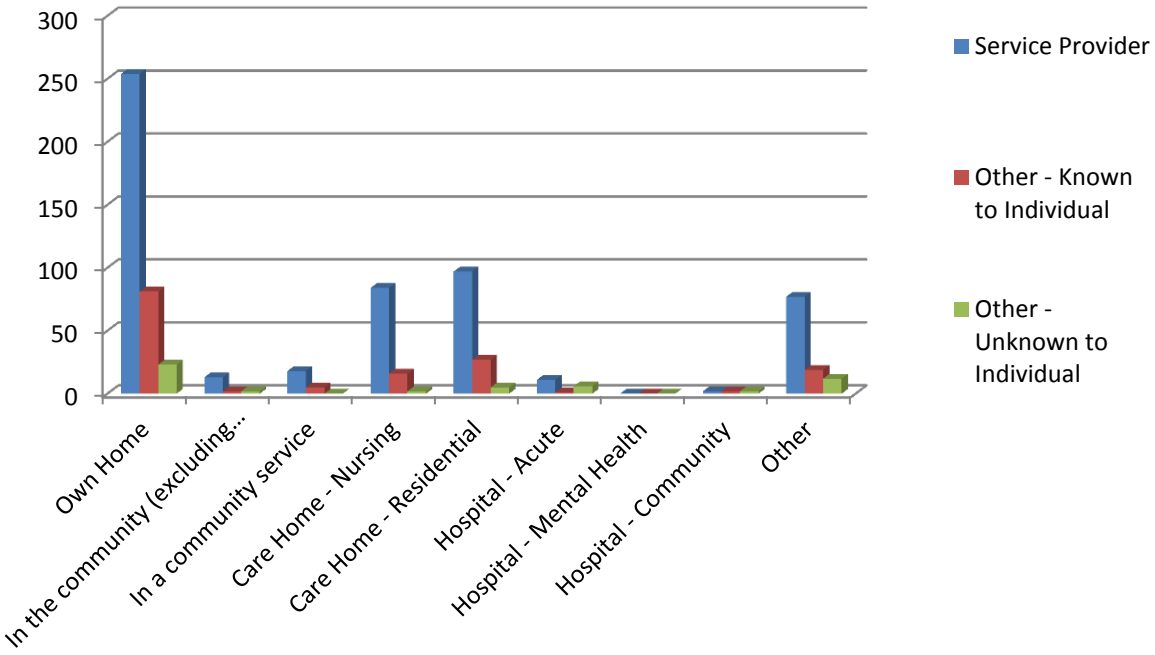
Rates at which safeguarding concerns are raised and then lead to a Section 42 enquiry reveal differences from a safeguarding alert to a Section 42 enquiry. As adults get older the alerts appear to become more aligned with Section 42 safeguarding enquiries. There is a need for more awareness-raising of what a care concern is and what a safeguarding issue is for service providers, staff and the general public.

Counts of enquiries by type and source of risk



In reviewing the types and source of risk it is evident that the predominant source for neglect and acts of omission, physical and financial/material abuse are from service providers. There are also a number of safeguarding enquiries from individuals known to the adult at risk, again, physical abuse then neglect and acts of omission are the highest types reported followed by financial/material and psychological abuse. In order to understand further what is known about the service provider data is captured for the location of risk.

Counts of enquiry by location and source of risk



Most safeguarding risks occur in the person's own home, accounting for almost half of all reported concerns (47.66%) in 2016/2017, this has reduced from 49% in 2015/2016. Combined with information on source of risk it appears that home care services are most likely to be those with care concerns. With regard to safeguarding concerns, medicines management is highlighted within the area of neglect and acts of omission as an area for future targeted work.

Hate crime

Halton's hate crime figures are provided by Cheshire Police covering the period 1st April 2016 to 31st March 2017. The highest prevalence types were racist (82) and homophobic (32) crimes, with racist crimes being significantly higher than all other types of hate crime recorded.

Key Findings:

Hate Crime Type	2016									2017			Total by Hate Crime Type
	April	May	June	July	August	September	October	November	December	January	February	March	
Disability		1		1	1	2	1			1	2		9
Hist - Religious		1	1				1						3
Homophobic	1	5	1	2	1	5	3	4	2	1	5	2	32
Racist	4	6	7	8	13	10	5	4	4	4	9	8	82
Religion or belief - Anti Jewish											1		1
Not yet Categorised								1					1
Total by Month	5	13	9	11	15	17	10	9	6	6	17	10	128

It is not currently known whether these individuals are adults who have been identified as at risk of harm under the Care Act guidance, (see Introduction section page 5). There is therefore potential to elicit this information in future data reporting to help inform HSAB and to enable targeted work to protect further those adults who are already identified as at risk of harm and who may become a victim of hate crime.

Deprivation of Liberty Safeguards (DoLS)

The DoLS are 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. If necessary, restrictions are only applied in a safe and correct way that is only done when it is in the best interests of the person, and there is no other way to provide appropriate care. This is achieved by a series of assessments, which are undertaken by a minimum of two professionals not previously involved in making decisions about the persons care.

The legislation only covers individuals who are in hospitals or care homes and can only be authorised when it is assessed to be in the best interests of the individual concerned, to protect them from harm. Where a deprivation of liberty is required in a person's own home or in supported living, an application is made to the Court of Protection. Under the legislation, Local Authoritys (Supervisory Bodies) have statutory responsibility for operating and overseeing the MCA DoLS, whilst hospitals and care homes (Managing Authorities) have responsibility for applying to the relevant Supervisory Body for a DoLS authorisation.

In response to the pressure on services, the government tasked the Law Commission with devising a replacement for the DoLS, and a series of Consultation events took place between July and November 2015. An interim statement regarding proposals was issued in May 2016, with the complete report expected for August 2016. This was then deferred to December 2016, and again deferred until March 2017 due to the complexity of the issues encountered.

On the 13th of March 2017 the final report and recommendations were released and can be found using the following link; http://www.lawcom.gov.uk/project/mental-capacity-and-deprivation-of-liberty/

Number of DoLS in Halton 2015/16 and 2016/17

Period	2015/16	2016/17
Q1	84	109
Q2	131	164
Q3	80	159
Q4	115	189
Total	410	621

Key Findings:

In response to the pressure on services, the government has tasked the Law Commission with devising a replacement for the DoLS and recommendations will be made. However, until recommendations are made the responsibilities and risks of managing DoLS remain with the Local Authority. The timeframe for the Government to consider the recommendations set by the law commission is not clear at present, but an estimate of 4-5 years have been given by some academics.

Halton Local Authority currently have 18 (including 2 dedicated practitioners based within IASU) registered Best Interest Assessors (BIA)Local Authority. The role of BIA is incorporated into the role of existing Social Work staff. There are issues with capacity in meeting the demands of the increase in requests for DoLS from 401 (2015/16) to 621 (2016/17). This has resulted in a backlog in requests for assessments which currently stands at over 100. The majority of which are classed as breeches as they have not been assessed within the required timescales of 21 days from the request for assessment. The IASU triage the requests the Local Authority receives on a daily basis, using the ADASS Screening Tool for DoLS, which aims to prioritise high risk cases for urgent allocation.

The data evidences a significant increase, in the number of DoLS applications received in light of the 2014 Supreme Court Judgement, which redefined the eligibility criteria for assessment, known as "The Acid Test". We expect the figures to rise, due to an increase in awareness of DoLS by provider services, as this is an area of focus for the regulation of their service. As requests continue to authorised, the requests for renewal of Authorisations will continue to increase. In addition to this, the demand placed on the Local Authority's arrangements for Paid Relevant Person's Representative's will continue to grow. If the 'acid test' remains the criteria given to determine if someone is being deprived of their Liberty, the demand placed upon Local Authorities will remain.

Challenges ahead for the Local Authority

- Meeting the demand of requests made for Standard Authorisation including the Local Authority's arrangements for Best Interests Assessors and Mental Health Assessors, addressing back log of assessments and reviewing arrangements to address backlog assessments
- Ensuring Paid Relevant Person's Representative arrangements are robust and Quality Assured
- Ensuring stakeholders are fully aware of their responsibilities, ensuring systems that are in place evidencing defensible application of the DoLS Code of Practice.

SECTION 6: JULIE'S STORY

Making Safeguarding Personal is an important focus for HSAB in that it enables the individuals story to be recognised and listened to. Julie's story highlights the most prevalent aspects of adult abuse that occur in Halton ie., an older person living at home and experiencing financial abuse.

The true identity of the adult at risk has been anonymised and will be called Julie, for the purpose of this case scenario. Julie has consented to her story being told.

Julie

Julie is an 84 year old woman who lived in her own home, who had recently been assessed as requiring care, meeting the eligibility criteria for services under the Care Act 2014, Section 9. Julie had chosen to have her care and support needs met by having a personal budget, hiring a Personal Assistant to meet her needs. Julie was the employee and had support from social care to facilitate this arrangement.

Referral

The Integrated Adults Safeguarding Unit (IASU) at Halton Borough Local Authority received a referral from Julie's Personal Assistant (PA), following some concerns raised. After gaining consent from the adult at risk, a Safeguarding Social Worker was assigned conduct further enquiries in line with Section 42 of the Care Act 2014.

The Social Worker met with the adult at risk and with the support of Julie's PA, who had identified that thousands of pounds had gone from their bank account. The account was in Julie's name and had an informal agreement with a family member to manage their finances. The family member was meant to provide Julie with an allowance each week; however they had not received any cash for several weeks. This meant that Julie may have been financially abused. Julie had also not received any bank statements to their home address. With the support of the Julie's PA, a visit to the bank revealed the detail, which established that the money had in fact been transferred to the family member's personal bank account.

Requested outcomes

Julie requested that the police were contacted for support as she wanted to either have control over her own finances or an appointee from the Local Authority.
Julie also expressed that she would like the family member's name to be taken off their bank account.

Actions

With the support of the Safeguarding Social Worker and the PA, Julie requested that the Police were contacted as she did not want the person to carry on having access to her funds and was concerned that her funds would leave her penniless and unable to pay her direct debits.
The Police were contacted and a strategy discussion held. The police advised that despite the concerns raised, there was nothing that they would be able to do as the Adult had agreed for the family member to have access to their bank accounts and funds. It was regarded as a civil rather than criminal matter. Julie's desired outcome needed to be reviewed in light of the Police's decision.
We then agreed to visit the Julie's bank and arranged to meet the bank manager, who gave advice on what could be done. We arrived early so before his appointment with the bank, we went for a cup of tea and were able to chat about her life and the relationship she had with her family member. She also felt quite anxious about meeting with the bank manager, but felt reassured with my support. It became evident that Julie was unable read or write, so she felt the family member was taking advantage of this. She said that she was not ashamed to tell me that she could not read and write she just didn't like the fact that the daughter took advantage of it.
During the meeting, various options were given to Julie, to enable her to make an informed decision. This included self-management of her account, setting up a new account, support from her PA to manage her account, or requesting if Halton BC Appointee's service can support her in managing her finances. Julie agreed for a withdrawal to be made from her account in the form of a cheque and the cheque given to HBC Appointee service. This would avoid any further funds being taken out of their account. A letter was also produced taking the family member's name off the account at Julie's request. Once this had been done with Julie's permission, the family member was contacted to advice of the findings and that Julie had decided to manage their own finances. The family member advised they had taken the funds out of the account and put them into a savings account which the adult 'apparently consented to'. The adult denies this. The family member then transferred the funds back into the bank account.
Julie was unsure of how the whole process would work and was quite anxious about it all; however they felt involved, at the centre of the enquiry and were happy with the outcome. Julie felt in control of their finances, as she did not have to rely on someone else giving her 'her hard earned money'. During the contact I had as a Safeguarding Social Worker I was also able to signpost Julie to other support that they required.

Review of outcomes

Each time I have visited Julie she has always told me how happy she was that it had all finally been sorted. Julie advised her PA that she was concerned about repercussions from her family member and lost sleep worrying about it all. Her PA has advised me that they have observed her as being less anxious and she has told them she is sleeping better. Julie and her PA have my contact number if they require any further advice and I am happy to signpost them to any support they may require. Julie has declined any support with reading and writing skills as she has 'coped until now, quite well'.

SECTION 7: RESPONSE

Summary

Halton Safeguarding Adults Board is designed to be responsive to local need and the local data gathered helps to inform what will be the most effective and appropriate activity. This is an ongoing process that builds year on year; some activity is ongoing, for example safeguarding prevention, but each year this may look different depending on what the local need is. Section 9 Future Priorities, pages 33-36, will summarise the work for 2017-2018 in response to the findings from this report. Whilst here we look at this year's data, combined with previous year's evidence to highlight a number of specific activities that took place during 2016-2017.

Financial or material abuse

- There has been a Financial Toolkit developed in response to previous years data, which has been made widely available. It can be accessed via an online eLearning course which any service can access –enabling all HSAB and Sub-Groups partners full access and also any member of the public can access it via the HSAB website: www.adult.haltonsafeguarding.co.uk
- Halton Borough Local Authority's Trading Standards Team continues it's great work helping to safeguard adults with the national SCAMS programme and Doorstep Crime initiatives. These are detailed in Section 8 of this report: Key Initiatives, pages 17-19.

Neglect and acts of omission

Neglect and acts of omission continue to raise concerns and were the most prevalent type of safeguarding alert reported for this year. When examining this type of safeguarding issue it can relate to a number of actions, a primary example being difficulties around administering prescribed medication. Time, dose, storage, renewal of medication are areas that both professionals and informal carers would benefit from understanding more. There follows some examples of work that addresses the care concerns of adults at risk of harm.

- Halton CCG Medicines Management Team (MMT) reviewed the existing Medication Management Policy during 2016/17 and work commenced on a new Medicines Policy for Social Care, which is scheduled to be agreed by September 2017.
- There have been a number of targeted pieces of work in relation to trends/emerging themes including:
    - Controlled Drugs in Care Homes – this was prompted by a number of incidents relating to safe management in care homes. Guidance was developed which was

sent out to practices and a joint session was done with Cheshire Police to raise awareness of safe management, the law and reporting mechanisms.

- Covert Medication – this was an emerging trend from social care settings that we found when dealing with queries and when reviewing patients. The required paperwork wasn't always in place and the process hadn't always been followed. Guidance has since been developed and piloted and a joint session with Halton's Safeguarding Adults Unit was done for both Care Homes and Domiciliary care Providers.
- Waste – There has been a general theme emerging regarding medicines waste and the safety issues associated with excess medicines. As such an audit was done in 2016/17 with patients, GP practices, Community Pharmacies and Care Homes to assess what has been driving this and what factors needed to be considered. As a result a project to support patient led ordering of prescriptions has been launched in 2017/18 across Halton and further work will be done with Halton Care Homes later in 2017/18. (not specifically joint work with Safeguarding)

- HBC hosts 2 Provider Forums, with regular meetings for both Care Home and Domiciliary Care & Supported Living. HSAB has regular reports from these Provider Forums to enable ongoing monitoring of trends/themes/needs for additional resources.
- Through the Provider Forums services accessed updated information, resources and awareness sessions on Care Concerns Guidance and DoLS update guidance.
- Raising awareness of what neglect is via the launch of HSAB's website, updating information leaflets and planning a long-term marketing campaign to be launched in 2017. This campaign will include information and resources suitable to both the general public, informal and formal carers and professionals.

Age and gender of adults at risk of harm

As evidenced through the report safeguarding issues are experienced mostly by older people. It is vital that we understand the needs of older people who may be at risk of harm and put in place initiatives to protect them. During 2016-2017

- Herbert Protocol is a National Police Initiative which assists with people experiencing Dementia and/or likely to go missing. Cheshire Police brought the scheme to Halton's Safeguarding Adults Board to implement locally. HSAB full endorsed the initiative and helped facilitate the scheme being adopted across Health, Social Care and community settings. Details of the scheme can be found in section 8 of this report, Key Initiatives, pages 17-19.

The website for more information can be found at: https://www.cheshire.police.uk/advice-and-support/missing-persons/herbert-protocol/

- Halton CCG Medication Management Team also looked at End of Life care as there had been a number of emerging themes during 2016/17. Specifically the area both prescribing and administration and as such a local End of Life medicines management group has been formed in 2017 to try and address some of these themes, namely paperwork, formulary, access to medicines and education.
- From 2015-2016 females aged 65 years and over living in their own home were the most highly reported safeguarding concerns. The following case study demonstrates how this has been addressed:

Location of risk

- Halton CCG Medication Management Team supported safeguarding investigations and shared learning for any medicines related issues that have been flagged to us. This is often across a wide range of settings and Healthcare Professionals including care homes, care agencies, GP practices, Community Pharmacies and other providers. Subject matter expertise into investigations regarding medicines is vital in order to understand the key issues and risks. The MMT is keen to further develop this joint approach with the Safeguarding and Quality Assurance Teams to ensure the best outcomes for Halton residents
- Halton Safeguarding Adults Board requested a revised training strategy, looking at what exists already and where information gaps are. This was to address both public and professional knowledge and skills.
- During 2017/2018 there will be a marketing and awareness raising campaign launched that will target specific areas across Halton. Free resources will be developed

Data and quality assurance

- Halton Borough Local Authority's Policy and Performance Team gather data that is required nationally and informs the work of adult safeguarding locally. Although not mandatory currently Halton have set up a reporting system for tracking Making Safeguarding Personal (MSP) outcomes for all adults who have contact with Social Care. See Section 7 on Key Initiatives for more details.
- 2017/2018 will also see a revised Business Plan to reflect targeted performance data on adults who are identified as at risk of harm under the Care Act 2014 to evidence the impact of safeguarding for those adults.

Safeguarding alerts

There is a great opportunity for HSAB to raise the profile of Safeguarding for adults, to help create a culture of care and support, not just in services for the residents and whole workforce within Halton. Safeguarding messages need to be consistent, relevant, accessible and easy to understand. It is hoped this will increase greater understanding and appropriate and timely discussions and reporting of safeguarding concerns. There will be a large scale consultation process to aid a yearlong marketing and awareness campaign that will incorporate free training and resources which HSAB has committed to providing. See Section 9: Future Priorities for further details.

Additional

- HSAB commissioned a Safeguarding Prevention Strategy, led by Halton Borough Local Authority's Public Health and developed with the support of Halton's Safeguarding Adults Partnership Forum and local community groups. Consulting with members of the public the Strategy was accepted by HSAB with ongoing work throughout 2017-2018 to create an Action Plan to ensure the recommendations in the strategy are put in place. HSAB will monitor and oversee the work from this Action Plan.

SECTION 8: KEY INITIATIVES

Summary

During 2016/2017 there were a number of key implementations that took place within Halton. These were based on national guidance and statutory provision e.g. the Care Act 2014 specifies the purpose of a Safeguarding Adults Board; in addition to specific service provision and local strategies that respond directly to the findings from a range of intelligence sources as mentioned in the previous section of this report (Performance pages 7-13). Additional sources of information gathering is also used along with multi-agency work that addresses safeguarding issues across all sectors including the community and voluntary sector and not just statutory services. All of this information and guidance is used to shape what services and support is made available, to ensure the most appropriate use of resources for those adults identified as at risk of harm. The following is a snapshot of the implementations that took place during 2016 to 2017.

Making Safeguarding Personal (MSP)

Making Safeguarding Personal is joint Local Government Association (LGA) and Association of Directors and Adult Social Services (ADASS) programmes that support Local Authoritys and their

partners to develop outcome-focused, person-centred safeguarding practice. The approach aims to facilitate a shift in emphasis in safeguarding from undertaking a process to a commitment to improving outcomes alongside people experiencing abuse or neglect.

Local Implementation:

In response to national guidance Halton Borough Local Authority's Integrated Safeguarding Unit (IASU) and Performance team have designed a questionnaire that is to be used for all adults with a safeguarding concern, to ensure they are consulted with and enabled to inform the care and support they wish to receive from the initial contact through to end of service. Halton Borough Local Authority hosts a Making Safeguarding Personal working group that is attended by Complex Care teams, Integrated Adult Safeguarding Unit, Mental Health Team and the Performance Team. This group looks at what and how information is being gathered as well as sharing best practice.

Self-Neglect Panel

When the Care Act 2014 was implemented in 2015, it brought a number of changes occurred including new categories of abuse added and 'self-neglect' was specifically mentioned. In response to this Halton's Self-Neglect Panel was established with regaular panel meetings taking place. What became evident through these panel meetings was a number of learning and development opportunities for Halton and Halton service providers, including:

- Learning around the types of referrals - what is appropriate and meets the threshold to be classified as a safeguarding issue.
- Agencies and services needed support in help to identify people who are at risk of harm due to self-neglect.
- Sharing of information and resources to service providers and the public, through awareness raising and training.

Peer Review

Context and summary

St Helens is a neighbouring authority with a comparable population profile to Halton and had a positive Peer Review in June 2015 which was undertaken by ADASS North West Region.

In September 2016, the Director for Adult Social Services at Halton Borough Local Authority and the Strategic Director of Peoples Services St Helens Local Authority discussed the potential for St Helens to conduct a scaled down version of their Adult Safeguarding Peer Review to give Halton the opportunity for constructive external feedback. This took place on 5 and 6 January 2017.

It was agreed an evidence based approach would be used and information gathered from a wide range of documentary, verbal and IT system sources.

Halton arranged for access and support for the Peer Team to navigate around the case management systems. Peer Team Members then selected 15 cases where adult Safeguarding procedures had been applied. A bespoke case file audit tool was produced by the Review Team to do this task in a meaningful way.

Recommendations for HSAB

There were 6 recommendations made from the review, with recommendation 3 directly relating to the HSAB as follows:

- Review the scope of the SAB and strengthen clarity and delivery of the Strategic Plan annual actions.

Herbert Protocol

A new initiative was introduced to Halton via Cheshire Police and supported by Halton Safeguarding Adults Board. The Herbert Protocol puts systems in place to allow for early intervention when adults who may be at risk of harm go missing. This addresses safeguarding prevention on a multi-agency level and fits with the strategic aims of HSAB.

- The Herbert Protocol is a national scheme being introduced by Cheshire Constabulary and other agencies to encourage carers and family members to compile useful key information which could be used in the event of a vulnerable person going missing.
- The idea is to complete a form recording all vital details such as medication required, mobile numbers, places frequented, their routines, description and photograph. In the event of a family member going missing the form can be sent or given to the police to reduce the time taken in gathering this information.

Resources include:

i) A Service Level Agreement available for Care Homes with recommended actions should a resident be missing.
ii) A Vulnerable Adult Missing Persons Profile Form
iii) Poster and information leaflet
iv) Further information available online

SAB agreed to support The Herbert Protocol scheme and liaised with Cheshire Constabulary and the local Provider Forums and Halton's Safeguarding Adults Partnership Forum to assist with promotion and uptake of the scheme within Halton.

Cheshire Police have got their own form, Service Level Agreement, poster and info leaflet. For more information and resources: https://www.cheshire.police.uk/advice-and-support/missing-persons/herbert-protocol/

SECTION 9: HSAB MEMBERS AND PARTNERS CONTRIBUTION TO SAFEGUARDING ADULTS IN HALTON

Health Providers and Health Sub Group

5 Boroughs Partnership NHS Foundation Trust

St Helens and Knowsley Teaching Hospitals NHS Trust

Warrington and Halton Hospitals NHS Foundation Trust

NHS Halton Clinical Commissioning Group (CCG)

NHS Halton Clinical Commissioning group (CCG) demonstrates a strong commitment to safeguarding adults within the local communities. There are strong governance and accountability frameworks within the Organisation which clearly ensure that safeguarding children and adults is core to the business priorities. The commitment to the safeguarding agenda is demonstrated at Executive level and throughout all CCG employees.

Accountability for the safe discharge of safeguarding responsibilities remains with the Chief Officer; executive leadership is through the Chief Nurse who represents the CCG on Halton Safeguarding Adult Board and who is also a member of the CCG Governing Body.

To meet with national safeguarding requirements, the CCG commission a Hosted Safeguarding Service with Designated Nurses for Safeguarding Children and Adults and a Safeguarding/ Mental Capacity Coordinator and administrative support. The CCG reviews this arrangement annually to ensure that it meets its statutory duties for safeguarding adults at risk of abuse and harm. The CCG continues to work in partnership with statutory agencies and third sector to support safe and effective delivery of services against the safeguarding agenda.

During the reporting year of 2016 -17 the CCG has supported Halton Safeguarding Adult Board (SAB) priorities in the following:

NHS Halton CCG commissioned a Multi -Agency Review (MAR) following the death of an adult who was in receipt of health commissioned services. A Multi Agency Review is a process of critical and reflective learning, designed to lead to improved outcomes for people who use services.

The main purpose of a MAR is to:

- Establish whether there are lessons to be learned from a particular case about the ways in which agencies and professionals work together to safeguard vulnerable adults
- To consider all the issues raised in the case and make specific recommendations for future actions

This MAR brought together the agencies involved in the care and treatment of the young adult to identify where lessons can be learned and to identify actions to address that learning. The action plan is overseen by the Health sub group of the Halton Safeguarding Adults Board. The health sub group is chaired by the Chief Nurse for NHS Halton CCG.

Additionally, to support the Safeguarding Adults Board priority of early intervention and prevention, Halton CCG led a thematic review of a number of reported suicides / attempted suicides which occurred over the summer of 2016. In all nine incidents were reported in a seven week period.

The aim of a Thematic Review is to prepare an overview of the themes and issues highlighted in the care and support provided by all services to the patients/service users involved in the suicides or attempted suicides and incidents. The process for the review is to pull together the findings from all information provided and involve all the providers of services with the individuals. The initial findings are that there are some important lessons to be learnt in relation to these incidents and that there are some gaps and issues in relation to the effectiveness of learning from this type of incident.

A plan for next steps has been presented to the Safeguarding Adults Board and has formed part of the work plan for the coming year.

NHS Halton CCG also supported the first Serious Adult Review (SAR) commissioned by Halton Safeguarding Adults Board under the new Care Act. The recommendations and action plan following the SAR will be overseen by the Health subgroup of the Safeguarding Adults Board.

NHS Halton CCG commissions services from Bridgewater Community Health Foundation Trust, Warrington & Halton Hospitals NHS Foundation Trust, St Helens & Knowsley Hospitals Trust and North West Boroughs Mental Health Foundation Trust. Amongst other quality and safety

governance arrangements the CCG also work closely with the Care Quality Commission to ensure commissioned services are delivering high quality services to the population of Halton.

The Care Quality Commission carry out regular checks on health and social care services. These are called comprehensive inspections and they are undertaken to make sure services are providing care that's safe, caring, effective, responsive to people's needs and well-led.

Current CQC Health Provider ratings 2016/17

	Safe	Effective	Caring	Responsive	Well led
Bridgewater Community Health Foundation Trust (2017)	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement
Warrington & Halton Hospitals NHS Foundation Trust (2015)	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
St Helens & Knowsley Hospitals Trust (2016)	Good	Good	Outstanding	Good	Good
North West Boroughs Mental Health Foundation Trust (2016)	Good	Good	Good	Good	Good

Bridgewater NHS

Work with partner agencies and organisations to focus on emerging forms of abuse e.g. modern slavery, self-neglect, honour based violence.

During 2016/2017 we have been engaged with work which supports the health sub-group objectives. This includes work to ensure that the trust has comprehensive safeguarding intranet pages which incorporates current and emerging themes in adult and children safeguarding for staff to access for support and advice. The trust intranet site includes pages on self-neglect, CSE, domestic abuse (covering forced marriage, honour based violence and forced marriage) and modern day slavery and human trafficking. Pages have been developed on hate and LD mate crime and are waiting to be uploaded.

Adult level 3 safeguarding training also includes self-neglect, hate crime, LD mate crime, domestic abuse (covering forced marriage, honour based violence and forced marriage) and modern day slavery and human trafficking.

Develop a better understanding of cross-cutting themes

The named nurses for safeguarding adults and children have implemented the NICE Guidance on domestic abuse incorporating this into the trusts policies and procedures for supporting patients when staff identify, suspect or have a disclosure of domestic abuse.

The Named Nurse safeguarding children and adults is actively engaged in safeguarding adults reviews within other Bridgewater boroughs with any lessons learnt or actions disseminated within the trust via meetings, bulletins and the HUB (Trusts internet site). However the Named Nurse for Safeguarding Adults has not been involved or invited to contribute to any Safeguarding Adult Reviews within Halton.

All agencies recruit staff, including volunteers, safely

- Bridgewater's has a Recruitment and Selection policy in place which supports the principles and safer recruitment and highlights the importance of ensuring that all staff involved in recruitment are appropriately trained.
- The organisation delivers a programme of HR skills training including a module on Recruitment.

Warrington and Halton Hospitals NHS

Safer workforce

The WHHFT Recruitment and retention policy remains in date. For all new appointees coming into the organisation for the first time, the Trust must seek to validate a minimum of three years continuous employment and/or training including details of any gaps in service. At least one reference should be from a current or most recent manager to enable confirmation to be made of their most recent employment history. Where an individual has been with one employer for three years or more, one reference confirmation of employment/training is sufficient, provided that all requested details have been confirmed by the previous employer. Where a prospective employee has changed employment frequently within the last three years, a sufficient number of confirmations must be obtained to cover the continuous three years history. Where an individual applies for a new position within the Trust all effort should be made to ensure any risk is minimised. Therefore, the Employment Services Team will take up a reference from the current line manager. All references are retained on the Employee's personnel file. The receipt of references is also recorded on individuals ESR record.

North West Ambulance Service NHS

North West Ambulance Service

The Trust has recruited additional safeguarding practitioners who are covering the 3 geographical areas. A communication was sent out in April 2017 to all adult and child boards in the area updating contact details. The Trust is delighted to announce that the Safeguarding Team has expanded to enable engagement support in each of the three areas, (Cheshire and Mersey, Greater

Manchester and Cumbria and Lancashire). The increase in safeguarding resource and agreed models of engagement will improve multi-agency safeguarding working and learning.

The Trust appreciates the diversity within each Board in the area and that many models of engagement exist. The Trust will endeavor to attend a minimum of one Board meeting each year and engage with the sub-groups as requested including child and adult safeguarding review processes (SCR and SAR).

The Safeguarding Practitioners are currently looking at key training priority areas for the next roll out of safeguarding training to staff in the organisation. In addition, the Trust's Safeguarding Vulnerable Persons Policy and Procedures has been reviewed and updated.

The Trust's continues to monitor safeguarding notification rejections each month. Adult rejections remain consistent at between 4-5%of concerns rejected each month and relate in the main to patients with mental ill health or referrals made for patients who remain as a hospital inpatient. Child rejections remain relatively uncommon. The Trust continues to use the ERISS system and the thresholds for accepting child concerns are being monitored and challenged where appropriate.

Halton Safeguarding Faith Forum

Here is a brief summary of the Faith Forum's activity for 2016 to 2017:

Standing items on the agenda of the Faith Forum include updates from both Halton Adult and Children's Safeguarding Boards and the CSE/Missing/Trafficking Sub Group. We use the group to help share information, training and resources and to raise the profile of safeguarding amongst people in the faith sector.

Other items discussed at the Faith Forum meetings included HSAB's work on Self-Neglect, E Safety training and awareness. Additionally people's issues within the faith sector e.g. poverty, relationship breakdown, loneliness, and addictive behaviours.

We also use the Faith Group to help with dealing with safeguarding concerns within the faith sector; Covenants of Care and issues surrounding them and safeguarding liabilities of others using church buildings for the provision of activities/services.

The Group also contributes to a local Parish newsletter which is shared across the sector. Topics included:

- What is Safeguarding and the Role of the Safeguarding Representative/Lead
- Types of Abuse – detailed information

- Responding to Allegations or Concerns
- Guidance for photographing and recording children, young people and vulnerable adults during events, activities and at other times
- Suicide Prevention

Faith Safeguarding Event

The Faith Group hosted a Faith Safeguarding Event held on 4th March in Farnworth Methodist Church. There were over 60 attendees, including four local Authorities, with 11 stallholders who all reported good interaction with attendees. The audience was Christian– not multi-faith.

The feedback was positive with a desire for future sessions and specific training topics raised included referral processes for Street Pastors and more detailed information on:

- internet safety re adults at risk as well as children and young people
- safer recruitment and management of volunteers

Trading Standards

Scams work

The National Trading Standards Scams Team and partners such as Adult Social Care refer individuals to the Service who may have been the victim of a scam. The individual will receive one-to-one visits from a specialist officer who works with the individual to help them to recognise the hallmarks of a scam so that they are better protected in the future.

Everybody that we work with on the scams project is given a Telephone and Mail Prompt card to help them to deal with cold callers and unsolicited post.

We have held training sessions with Royal Mail who have helped us to identify a further 110 people in Halton who are being targeted with scam mail.

Trading Standards have installed 11 call-blocker devices for scam victims who have been receiving high volumes of nuisance and scam calls. The call-blockers let calls from the consumer's 'trusted numbers' straight through, it blocks unwelcome callers (nuisance and scams), and asks unrecognised callers to identify themselves before it puts them through. The call-blockers continue to block a significant number of calls to those numbers.

Within the first 10 months of the project the key financial findings were:

- The total lost by Halton residents was £281,398
- The amount lost to Halton's economy per year was £96,468
- The annual savings for participants was £46,445
- The annual saving to the public purse was £5,307
- The non-financial benefits were:

- The project had registered 27 participants with the Telephone Preference Service to reduce the volume of unwanted calls
- The project had registered 23 participants with the Mailing Preference Service to reduce the volume of mass marketing letters received
- 137 people had joined the Trading Standards iCAN system (a Consumer Alert Network whereby information about scams and rogue traders is shared with members via email)

Examples of added value resulting from the unique positioning of Trading Standards to deal with breaches of consumer rights and contraventions of criminal legislation included:

Mr E is 97 and he's has lost around £20,000 to scam mail but was reluctant to stop replying. He had no money for food and he'd stopped paying his care bills. He was being sued by a betting company for an unpaid debt of £59. An officer contacted the company concerned who as a gesture of good will cancelled the debt. He had bought a call blocker device for £85 which was very poor quality and would not afford the protection he needed. Trading Standards obtained a full refund for him.

A survey of participants was undertaken in November 2015. The survey was sent to 44 participants, 21 responded. The main findings are summarised as:

11 respondents

Said that before contact with Trading Standards they could spot some types of scam but thought others were genuine

13 respondents

Said that after contact with Trading Standards they spend less money on scams

14 respondents

Said after contact with Trading Standards they think they are a lot better at spotting scams

12 respondents

Said after contact with Trading Standards they definitely will not respond to scams in the future

5 respondents

After contact with Trading Standards 5 people feel better about the future

8 respondents

After contact with Trading Standards 8 people feel less worried and less isolated

13 respondents

know what to look out for and feel more knowledgeable

6 respondents

Said they had lost sleep because of scams

Doorstep Crime

A specialist officer will make contact with every individual that the Service becomes aware of who has been targeted by doorstep criminals. Every person is supported to understand how such criminals work and how to protect themselves against similar incidents in the future. They are all given No Cold Calling Cards and letterbox stickers to deter doorstep callers from knocking.

iCAN

The service operates a free email alert system to warn members of the public about scams, doorstep crime incidents and other useful consumer information.

During last year 73 iCAN messages were issued covering things such as scam phone calls, letters, emails, texts and doorstep crime incidents.

Halton Disability Partnership

The work of Halton Disability Partnership addressed a number of the HSAB key strategic aims and objectives; here is just a brief description of their contribution:

- HDP chair Tom Baker was a member of the board he spectated our co-production project and the need for real pre-action consultation with stakeholders.
- Chair met with HDP lead “old town enabled” group of stakeholders
- HDP works with more than 300 people who have a personal budget. Once choice and care is assessed we do ongoing follow ups and support so we can intervene as soon as concerns arise.
- In Halton quite low incidents of abuse of people with disabilities under care of HDP when concerns, hate, anger. Our PA's are trained "Alerters" and hate contact HDP manager.
- Through our co-production work, HDP supports Old Town Enabled (OTE) and New Town Enabled group. Updates and discussions also safeguarding here taken place.
- OTE and NTE members have shaped their knowledge with other groups they have been involved with. On occasion they have alerted HDP about a concern.
- Safeguarding is a key component of HDP's work that balances choice for service users with robust safeguarding. This is highlighted in our leaflet and on our website. All HDP tasks are measured and reported on by our external evaluation.
- All the people HDP work with have a care worker who is their “personal assistant”. Consequently, care is personal but also risk and vulnerability are individualised and ongoing. One example is client “RB” who was placed in a violent situation via a registered “PA”. HDP’s PA assessed the situation and risk affected us and the matter was directed to police before serious harm could be done

Halton Carers Centre

What’s worked well: what has been done by HSAB and/or your respective services that should be shared?

- Halton Carers Centre has provided a private interview room at our Carers Centre to enable carers and members of the public to discuss safeguarding issues with social workers and other professionals if they prefer not to attend a Local Authority building.
- The profile of safeguarding remains high within our organisation due to staff attending ongoing training and awareness courses.

HALTON
SAFEGUARDING
ADULTS
BOARD

What would be good to have or do to support the work of Halton's Safeguarding Adults Board?

- Staff would appreciate updates following safeguarding referrals where possible, as our carers may attend with similar issues and we don't know if the safeguarding referral has been addressed
- Carers Centre can publicise safeguarding issues in our quarterly newsletters

What, in your view could be HSAB main area of focus for 2017-2018

- Increased communications to organisations in Halton and the public. Many carers are unaware that they can raise a safeguarding issue or what constitutes a safeguarding issue.
- Perhaps our carers could attend a safeguarding awareness at a Carers Forum in the future?

Mid Mersey age UK

Age UK Mid Mersey

Age UK Mid Mersey will support the Halton Adults Partnership Forum. We aim to work hard and remain committed for the success of the Safeguarding Adults Board for the residences of Halton.

We recognise the importance of educating and training staff, volunteers and the public is the best way forward. If we are contacted by members of the public who are very concerned about a person we take the matter very seriously. We have a Safeguarding lead person in Age UK Mid Mersey who is Dawn Kenwright. We are supported by Age UK Nationally who also has a Safeguarding Lead person. Age UK also provide a safeguarding training pack for the organisation to use for training. We have an Age UK. Factsheet no. 78 safeguarding older people from abuse and neglect. Also, two Age UK Booklets protecting yourself and Avoiding Scams. All Age UKs Information is kept up to date if there are any changes to legislation.

Age UK Mid Mersey tries to identify frail older people and advise them of the support that Age UK Mid Mersey. We aim to maximise their income by supporting them completing an attendance allowance Claim. The additional income helps them buy in the care and support they need. A lot of people in their late 80's are on low incomes and without additional income for care could end up self-neglecting themselves.

Age UK Mid Mersey carries out work in its offices and in the local community, we have a Market stall in Widnes that is very successful at raising awareness to local people and every week on a Wednesday morning we go into Halton Hospital onto ward B1 this is the long stay ward for older people. We raise aware of the work we do in supporting Halton residents not only to older people but also to family carers and friends. We work very closely with other professional the nursing staff

and OTs preparing people for safe discharges from Hospital. We provide free Factsheets and Information booklets on issues of concern for older people.

Everybody is unique it's important that we respect the individuals personal traits. We are none judgemental and will always listen and treat the person with respect and dignity.

Halton Housing Trust

Halton Housing Trust provides a variety of support for its 7,000 households in terms of support, financial assistance and referrals to other agencies. We have supported individuals to improve the condition of their homes, assisted them to move to more suitable accommodation due to health or other financial constraints to allow them to remain independent.

When necessary made referrals due to abuse, neglect or other concerns to ensure the correct support is put in place to support their individual needs. We deal with a large number of victims of domestic abuse and provide Sanctuary measures to improve their safety while working with partners to ensure their health and wellbeing is maintained. Our customers have benefitted through either maximising their income, improved quality of life, or simply getting the support needed to reduce the risk.

Healthwatch Halton

Healthwatch Halton's powers and remit are defined by the Health and Social Care Act 2012, the Local Healthwatch Regulation 2012 and the Local Healthwatch Organisations Directions 2013 section 5 but in summary we are the official consumer champion for users of Health and Social Care services. In Halton, Healthwatch is a relatively new service and we are a relatively small team (4 paid members of staff and 15 volunteers) and so we have developed strategic partnerships with other key voluntary sector groups (e.g. Citizens Advice, Age UK, SHAP, Halton Disability Partnership) to increase our reach into the community and also ability to gather intelligence.

Because of the nature of the work we do we are always alert to potential safeguarding concerns and also ways to minimising the risk of a potential safeguarding issue escalating. Key pieces of safeguarding-related work we have undertaken in the year and our impact include:

Helping to support the redesign of the Safeguarding Adult Board structures so that whilst there is an overarching strategic board, there is also a more operational and inclusive "partnership forum" where other voluntary sector groups can participate and share intelligence and feedback from their service users.

Conducting "Enter and View" visits to local care homes; in the last year we have conducted 12 Enter and View (E&V) visits and 5 "focus group" meetings (with residents and their families) to look at the living conditions of residents and help be their voice to drive up standards of care. Our E&V reports are public documents, published on our website, and this transparency acts as a real motivator for local managers to improve their standards of care. During these visits we identified 5 potential safeguarding issues and these were duly reported and acted upon by Halton BC.

We carried out a Service User Engagement mapping exercise to see how we could all work in better partnership to improve our collective reach into local communities. We surveyed 7 organisations with a combined marketing reach of over 12,000 and we discovered a real appetite and willingness to participate in joint campaigns. As a result of this exercise we also submitted two formal recommendations to the SAB;

We create a "safeguarding adults risk register" which is a standing agenda item for the SAB "Partnership meetings". Partners around the table can then discuss what steps we can do to raise awareness of any issues. E.g. post Brexit there was a spike in hate crimes, could we all have done more collectively to mitigate this?

In the SAB "partners directory", we include contact details of each organisation's "Communications Officer" and/or their Service User Engagement Lead… this will help us all easily identify who we need to talk to if we have ideas for a joint campaign.

Citizens Advice Halton

Citizens Advice Halton (CAH) is a free, confidential and independent information and advice charity operating from sites across Widnes and Runcorn. Each year CAH deals with over 7,000 local service users need support and advice on a range of different issues e.g. debt, housing and homelessness, disability rights, etc. A significant proportion of CAH's service users are vulnerable; either because of a physical disability or because they have poor mental health and as such can present as potential safeguarding issues.

Key areas in the last twelve months where CAH has contributed to the local Safeguarding Adults agenda include:

We have played an active role on the SAB Partners forum and we actively support the local Healthwatch Halton service by providing senior management support and sharing intelligence,

CAH staff are now trained to talk to people seeking debt or benefits advice to identify and support potential victims of domestic and gender violence. This is because there is a proven correlation between this form of abuse and "lack of money".

We have developed our financial literacy programme to include digital safety and raising awareness of the risk of online abuse, especially scams.

In partnership with the Institute of Trading Standards, we play an active role in national Scam Awareness campaigns and anti-loan shark campaigns

We renewed our registration as a Hate Crime reporting centre and we are the only organisation in Halton that provides free discrimination advice.

CAH staff have been trained to deliver "suicide awareness" training to community groups and volunteers so that more members of the community know what support is available if they have any concern about their friends or family. There is a real need to de-stigmatise asking for help because from the CAH alone on average one service user per week tells their adviser they have had thoughts about suicide.

We have delivered trained to our frontline staff to identify any concerns and to refer into our internal resources to raise any safeguarding concerns to the appropriate service areas. This has resulted in an increase in the number of referrals to our designated Tenancy Support Team, who have carried out a home visit to ensure that our customers are safe in their home.

Our designated staff have received training to support our most vulnerable staff and work closely with partnerships across Halton to direct the correct support. Greater joined up approach, more communication between the services and a general interaction to improve the position that these individuals have found themselves in.

http://www.haltonhousing.org/blog/ this is a link to some of the stories where we have supported vulnerable adults.

Care Quality Commission

Safeguarding is a key priority for CQC and people who use services are at the heart of what we do. Our work to help safeguard adults reflects both our focus on human rights and the requirement within the Health and Social Care Act 2008 to have regard to the need to protect and promote the rights of people who use health and social care services.

CQC's primary responsibilities for safeguarding are:

1. Ensuring providers have the right systems and processes in place to make sure adults are protected from abuse and neglect. We do this through our inspection regime. We publish ratings and inspection reports, so people who use services can understand if providers have effective systems to safeguard people.

2. Working with other inspectorates (Ofsted, HMI Probation, HMI Constabulary, and HMI Prisons) to review how health, education, police, and probation services work in partnership to help and protect young people and adults from significant harm.

3. Holding providers to account and securing improvements by taking enforcement action.

4. Using intelligent monitoring, where we collect and analyse information about services, and responding to identified risks to help keep adults safe.

5. Working with local partners to share information about safeguarding.

We do not routinely attend SABs although we may share information and intelligence to help them conduct enquiries. Engagement with these Boards is at a local level, with local partners liaising with one another to agree involvement and attendance so that there is a joined-up approach.

SECTION 10: FUTURE PRIORITIES

The Care Act 2014 advocates a coproduction approach to local authority Safeguarding Adults Board. There has been some work done already using coproduction; last year HSAB hosted a development day and Halton Disability Partnership continues to build on their coproduction work. This year recruitment of a Safeguarding Board Officer enabled HSAB to consult with partner agencies and the general public to seek opinion and perspective on their views of adult safeguarding locally. The consultations used an 'Appreciative Inquiry' approach to draw out existing knowledge, skills and good practice and to identify opportunities to share these and other resources to help achieve the strategic aim of strengthening the board. HSAB members, sub-groups and partners have evidenced their commitment to safeguarding and working collaboratively towards true integrated Safeguarding Board and all relevant activity.

2017 to 2018 will continue this work and build on the existing strategic aims, producing a revised action plan with key objectives for the activity of each sub-group and HSAB as a whole.

HSAB hopes to have true coproduction by finding mechanisms where 'experts by experience' can help shape the ongoing work of Adult Safeguarding within Halton in a meaningful way to service providers and more importantly the people that HSAB should be helping i.e. adults who have health and care needs and are identified as at risk of harm.

The strategic aims of Halton Safeguarding Adults Board 2016-2018 remains:

- **Strengthening the Board**
- **Early Intervention and Prevention**
- **Awareness Raising and Engagement with the Community**
- **Performance and Quality Assurance of Providers and Services**
- **Making Safeguarding Personal – listen to and do when adults tell us about their experiences of abuse and neglect, and the services and support they receive**

There will be a strong focus on the following three priority areas of work for the year ahead:

Priority 1: Creating a safer place to live for all adults living in Halton (Safeguarding Prevention)

Everyone deserves to live a safe and happy life, we have a duty to care for those people who may need more support to enable them to live a safe and happy life too.

As mentioned throughout this report HSAB has already delivered focussed work on achieving the first strategic aim of 'Strengthening the Board'. This is evidenced throughout sections 2, 6 and 7.

There has also been additional work that commenced towards the end of the year on early intervention and prevention with the development of a Safeguarding Adults Prevention Strategy with Public Health. In the coming financial year there will be an Action Plan developed to implement the key recommendations, in partnership with Halton's Safeguarding Adults Partnership Forum and the wider community.

There was also a well received National Police initiative , which HSAB supported Cheshire Police in implementing locally, it was disseminated across local services and venues.

The work of Early Intervention and Prevention will continue through 2017/2018 to help embed the work already identified and help to reduce the high number of safeguarding concerns currently reported.

Priority 2: Providing the skills and knowledge to enable genuine care and understanding for adults at risk of harm (Awareness-raising and Training)

What was evident through consultations with the Safeguarding Adults Partnership Forum members, HSAB sub-groups and wider partners, a training needs analysis (TNA), safeguardinmg concerns reported and data examination was the need for continued training and awareness-raising of adult safeguarding.

The TNA has helped inform a Training and Marketing Strategy that will be used to develop a year long marketing campaign and traning package. This will include updating of free resources, leaflets and an updated training offer, with information that will be accessible in various ways to enable the greatest access to the wider public as well as service providers.

What was apparent from this year's data was the ratio of adults aged 75 years and over, in addition to an increase in males experiencing a safeguarding issue. HSAB has committed to implementing the Training and Marketing Strategy to ensure targeted resources are focussed on where they are most needed.

The development of Halton Safeguarding Adults Webpage will enable a central point of access for information, with details on all resources, latest guidance and updated policies. The website address is: www.haltonsafeguarding.co.uk

- Following on from the development of a Training Strategy HSAB will refresh all resources including leaflets and design of a pocket guide for easy reference.
- Free training programme for all staff, volunteers and informal carers living and working in Halton
- Free learning events including a Development Day
- A 12 month Public Awareness campaign to raise the profile and understanding of Adult Safeguarding.

Priority 3: Gaining a greater understanding of how mental health can impact adults at risk being protected and cared for in the best way possible (Mental Health)

Another theme that arose through consultations in addition to initial trends emerging from reviews was mental health. Mental health and it's impact on daily living can cause additional complications when a safeguarding concern occurs.

Anecdotal information through consultations with local service providers, service user groups, during the Safeguarding Prevention Strategy Consultation process and from questions emerging from a Thematic Review there were a number of areas around working with adults at risk of harm who may have mental health problems, for example:

- Is there a difficulty in understanding that not all adults with a mental health issue and/or diagnosis classifies them as an adult at risk of harm and so therefore would not necessarily need social care support?
- That sometimes adults who had health and care needs where mental health problems were also present had additional barriers to accessing support.
- Could service providers benefit from understanding how to support an adult with mental health when there is also a potential safeguarding concern?

Healthwatch have made a commitment to Halton Safeguarding Adults Board to work in partnership across services and with the local population to establish local needs and knowledge around safeguarding and mental health towards developing targetted resources.

2017-2018 workplan

These priorities will help shape the activity of HSAB and HSAB sub-groups and key partners for 2017-2018 to enable HSAB to continue to meet it's strategic aims.

The key objectives for each of this coming year's priorities will be included in a revised workplan. The workplan will make explicit the objective activities, which priority they relate to and how this objective will address the overarching strategic aims of HSAB. It will detail which sub-group will hold responsibility for each objective, with additional information if it relates to a specific service/provision and where the information will be reported to contribute to the stratgeic aim aim of performance and quality assurance of providers and services

HALTON
SAFEGUARDING
ADULTS
BOARD

SECTION 11: APPENDIX 1

Financial Report 2016/17

Funding Streams	**Income**
Contribution from HBC Base Budget	£30,000
Contribution from PCT	£37,000
Contribution from Police	£10,000
Total funding	**£77,000**

Allocation of budget and total spend to date	**Budget**	**Spend**
Independent Officer	£12,000	£11,993
Safeguarding Adults Board Officer	£40,000	£6,151
Other costs: inc. training, SAR	£25,000	£1,650
Total	**£77,000**	**£19,794**
Current balance		**£57,206**

REPORT TO:	Health and Wellbeing Board
DATE:	17 January 2018
REPORTING OFFICER:	NHS Halton CCG Director of Commissioning/Director of Public Health
PORTFOLIO:	Health and Wellbeing
SUBJECT:	One Halton and the development of an Accountable Care System
WARDS:	Borough wide

1.0 PURPOSE OF THE REPORT

This report seeks to provide an update on One Halton and the development of an Accountable Care System (ACS) and asks that the Board endorses the revised One Halton strategic vision and governance structure.

2.0 RECOMMENDATION: That the Board

1) endorses the One Halton (ACS) Vision;

2) agrees the memorandum of understanding for the One Halton Accountable Care System Board; and

3) agrees the Terms of Reference for the One Halton Accountable Care System Board.

3.0 SUPPORTING INFORMATION

3.1 An accountable care system (ACS) is one in which several social and health care organisations agree to provide all health and social care for a given population. There are three core elements to this system. The first involves an alliance of providers collaborating to meet the needs of a defined population. Secondly, these providers take responsibility for a budget allocated by a commissioner, or alliance of commissioners, to deliver a range of services to that population. Finally, an accountable care organisation will work under a contract that specifies the outcomes and other objectives they are required to achieve within the given budget, often extending over a number of years. Significantly, the ACS will centre on the involvement of general practitioners in the network of providers delivering care along with local authorities as providers and commissioners of services.

3.2 NHS England has, through sustainable transformation plans (STPs), committed to the development of accountable care systems.

3.3. In 2014/15, Halton as a borough committed to the development of an integrated model of health and social care. The Council with all its health partners developed the concept of One Halton, and agreed a shared vison:

"To improve the general health and wellbeing of the people of Halton, working together to provide the right level of treatment close to home, so that everyone in the borough can live longer, healthier and happier lives."

3.4 Halton Borough Council Executive Board at its meeting on 14th December 2017, endorsed the revised One Halton strategic vision and governance structure as described in this paper and approved the recommendations highlighted above.

3.5 The revised One Halton Accountable Care Strategic Vision (Appendix 1) builds on the initial commitment of partners to improve the delivery of health and social care by ensuring:

- Services enable people to take more responsibility for their own health and wellbeing;
- People stay well in their own homes and communities as far as possible; and
- When complex care is required it should be timely and appropriate.

3.6 To achieve the ACS, and achieve the goals set out in the strategy, partners have established the "One Halton Accountable Care System Board" with a memorandum of understanding (Appendix 2) and Terms of Reference (Appendix 3) which underpin the commitment to move towards a more integrated community based system reducing the demand on acute services and providing care closer to home.

3.7 The *One Halton* Accountable Care Programme Board is not a decision making body. Through the MoU it provides the forum by which the partners provide system leadership and meaningful engagement in the development of the *One Halton* Accountable Care System. The Board will provide oversight of any necessary work streams and be the reporting body to the Halton Health and Well Being Board.

3.8 The Board will have an independent chair, Dr David Colin-Thome. Membership of the Board is set out in the terms of reference for the Council the lead officer is the Strategic Director for People, and the Chief Executive is the senior responsible officer for the development of the ACS.

4.0 FINANCIAL IMPLICATIONS

4.1 The ACS will necessarily be funded through existing resources. There will be project development costs but these are yet to be determined.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 Children & Young People in Halton

An ACS will provide integrated, multi-disciplinary health and social care services for all families, and improve services specifically for children with learning difficulties and disabilities.

5.2 Employment, Learning & Skills in Halton

None.

5.3 A Healthy Halton

An ACS priorities and operation will be driven by the Health and Wellbeing Strategy and outcomes monitored by the Health and Wellbeing Board.

5.4 A Safer Halton

None.

5.5 Halton's Urban Renewal

None.

6.0 RISK ANALYSIS

6.1 NHS England through the Sustainability Transformation Programme are committed to the development of accountable care organisations. These do not necessarily require the inclusion of local authorities nor do they need to be confined to local authority boundaries.

6.2 The final version of what an accountable care system, and any associated new organisational structures, look like are unclear but the potential impact on Council services and staff will be closely monitored and reported back to the Council.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 The ACS will operate fairly and transparently.

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

Document	Place of Inspection	Contact Officer
NHS Five Year Forward View	https://www.england.nhs.uk/five-year-forward-view/	Mil Vasic Strategic Director

The King's Fund (2016). Accountable care organisations (ACOs) explained	www.kingsfund.org.uk/ACOs	Mil Vasic Strategic Director

Appendix 1. One Halton Accountable Care Strategic Decision

One Halton Accountable Care Strategic Vision

One System, One Plan, One Halton

NHS Halton Clinical Commissioning Group
HALTON BOROUGH COUNCIL
Warrington and Halton Hospitals NHS Foundation Trust
Halton Housing Trust
NHS Bridgewater Community Healthcare NHS Foundation Trust
NHS St Helens and Knowsley Teaching Hospitals NHS Trust
myhalton living life well
Halton & St Helens Voluntary and Community Action
healthwatch Halton
NHS North West Boroughs Healthcare NHS Foundation Trust
GP Health Connect

Contents

Background and Introduction

The Health and Social Care Act 2012 placed a statutory duty on the NHS and local authorities to promote and enable integrated care, further reinforced by the Care Act 2014. A raft of policy initiatives and incentives have been implemented to support greater integration and partnerships including the Better Care Fund, a national pioneer programme and, most recently, actions to support the vision for the NHS in England described in the Five Year Forward View. The new care models proposed in the Five Year Forward View are particularly aimed at overcoming barriers between hospital and community services. They are aligned with the wider policy direction of organising care in the community around the needs of service users, shifting the focus from episodic and acute care to whole life care, expanding preventative support that encourages "self-care", independence and wellbeing.

In 2014/15 Halton as a borough started its journey towards an integrated model of care with a shared vison across health and social care.

Our Strategic Vision

To improve the general health and wellbeing of the people of Halton, working together to provide the right level of treatment close to home, so that everyone in the borough can live longer, healthier and happier lives.

We are building from the strong legacy and foundation of **One System, One Plan, One Halton**.

Our **values** are based on strong partnerships; Collaboration (engagement & participation), System leadership (values based approach) Strong relationships, shared goals and an agreed set of outcomes.

Ultimate responsibility for the implementation of One Halton lies with the Halton Health & Wellbeing Board, however, in order to deliver our vision and priorities we need everyone who lives and works in Halton to take an active role. We are passionate about improving the health and wellbeing of people living in Halton. Local

residents, statutory, voluntary, community and commercial organisations all have an important role to play in achieving this goal.

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

Integration is key to our strategic approach with all partners working together to deliver:

joint commissioning, culture change through community development, training for all staff in how to deliver health messages so every contact

counts, development of multi-disciplinary teams and joint advocacy and policy work.

A governance structure for One Halton will oversee the development and delivery of our priorities. Specific groups will be responsible for the development of an action plan setting out what all stakeholders will do to deliver the outcomes we want. They will use a life course approach and ensure each action plan includes action to maximise “self-care” prevention and early intervention, provide high quality treatment and care based on need close to home where this is possible and supports people in both the short and long term.

Transformation

Partners across Halton are developing new models of integrated working, based around the two towns of Runcorn & Widnes .These two towns will for this document be referred to as ***Service Delivery Footprints (SDFs).***

The SDFs are effectively a “functional geography” that can help us better plan and deliver our local services. SDF footprints are natural communities that are big enough to base services on but small enough to be sensitive to the populations needs. This work builds on the successful early implementation of hubs either side of the river, with integrated community services such as community nursing, social care in practice, wellbeing practitioners and the development of a single operating model.

Our ambition is for these SDFs to connect a number of services including community health services, GP surgeries, adult social care, housing, schools, children’s services and others. This is about creating integrated working that takes joint responsibility, working with residents, using new conversations, scaling our early intervention work to prevent reactive and unplanned cost, and knowing the assets of the community. services will work together in multi-disciplinary teams to offer early intervention and, if necessary, intensive support to families and individuals who are dealing with issues including mental health; debt; drug and alcohol misuse; domestic abuse; worklessness and long term health conditions.

Some of the potential wider integration could incorporate (but not exclusively):

- Integrated Community Services (including Community Nursing, Therapies and Adult Social Care)
- Primary care out of hospital services (Extended access/Out of hours)
- Mental Health
- Public Health Based Interventions
- Wellbeing
- Health Improvement teams
- Start Well, Live Well, Age Well
- Primary School Alignment
- Housing
- CCG Primary Care Commissioning and Improvement Capacity
- Consultant Outpatient Transitions (Tiers 3 & 4)
- Early Intervention and Prevention Services
- Improving Healthy Lifestyles
- National Probation Service
- Cheshire Fire and Rescue Services
- Alcohol and Drug Treatment Services
- Community Link Workers
- Children's centres
- Nursing and Residential Care
- Admiral (Dementia) nurses


PHARMACY

Design principles and objectives

We will;

- Manage demand for services by promoting self-care independence and prevention;
- Enable health and social care service integration wherever possible and appropriate;
- Design services around users and not organisations;
- Incentivise providers to work together to meet the needs of the whole person;
- Treat people in the home and community for as long as it is appropriate and possible;
- Reduce dependence on oversubscribed and expensive specialist resources such as emergency services, non-elective admissions and care homes;
- Manage length of stay in hospitals, avoid delays to discharge and prevent readmissions where possible;
- Allow system efficiencies to be realised – duplication and over supply is eliminated while “cost shift” from one service line or organisation to another is avoided;
- Create the climate for staff from different professional backgrounds to work together in a positive, open and trusting multi-disciplinary climate;
- Allow every member of staff to be trained in having new conversations with residents that focus on assets rather than need; and
- Make full use of digital technology, including development of a joined-up electronic record

An asset based approach is at the heart of One Halton, enabling staff to have a different conversation with patients and residents to promote self-care and independence and improved links to positive opportunities within the community to improve health and wellbeing.

Scope

NHS Halton Clinical Commissioning Group (HCCG), Halton Borough Council, Bridgewater Community Healthcare NHS Foundation Trust, North West Boroughs Healthcare NHS Foundation Trust, St Helens and Knowsley Teaching Hospitals NHS Trust, Warrington & Halton Hospital NHS Foundation Trust (WHHFT) and local GP federations have come together to develop a One Halton Accountable Care System model for Halton.

In the **first instance** the model will be formed around 2 GP service delivery footprints (SDFs) across Runcorn and Widnes and the integration of health and social care services.

In the **medium to long term** there is an ambition to extend this to integrate with public health and a wider set of public, voluntary and community services, such as leisure, housing and others.

In the **long term** there will be a badgeless provision of services with integration across organisational boundaries, increased investment in community based services and a sustainable primary care.

The approach is place based, based on SDFs using registered GP lists and a whole population budget to deliver a range of services against an agreed set of outcomes.

The scope of the One Halton Programme is to develop the vehicle to support both commissioner and provider integration to deliver a set of improvement outcomes delivering health and social care services across a whole population.


maclaren

Goals

Through this process we will deliver a set of key goals for the health and wellbeing system in Halton;

Goal 1	Goal 2	Goal 3
Services should enable people to take more responsibility for their own health and wellbeing	People should stay well in their own homes and communities as far as possible	When complex care is required it should be timely and appropriate

Prioritisation

It is our desire to change or 'transform' health and social care to make sure the people of Halton get the right care and support, the right way, when and where they need it.

To help us achieve this, we've identified the six themes prioritised within our **One Halton Health & Wellbeing Strategy**:

Our priorities for 2017-2022:

1. **Children and Young People**: improved levels of early child development
2. **Generally Well**: increased levels of physical activity, healthy eating and reduction in harm from alcohol
3. **Long-term Conditions**: reduction in levels of heart disease and stroke
4. **Mental Health**: improved prevention, early detection and treatment
5. **Cancer**: reduced level of premature death
6. **Older People**: improved quality of life

Our priorities contribute to our shared outcomes:

- More Halton children do well at school by reaching a good level of development educationally, socially and emotionally
- Healthy fit workforce to drive economic prosperity with fewer people suffering long term conditions from the age of 50
- More people will be supported to stay well and live independently for as long as possible
- People lead full, active lives using a wide range of facilities within local communities including good quality housing, parks, arts and cultural facilities, leisure services and safe cycling routes
- Reduced demand on services, improved quality and access
- More efficient use of financial resources

Our Commitments

Through signing up to deliver this One Halton Accountable Care Vision we are jointly:

- Taking ownership of where we are now. We all recognise progress has been made but that there is more work to do

- Being responsible for delivering on the agreed priorities and actions set out within our plans
- Making a commitment to make things better. For us to be successful all partners in Halton need to play their part including our local people
- Being accountable for developing systems that deliver more joined up approaches to delivering services

Strong leadership

Leadership is critical in the context of developing integrated systems and services. Stakeholders have different agendas and levels of understanding. A locally tailored leadership programme, supported by management is an essential component of One Halton.

Through our leadership we will talk to staff, ensure they understand the change and are motivated to change at both a strategic level and operational level. We are

committed to work across all agencies with all staff and our population to collaboratively transform services for the future.

Integrated Strategic Commissioning

There is recognition that there are constraints that apply nationally and limit the flexibility in relation to local commissioning arrangements. Commissioning arrangements sit within NHS Halton ~~CCG~~ and Halton Borough Council. We will embrace learning from areas that have progressed in this area and take the opportunities that have arisen.

We will commit to and where permitted to, develop an integrated strategic commissioning function that will develop an alliance contracting model in line with our vision of “one system, one budget, one plan”.

Provider Partnerships (Alliance)

Providers are often constrained by contractual, legal and statutory constraints.
Providers will need to work together to identify and agree who is best placed to deliver the best treatment and care for our population. They will need to agree a set of working principles that align with the national and local agendas.

Financial Resilience

Development and implementation of the detailed proposals will need to be completed from within existing expertise within partner organisations supported by the One Halton Programme Board.

In order to commission integrated services NHS Halton ~~CCG~~ and Halton Borough Council will be responsible for the commissioning budget allocation and the alignment of this to any decisions on pooling financial budgets. Proposals for pooled budgets will need to take into account that “health population” is funded by GP registered lists and LA funding by geographical population.

Partners will need to ensure any future integrated arrangements have robust financial accountability and governance. Estimates of the financial benefits of integration are constrained by the limited nature of the current evidence base.

Co-Located Service Provision (where appropriate)

Providers and commissioners will need to work together to build a community based service provision that supports patients, clinicians and multi-disciplinary workforce. Co-location of service provision should be the ultimate goal in the medium to long term. In the short term consideration of the constraints of existing building stock will need to be considered.

Governance

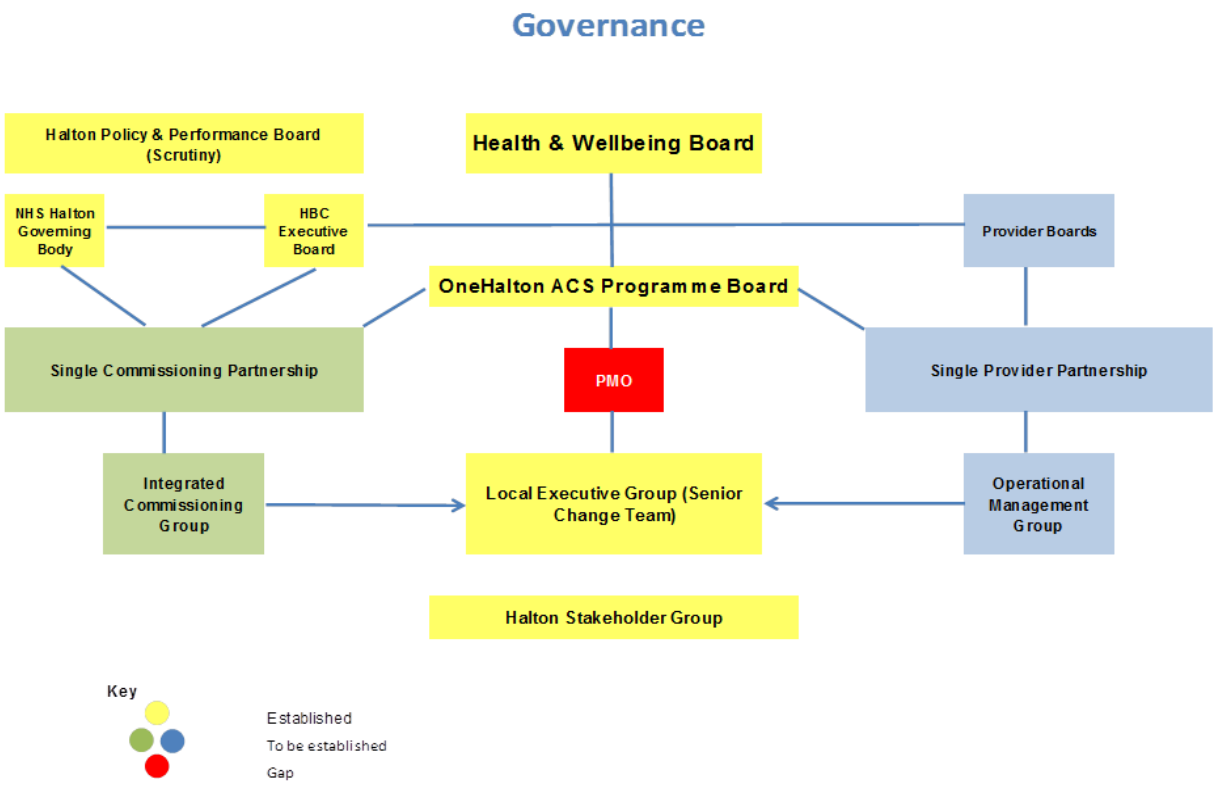
The integration of Health and Social Care in Halton will require the involvement of different commissioning and provider organisations, from both the statutory and non-statutory sector, working together in new ways.

Poor governance arrangements are one of the most frequently cited organisational barriers to successful integration so it will be vitally important to the success of this programme that robust governance arrangements are in place to oversee the delivery and evaluation of this complex work programme.

The following strategic groups and Boards will ensure effective governance of the programme:

- Halton Health and Wellbeing Board
- Halton Policy & Performance Board (Scrutiny)
- NHS Halton Governing Body
- Halton Borough Council Executive Board
- One Halton Accountable Care System Programme Board
- One Halton Single Commissioning Partnership
- One Halton Single Providers Partnership
- Local Executive group
- Halton Stakeholders group
- Engagement & Involvement of Population

Each agreed work stream will have a separate project group that will report into the One Halton Programme Management Office (PMO) reporting to the One Halton ACS Programme Board. Terms of reference and memorandum of understanding for the One Halton ACS Programme Board is attached in appendix 1. Each group will develop its own work plan to achieve the stated outcomes. Part of this work will involve engaging service users and residents in the co-production of new approaches. Project leads will also ensure alignment of activity with existing enabling programmes/groups.



Project implementation plans will be created which will form the basis of the monitoring process. This will be updated by the One Halton PMO as the project progresses, and referenced by the highlight reports. Regular reporting will be via a monthly highlight report, and will be produced by the programme/scheme lead to show actual and projected progress against plan.

The report will be submitted to the One Halton ACS Programme Board on a bi-monthly basis.

Project planning and control

The overall control of the project will be in line with Prince 2 methodology and adopts the “manage by exception” approach.

The Senior Responsible Officer (SRO) will have oversight of the whole programme and will be held to account by the Chief Executive Officer of Halton Borough Council and the Interim Chief Officer of NHS Halton CCG. The programme manager (when appointed) will carry out day-to-day management of the project within the delegations of authority.

Members of the project Team will raise or review project issues/changes/risks at the monthly project meetings. Project issues and risks will be reviewed and assessed for impact against the project timescales, cost and quality.

Programme approach

- Current services have been reviewed and evaluated against a number of criteria to establish which services should be in scope for the first phase of implementation.
- Phase 1 identifies the core services within the initial scope.
- Work is already progressing on these programs to redesign care pathways and integrate services from the bottom up.

Benefits & Outcomes

People will be supported to live longer healthier lives.
People with health and/ or social care needs will know how to navigate the health and social care system;
People with health and/or social care needs will be able to access the right information at the right time and will be able to access the support they need;
People will have an increased understanding of the benefits of wellbeing and will utilise local community resources to put this into practice;
People in local communities will have a range of locally grown support mechanisms such as carer led support groups, patient led self-management groups for long term conditions;
Through social prescribing GPs will support people to get to the right support and avoid more expensive and often unnecessary interventions;
Integrated teams will work closely with GP practices and will envelop individuals and work closely with provider services including local community and voluntary sector services;
People with long term conditions will have the ability to hold their own personalised care records and use Personal Budgets and Personal Health Budgets to manage their own care;
People with long term conditions and those defined at risk will have the ability to see and share their health and social care records;
People will be able to have repairs, adaptations and improvements made to their homes quickly and within timescales acceptable to them;
Carers will be supported to have a life outside of caring and will be supported in their caring role;
There will be improved access to services (parity of esteem) for all patients/clients, including children and young people, with mental health issues. Mental health conditions will be treated and assessed on a par with physical conditions;
Over time we will create a flexible workforce that can deliver more than one service for the benefit of patients and carers and the health and social care

system;
We will manage demand for unplanned, emergency and urgent care services across the Borough where people choose the right place first time every time.
We will have greater control of our local pound and annual spend.
There will be Improved Value for Money through identifying cross-organisational efficiencies and economies of scale
Maintain financial resilience & sustainability of the Halton Health and Social Care System

NHS
Halton
oup

Appendix 2: Memorandum of Understanding

One Halton Accountable Care System Board

Draft Memorandum of Understanding

The signatories to this MoU have come together to improve health and wellbeing services for local people and to encourage self-health.

In doing so we are committed to:

- Improving health and wellbeing outcomes for local people
- Collaboration between health and social care services, providing accessible high quality services to local people
- Developing new ways to prevent and better detect illness
- Reducing the levels of demand on hospital, acute care and healthcare services generally
- Delivering service closer to home and within local communities

Our Commitment

We agree to the following principles in the development of an integrated health and social care eco system in Halton Borough:

1. We agree that an integrated system of health and social care is the best way to ensure optimum health, wellbeing and care outcomes for our population and to ensure collective financial sustainability.

2. We agree that the Halton Health & Wellbeing Strategy provides the focus for our work together and sets out our vision to work together to reform health and social care services to improve the health outcomes of our residents and reduce health inequalities, as quickly as possible,.

3. We agree the One Halton ACS Board will provide a focal point for prevention and early intervention, proactively identifying potential future demand and shifting the focus from unplanned and reactive services to planned and targeted interventions.

4. We agree to put patients and residents at the heart of what we do.

5. We agree to put General Practice and other community practitioners at the centre of our care model.

6. We agree to design and plan services around functional geographical footprints with populations of 30,000 to 50,000 based on registered patient lists.

7. We agree to design services for users and not our organisational needs.

8. The Commissioners agree to deliver a single approach to commissioning health, wellbeing and care services in order to transform services and improve outcomes. This will enable collaboration integrated working and include the development of pooled budgets.

9. We agree that we will consider the options available to us, and select the best delivery model for the integrated care system in Halton, but not withstanding this, we will continue to integrate our services on the ground, at pace, using the existing options available to us to do so.

10. We acknowledge that creating a Locality Care Partnership will not resolve the significant budget challenges facing all organisations but it will go some way to reducing it and it will be necessary to continue to work closely together with all stakeholders to manage the deficit around health and social care

Asset Based Approach

11. We agree in an asset based approach to the design and delivery of our integrated services including:
    a) A commitment that staff delivering services in Halton will be trained and updated in having new conversations with residents that focus on assets rather than need.

    b) Managerial arrangements within our organisations create the climate for staff from different professional backgrounds to work together in a positive, open and trusting climate

    c) That people are supported to be in control of their own lives

    d) That services are co-ordinated in a place, in a way, that is informed by a deep understanding of the community assets and capability in that place to support residents to be connected to their community and each other.

    e) That service administration is organised in agreed functional geographical footprints, allowing alignment with key service providers organised on the same footprint.

    f) That the partnership encourages its workforce to be positive, courageous and accountable in the way they deliver their services to the public.

g) That our partnership embraces positive risk taking and permission based working, with the workforce liberated to demonstrate innovation and creativity on a daily basis.

Governance

12. We agree to working together to reform health and social care services to improve health outcomes for residents, as quickly as possible, and enable system wide change to develop transparent, robust and inclusive governance structures.

13. The key principles of our governance arrangements will be:

a) The objective of providing governance arrangements which aim to provide streamlined decision making; excellent co-ordination of services for the residents of Halton; mutual co-operation; partnering arrangements, and added value to the way we deliver our services.
b) An acknowledgement that the arrangement does not affect the sovereignty of any party and the exercise and accountability of their statutory functions.
c) A commitment to open and transparent working and proper scrutiny and challenge of the work of the One Halton Accountable Care Services Board and any party to the joint working arrangements.
d) A commitment to ensure that any decisions, proposals, actions whether agreed or considered at the One Halton ACS Board carry with them an obligation for the representative at the One Halton ACS board to report these to their own constituent bodies, and seek agreement if required through the appropriate governance route.

14. We agree that the governance arrangements will be kept under regular review and be revised from time to time to reflect the changing status of the integrated care delivery vehicle.

15. We agree that any decision affecting the statutory duties of an organisation will be referred through that organisation's governing processes.

16. We agree to provide mutual assurance to the constituent bodies and that the minutes of the One Halton ACS board will be circulated to the Boards of the constituent bodies.

Resources

17. We agree to the formation of the One Halton ACS PMO to manage the implementation of our work programme, with a commitment to seek resources and expertise from partner organisations, as appropriate, to support our integration journey.

18. We agree to use the assets and resources available to us within our organisations, such as buildings, IM&T and other infrastructure to support the adoption and enablement of integrated working arrangements.

19. We agree to work together to transform our collective workforce to ensure we have the right skills, capabilities and resources to deliver sustainable integrated working arrangements across health and social care now and in the future.

Appendix 3: Terms of Reference

One Halton Accountable Care Programme Board

Terms of Reference

The *One Halton* Accountable Care Programme Board (One Halton ACPB) is a forum for development and partnership working. It is not a decision making body but will seek delegated decision-making responsibilities from Joint Committee status at a later stage. For any strategic and/or significant decision-making, Programme Board members will be expected to make recommendations to appropriate bodies and committees.

Overall Objective

To secure, via partnership working, the provision of system leadership and meaningful engagement in the development of the *One Halton* Accountable Care System. This aims to secure sustainable, high quality services which meet patient needs and optimise the health of the borough, delivering organisational sustainability.

Membership (to be confirmed)

Chief Executives / Chairs / Clinical Executive Officers from the following organisations:-

- Independent Chair
- NHS Halton Clinical Commissioning Group
- Halton Borough Council
- GP Health Connect
- Widnes Highfield Health Ltd
- St Helens & Knowsley Teaching Hospitals
- Warrington & Halton Hospital NHS Foundation Trust
- Bridgewater Community Healthcare NHS Foundation Trust
- North West Boroughs Partnership NHS Foundation Trust
- Halton & St Helens Voluntary and Community Action
- Halton Housing Trust
- Halton 3rd sector consortium (rota basis)

Key Tasks

- To ensure effective leadership in the *One Halton* AC Programme, ensuring SMART plans for future service models and that are ambitious, sustainable and achievable;

- To make recommendations for actions as appropriate to Halton Health & Wellbeing board but not to take decisions which are binding on other organisations;

- To ensure alignment between the *One Halton AC* Programme and the plans for each organisation, highlighting any tensions or interdependencies, and agreeing with all how these should be resolved;

- To ensure key staff from each constituent organisation are enabled to participate in the Programme work streams;

- To review the results of the programme at the end of Phase 1, and to advise on how these are taken forward;

- Develop and deliver a strategic vision for Halton with an agreed set of co produced outcomes;

- Support the development of a shadow integrated commissioner and local delivery partnership by 2018.

Reporting Arrangements

The *One Halton* AC Programme Board will meet on a bi-monthly basis. Standard progress reports will be produced for presentation to all relevant committees to ensure consistency of message.

It will be accountable to the Halton Health and Well Being Board

Administrative Support

NHS Halton CCG

Review Date

November 2017