HALTON BOROUGH COUNCIL

NHS

Halton Clinical Commissioning Group

Supporting Evidence Paper for

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

&

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

myhalton living life well

Foreword

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Care Act 2014

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

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

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

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

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

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

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

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

Health and Social Care Act 2012

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

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

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

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

Fair Society, Healthy Lives

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

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

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

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

National Service Framework for Long-term (Neurological) conditions

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

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

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

Vision 2020

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

The aims of the *UK Vision Strategy 2013-2018: Setting the direction for eye health and sight loss services*[12] are supported by UK governments, and implemented through a strong alliance of statutory health and social care bodies, voluntary organisations, eye health professionals and individuals.

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

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

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

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

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

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

Public Health Outcomes Framework 2013-2016

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

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

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

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

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

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

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

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

The Funding streams that were available were:

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

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

Making It Real - Personalisation (Self Directed Support)

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

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

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

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

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

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

The Welfare Reform Act 2012 and resilience to the economic downturn

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

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

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

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

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

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

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

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

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

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

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

Part Three: Disability in Halton

Halton's Vision

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

Halton Core Strategy Local Plan

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

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

Halton Priorities

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

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

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

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

- Environment and Regeneration in Halton

Corporate Plan

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

Health and Wellbeing Board and Strategy

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

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

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

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

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

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

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

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

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

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

Integrated working

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

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

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

- joint commissioning

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

Better Care Fund (formerly Integration Transformation Fund)

Government believes that*:*

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

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

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

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

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

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

[19] Spending Review 2013, HMT

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

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

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

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

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

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

The strategic aims of the plan are:

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

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

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

Urgent Care Partnership Board

Admissions data needed

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

The Department of Health defines what urgent care is:

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

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

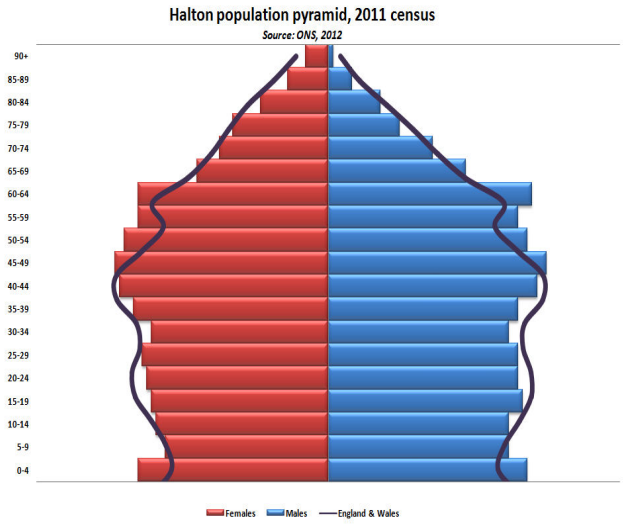
Current focus of work is the development of an Urgent Care Centre in both Widnes and Runcorn to offer community based diagnosis and treatment of conditions to prevent deterioration of health and avoid inappropriate attendances at Accident and Emergency Departments. The Centres should be operational in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

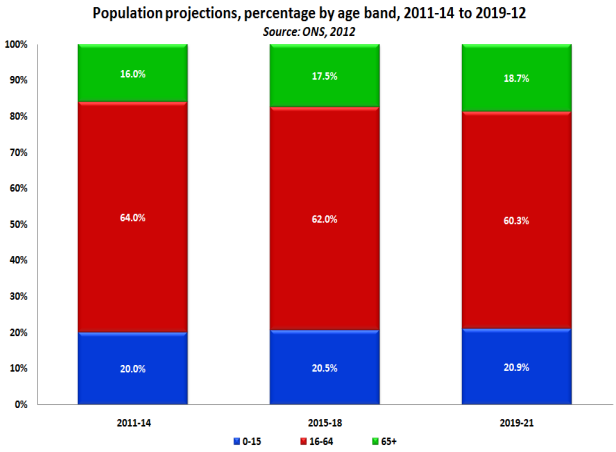
Halton's Demographic Information

Population

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

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





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

Deprivation

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

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

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

Health

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

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

Numbers of disabled people in Halton

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

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

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

Young disabled people

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

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

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

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

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

Young People with identified social care needs as adults

Age at 31st August 2014

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

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

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

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

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

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

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

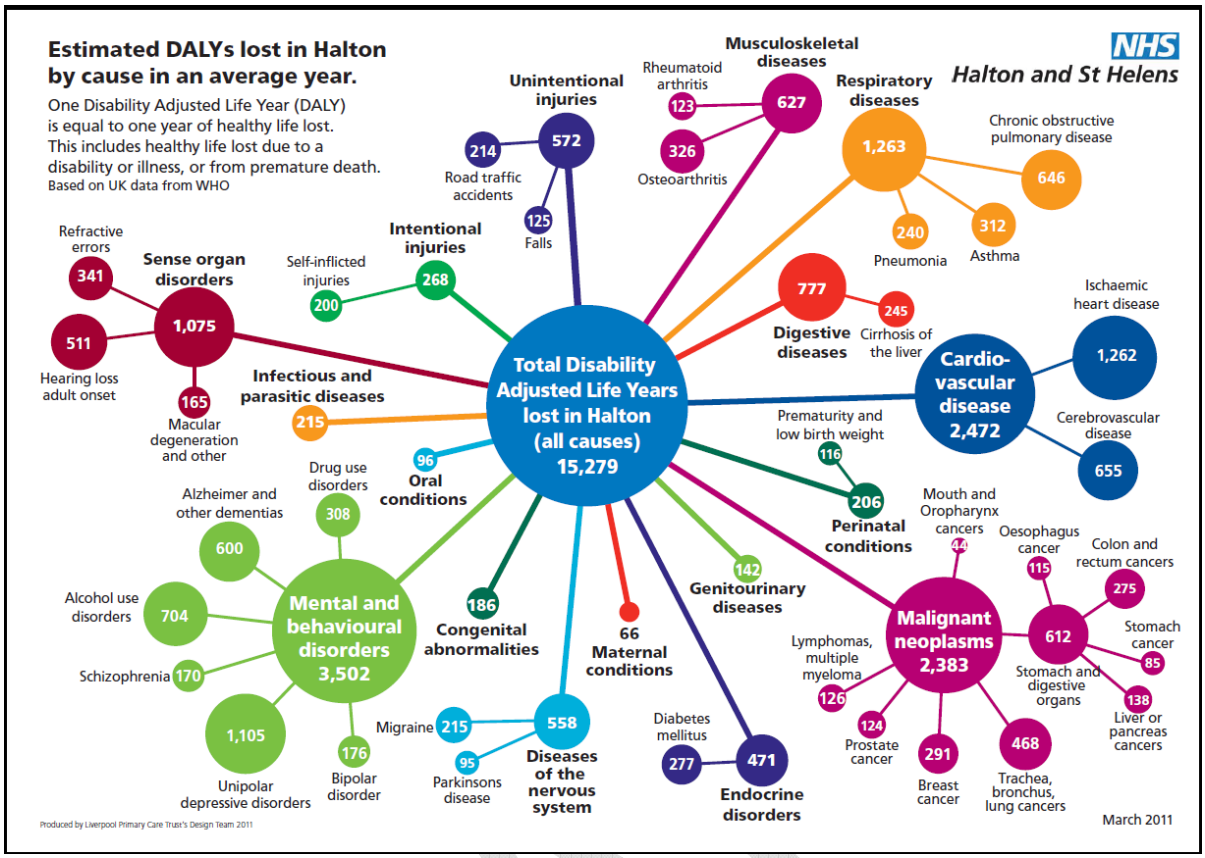
As life expectancy continues to increase in the UK, it is important to ask what proportion of these additional years of life are being spent in favourable states of health or in poor health and dependency. The figures represent a snapshot of the mortality and health status of the entire specified population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

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

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

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

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



Disability and Impairment

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

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

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

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

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

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

Disability and health

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

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

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

Disability and Secondary Health Conditions

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

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

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

Long Term Conditions (LTC) and Limiting long standing illness

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

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

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

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

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

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

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

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

Long Term Conditions and Mental Health

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

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

Long-term neurological conditions (LTNCs)

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

LTNCs can be broadly categorised as follows:

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

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

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

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

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

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

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

Promoting Equality and Reducing Inequality

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

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

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

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

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

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

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

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

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

- Although the gap in non-decent accommodation has closed over recent years, one in three households with a disabled person still live in non-decent accommodation

Fulfilling Potential identifies the following aspects to reducing inequality for disabled people:

- Access to housing
- Environmental barriers

[37] www.odi.dwp.gov.uk/disability-statistics-and-research/disability-facts-and-figures

- Transport
- Social participation
- Choices
- Information
- Public Attitudes

There have been significant improvements in educational attainment, in the employment rate and a reduction in the employment rate gap between disabled and non-disabled people. There have also been improvements in other factors contributing to quality of life, for example in access to transport and access to goods and services. Even so, disabled people can still face significant barriers to fulfilling their potential and playing a full part in society[38].

Through its enabling role the Council works with local communities on service developments, facilities and resources to ensure they promote equality through inclusion and equitable treatment whilst eliminating discrimination and advancing equality of opportunity for disabled people.

Employment

Disabled people are more likely to be long term unemployed and economically inactive. Fulfilling Potential highlights that 60% of disabled working-age adults are not in paid work compared to only 15% of their non-disabled counterparts. A third of these people - 1 million people - say that they want to work but that they have not been able to find a job.

The Labour Force survey provides an insight into numbers of disabled people who would like to work. It categorises the unemployed working age population into two groups:

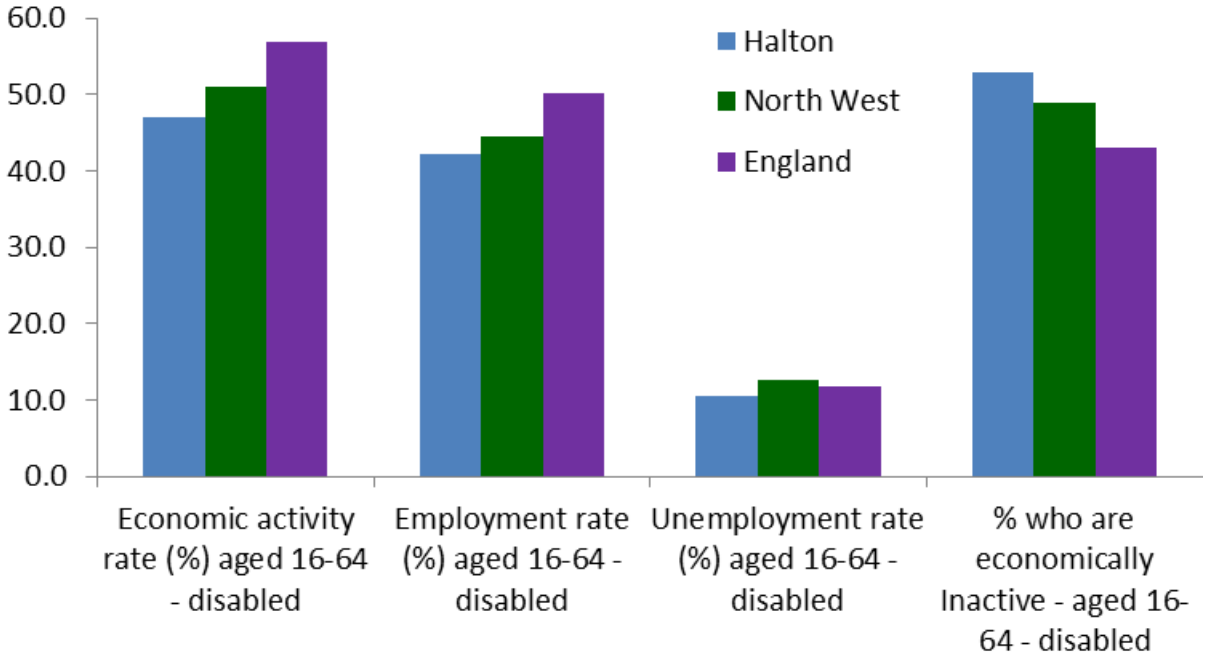
- **Unemployed** includes only people who are: without a job, but want a job, are seeking a job, and available to work.
- **Economically Inactive** includes all other people who are out of work (the highest reason for these… around a third of this group are out of work due to 'long term sick').

In Halton we have a larger proportion of people who are economically inactive (disabled or not-disabled), than NW and England. This is mainly explained by those who are 'long-term sick' as Halton has a higher proportion of people reporting this.

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

The proportion of disabled people in Halton who are 'without a job, but want a job, are seeking a job, and available to work' is lower than the North West and England. It is however 800 local people who would like to work.

Economic activity and unemployment, disabled group, Halton, NW and England (Apr-12 to Mar-13)



Accessible Homes

The need for accessible properties for adults of working age and older people is considered in the Halton Housing Strategy 2013-18. The Council has responded to this identified need and Naughton Fields now open and Barkla Fields currently in development offer 97 Extra Care housing units.

Property Pool Plus hosted by Halton Housing Trust is an approach to allocating property, which gives home seekers greater control over the property they are offered as it requires them to express an interest in homes which are advertised locally. Analysis of registrations indicates numbers of families, adults and older people currently waiting for accessible accommodation:

Accessible accommodation needs logged on Property Pool Plus May 2014

	1BED	2 BED	3 BED	4+ BED
Families with disabled children requiring specialist wheelchair housing			3	1
Families with disabled parent/adult requiring specialist wheelchair housing		2		
Older people requiring specialist wheelchair housing	3	2		
Older people requiring Sheltered or Extra Care specialist wheelchair housing	1	2		
Adults requiring specialist wheelchair housing	3	1		
Older people requiring Sheltered or Extra Care	10	1		

Learning Disabilities and secondary long term conditions

There are estimated to be 1.14m people with learning disability in England[39] and evidence shows that people with learning disabilities on average die 5 to 10 years younger than other citizens, often from preventable illnesses. People with learning disability face inequalities in health status and some evidence suggests the prevalence of asthma is twice as high amongst those with learning disabilities and epilepsy is 25 times more likely to occur, being present in around 1 in 4 (24.9%) of all adults with a learning disability, compared to only 1% of the general population.[40]

This poorer physical health, means people who are already exceptionally socially excluded – on every measure from education and employment to housing and social networks – often face the additional challenge of diabetes, heart disease or other long term condition. This makes it harder to participate socially and economically and harder to play an active, valued role in family and community.

The Halton Adults with Learning Disabilities Strategy currently in development considers the health and support needs of this vulnerable group arising from both their learning disability and physical health needs.

[39] People with learning disabilities in England 2012 IHAL

[40] Full Summary and Recommendations: Learning disabilities and autism: A health needs assessment for children and adults in Merseyside and North Cheshire. Liverpool Public Health Observatory

Loneliness, Social Isolation, Depression

Whilst 'social isolation' and 'loneliness' are often used interchangeably, people attach distinct meanings to each concept[41]. 'Loneliness' is reported as being a subjective, negative feeling associated with loss (e.g. loss of a partner or children relocating), while 'social isolation' is described as imposed isolation from normal social networks caused by loss of mobility or deteriorating health. Although the terms might have slightly different meanings, the experience of both is generally negative and impacts upon individuals' quality of life and wellbeing, adversely affecting health and increasing their use of health and social care services.

The different issues faced by disabled people are inter-linked. In the working age population for example, low educational attainment can lead to poor employment outcomes. Not having a job can be associated with poverty and social isolation. Experiencing barriers to transport can result in not being able to get to work or education.

Estimates of prevalence of loneliness tend to concentrate on the older population and they vary widely, with reputable research coming up with figures varying between 6 and 13 per cent of the UK population being described as often or always lonely[42]. There is growing recognition that loneliness is a formidable problem which impacts on an individual's health and quality of life and even on community resilience. There is increasing evidence that people who are lonely are more likely to use health and social care services and a developing confirmation, through personal stories, of the emotional costs and misery that loneliness can cause.

People with poor physical health are at higher risk of experiencing common mental health problems, and people with mental health problems are more likely to have poor physical health.

Physical illness is associated with increased risk of depression:

[41] http://www.scie.org.uk/publications/briefings/files/briefing39.pdf

[42] http://www.ageuk.org.uk/documents/en-gb/for-professionals/evidence_review_loneliness_and_isolation.pdf?dtrk=true

- Depression is three times as common in people with end-stage renal failure, chronic obstructive pulmonary disease and cardiovascular disease as in people who are in good physical health.
- Depression affects 27% of people with diabetes, 29% of people with hypertension, 31% of people who have had a stroke, 33% of cancer patients and 44% of people with HIV/AIDS.[43]
- People who experience persistent pain are four times as likely to have an anxiety or depressive disorder as the general population.
- Depression is more than seven times more common in those with two or more chronic physical conditions.

These issues are explored further and actions proposed in *A Mental Health and Wellbeing Commissioning Strategy for Halton.*

Carers

There are 5.8 million unpaid carers in England and Wales (Census 2011) and adults with impairments are likely to be carers themselves (15 percent of adults with impairments provide informal care compared with 8 percent adults without impairment)[44] Adults with impairments are more likely to spend longer hours caring for others than adults without impairment and the majority of carers in Halton spend more than 19 hours in their caring role with a significant number providing more than 50 hours of care per week.

Table 7: Unpaid care hours per week

	1-19 hours	20-49 hours	50+ hours
Number of carers	8,009	2,440	4,569
Halton %	6.4	1.9	3.6
England %	6.5	1.4	2.4
North West %	6.4	1,6	2.0
Ranking	247th	10th	12th

Source: ONS Census data 2011

[43] Mental Health Foundation The fundamental Facts 2007
[44] Life Opportunities Survey Wave 1 2009/11

From 2008 to 2022 the number of disabled older people with informal care (in households) will rise by 39%. Many of these informal carers will be of working age now and it is imperative they receive support to maintain their own health and wellbeing to carry on this role.

Caring can impact on the health of the carer and when this is compounded with an existing impairment can seriously diminish quality of life and mental wellbeing. The latter is addressed within *A Mental Health and Wellbeing Commissioning Strategy for Halton* whilst the *Carers Action Plan* considers support for the caring role.

Prevention

The primary aim of the prevention agenda is to offer support and early interventions to avoid the high cost hospital admissions and crisis management. There are a range of generic low-level services provided across the Borough ranging from information and advice services and exercise groups to intermediate care and rapid response services delivered through strong partnership working across the CCG, Council and the voluntary sector. Many of these services are accessed by younger adults but could offer people with long term conditions effective ongoing support to live their everyday lives and should form part of the care pathway for re-enablement and self–management of the condition.

Personalisation and Co-production

Co-production emphasizes that people are not passive recipients of services and have assets and expertise which can help improve services. At an individual level this is generally referred to as personalised support developed in conjunction with health and social care professionals. In Halton this means:

…*everyone having choice and control over the shape of their support, along with a greater emphasis on prevention and early intervention*.

Co-production goes further than this by offering a broader model of active citizenship, equality and mutual support. Collaboration between the Council and Halton CCG, the voluntary sector and other community partners to identify and work through local challenges and opportunities will enable transformative, innovative local solutions to be developed based on the in-depth knowledge of local citizens who know what is required.

Advanced decision making and end of life care

All decisions about care and treatment interventions should be made jointly between the individual and professionals. For those who do not have legal capacity or may lose that capacity in the future it is important that the right choices are made. Decisions must be centred on the individual and minimise the likelihood of unnecessary or unwanted interventions.

Professionals should encourage individuals with degenerative illness to think about their prognosis and options for how this is managed. The person is then in a position to decide what is best for them and to communicate their wishes to professional staff and family members.

These conversations are not easy and families may disagree with the individual's decision. Staff should receive appropriate training in how to approach these discussions.
All decision

Part Four: Sensory Impairment

Commissioning of support for sensory impairments is across all age groups and includes varying degrees of sight loss, hearing loss and loss of both senses:

Visual impairment (severely sight impaired to partial sight loss)

Hearing impairment (profound deafness to partial hearing loss)

Deafblind (dual sensory impairment)

Evidence shows significantly higher prevalence of sensory loss in areas with higher levesl of socio-economic deprivation and this effect is more prominent in younger people.

In Halton, there is a small decline (1.4%) in the numbers of working age adults with sensory loss. However, there is a significant rise in numbers aged 65+ due to age related conditions in an aging population. Around 30% of those reporting either a hearing or visual impairment and 60% of those reporting dual sensory loss in those over age 65 have at least four long term conditions and feel less confident in managing their own health[45].

The Chief Medical Officers report also shows that the proportion of 55-84 year olds with deafness or blindness who report dementia or Alzheimer's disease is substantially greater than those reporting neither deafness nor blindness. This association is not understood but may have implications for the prevention and management of dementia.

Visual Impairment

The term "sight loss" has been used as an inclusive term to cover all people who are blind or partially sighted, including people who have no sight from birth, people with sight loss at certifiable levels and people with sight loss below these levels. This does not imply that the needs and requirements of people within these different groups are the same.

[45] Annual /report of the Chief Medical officer (DH 2014)

Sight loss is a major health issue affecting about 2 million people in the UK the majority of which are older people. This figure includes around 360,000 people registered as blind or partially sighted in the UK, who have severe and irreversible sight loss.The number of people in the UK with sight loss is set to increase dramatically and it is predicted that by 2050 the number of people with sight loss in the UK will double to nearly four million[46].

Sight loss and eye health costs the UK economy at least £8 billion each year.[47] Thousands of people lose their sight each year and it is estimated that 50% of sight loss is from avoidable causes.[48]

Sight loss affects people of all ages but especially older people: 1 in 5 people aged 75 and 1 in 2 aged 90 and over are living with sight loss. At all ages there is a significant trend for higher prevalence in areas of socio economic deprivation. This may be related to differences in exposure to risk factors for sight loss. There is an association between age-related macular degeneration and smoking and smoking levels are higher in more deprived areas.[49] There are more women (59%) than men reporting blindness though the reason for this is unclear. It may be partly explained by demographics as sight loss is age related and there are more women than men in the older age groups.

Causes of visual impairment in the UK are changing with disability adjusted life years (DALYs) attributable to glaucoma and macular degeneration increasing by 50% over the last 20 years and those attributable to cataract decreasing.

In Halton the prevalence of sight loss is reducing slightly amongst the working age population but by 2020 there is a projected 21% increase (an extra 460 people) in those aged over 65 with severe hearing impairment. These figures are significantly higher than the predictions for the North West (16.8%) and England (19.1%)[50].

Consultant ophthalmologists in an eye clinic complete a Certificate of Visual Impairment and forward a copy to social services who then offer registration and other relevant advice and support. Halton's maintains register shows 250 people are registered blind and 345 people

[46] Access Economics, 2009
[47] RNIB, 2013
[48] Access Economics, 2009
[49] Annual Report of the Chief Medical Officer (DH 2014)
[50] www.pansi.org.uk

are registered partially sighted. 79% of registered blind and partially sighted people are also recorded as having an additional disability

Sight loss has a significant impact on quality of life and independence by increasing vulnerability to social isolation, depression and falls. However some important causes of vision impairment, such as glaucoma, are treatable if detected early. Investment in public awareness of eye health, early detection and treatment of eye conditions can have a significant impact on people's quality of life. Prevention of sight loss reduces or avoids the need for health, social care, education and training to support people in the later stages of eye disease.

Eye health has been recognised as a national priority and is included in the Public Health Outcomes measures. Effective health promotion and improvement initiatives are key to promoting the importance of eye care and to reduce levels of preventable sight loss.

The provision of emotional and practical support at the right time can help people who are experiencing sight loss to retain their independence and access the support they need. Visual impairment rehabilitation is an early intervention delivered by specialist professionals to help people to maximise their functional vision and skills for confident daily living.

Children and Young People

There are almost 25,000 blind and partially sighted children in Britain. That is equal to 2 in 1,000 children and as many as half of these children may have other disabilities.

Halton's JSNA estimates how many children and young people are blind or partially sighted in the Borough. This figure is 53 0-16 year olds and 29 17-25 year olds. [51]

Sight loss in children is attributable to numerous causes and often is part of a wider picture of childhood disability. The report, 'Sight Impaired at Age Seven'[52], reveals worrying differences between children with sight loss and their sighted peers around happiness, success at school, financial hardship and social inclusion. The findings show that sight loss can have a major impact on every aspect of a child's development and that without the right support many are at risk of being less confident, having fewer friends and under performing at school. However, the results also indicate that with the right kinds of early intervention, blind and partially sighted children can flourish.

[51] Halton Children's Joint Strategic Needs Assessment 2014
[52] https://www.rnib.org.uk/aboutus/Research/reports/education/Pages/sight_impaired_age_seven.aspx

Working Age Adults

Historically the leading cause of blindness in the UK working population was diabetic retinopathy but is no longer the leading cause of certifiable blindness among adults aged 16-64 having been overtaken by inherited retinal disorders. This change may be explained by the introduction of nationwide diabetic retinopathy screening programmes and improved glycaemic control [53].

Employment rates for people with sight loss are consistently lower than the general population and two-thirds of people living with sight loss say that they experience restrictions in being able to access and fully participate in employment.[54] The Chief Medical Officers annual report suggests less than 30% of those with blindness are in employment. Many registered blind and partially sighted people reported the main reason for leaving their last job was onset of sight loss or deterioration in their sight.

Older People

Evidence suggests 50-70% of sight loss in the older population is due to preventable or treatable causes including: age-related macular degeneration, glaucoma and diabetic retinopathy. 1 in 5 people aged 75 years and 1 in 2 aged 90 years or over is visually impaired

In Halton between 2012 and 2020 there is a predicted 22% increase (an extra 360 people) with serious visual impairment amongst those aged over 65. This is significantly higher than both the North West (16.8%) and England (19.1%) figures. Those aged over 85 are most at risk of eye disorders causing vision impairment.

Evidence suggests that there is a strong link between sight loss and reduced psychological wellbeing, particularly amongst older people who develop sight loss later in life.[55] People living with sight loss report lower feelings of wellbeing, reduced self-confidence and lower satisfaction with their overall health.

[53] http://bmjopen.bmj.com/content/4/2/e004015.full
[54] UK Vision Strategy – A case for change 2013-2018
[55] UK Vision Strategy A Case fro Change 2013-2018

Impaired vision is a recognised risk factor contributing to falls in older people. This can be for a number of reasons including[56]:

- Change in gait of those with sight loss
- Sight loss reduces mobility which impacts on balance increasing risk of falling
- Wearing multi-focal glasses
- Changes in the home environment – e.g. moving furniture

It is suggested that generic falls prevention programmes and strategies may not work for those with visual impairment and that a different approach should be adopted with a focus on the home environment, lighting and colour schemes.

Social Inclusion and Mobility

Over one-third of people with sight loss say that they have little or no choice about how they spend their free time. This includes activities such as going on holiday, playing sport, visiting friends or family or undertaking voluntary work. Half of people with sight loss experienced difficulties getting into and moving around buildings.[57]

Travel is a crucial element of independence and inclusion, but for many blind and partially sighted people travelling is a challenge. This can result in blind and partially sighted people being trapped at home and can lead to isolation, reduced wellbeing and low confidence. Nearly two-thirds of blind and partially sighted people say that because of their sight loss they need help to get out of the house

More broadly, the needs of blind and partially sighted people are often not taken into account by designers or planners. For example, the design of transport systems, signage, labelling, public buildings and shared space environments often fail to take into account the needs of people with sight loss.[58] Half of people with sight loss say they experience difficulty getting into and moving around buildings.

Support for those with sight loss

People with sight loss should be able to make informed choices about their lives. Access to support and services should enhance independence and wellbeing and provide opportunities to learn and work. But evidence tells us that people with sight loss continue to

[56] http://www.pocklington-trust.org.uk/Resources/Thomas%20Pocklington/Documents/PDF/Research%20Publications/RDP%2012_final.pdf

[57] Sight Loss UK 2013 RNIB

[58] RNIB 2011

face restrictions and barriers in accessing services. Tasks that most of us take for granted, such as catching a bus or shopping for everyday necessities, can provide major challenges for blind and partially sighted people.[59]

"Seeing it my way"[60] is an initiative to ensure that every blind and partially sighted person, regardless of age, ethnicity, extent of sight loss, other disabilities, or location across the UK, has access to the same range of information and support.

Living with little or no sight requires access to a range of information and support from a number of services, such as social services and voluntary sector organisations in order to live independently. This includes information in a format that people can read, rehabilitation for people who lose their sight so they can gain the skills and confidence to carry out day-to-day tasks and get around easily.

Seeing it my way sets out a range of outcomes, that is specific changes that blind and partially sighted people have told us are most important to them and want to make a reality.

'Seeing it my way' has 10 outcomes:

1. That I have someone to talk to.
2. That I understand my eye condition and the registration process.
3. That I can access information.
4. That I have help to move around the house and to travel outside.
5. That I can look after myself, my health, my home and my family.
6. That I can make the best use of the sight I have.
7. That I am able to communicate and to develop skills for reading and writing.
8. That I have equal access to education and lifelong learning.
9. That I can work and volunteer.
10. That I can access and receive support when I need it.

Hearing Impairment

The term "hearing loss" has been used as an inclusive term to cover all people who are deaf or hard of hearing, including people who are deaf from birth and people with mild hearing

[59] McManus and Lord, 2012
[60] http://www.vision2020uk.org.uk/ukvisionstrategy/page.asp?section=301&sectionTitle=Seeing+it+my+way

loss and profoundly deaf. This does not imply that the needs and requirements of people within these different groups are the same.

For around 15,000 people in the UK their first language is British Sign Language (BSL). BSL is a visual form of communication using hands, facial expression and body language mainly used by people who are Deaf. BSL is a fully recognised language and is independent of spoken English.

Normal ear function is important not only for hearing but also balance and any impairment compromises a person's ability to interact socially and with the environment. Loss of balance impacts on abilities to walk and drive making them difficult to impossible. The primary cause of hearing loss is age related damage occurring naturally as part of the ageing process. Other causes and triggers include:

- Regular and prolonged exposure to loud sounds
- Ototoxic drugs that harm the hearing nerve
- Infectious diseases such as rubella
- Complications at birth
- Injury to the head
- Benign tumours of the auditory nerve
- Genetic predisposition – half of childhood deafness is inherited

One in 6 of the UK population, more than 10 million people have some form of hearing loss. Of this figure 3.7m are working age (16-64) and 6.3 aged over 65. More than 800,000 people are severely or profoundly deaf. The prevalence of hearing loss is growing and the Medical Research Council estimates it will increase by 14% every 10 years. By 2031 there will be 14.5 million people with hearing loss in the UK.

The WHO predicts that by 2030 adult onset hearing loss will be in the top 10 disease burdens in the UK above diabetes and cataracts (See DALY chart in Part 3)

In Halton the prevalence of hearing loss is reducing slightly amongst the working age population but by 2020 there is a projected 22% increase (an extra 1700 people) in those aged over 65 with moderate, severe or profound hearing impairment. These figures are again significantly higher than the North West (17.5%) and England (19.8%) predictions. There is a north/south imbalance in prevalence of deafness with rates being higher in the

north. This is believed that this reflects the concentration of noisy industry in the north when those now in their 70's and 80's were at the start of their working lives[61].

There is no cure for hearing loss and those who experience it are also likely to have other problems such as tinnitus and balance disorders which contribute as risk factors to falls and other accidental injuries.

Dual sensory impairment (Deafblindness)

The term dual sensory impairment can be used interchangeably with deaf blindness; denoting the fact that combined impairment of sight and hearing are significant for the individual, even though they may not be profoundly deaf or totally blind and each of the impairments may appear to be mild. The loss of both senses affects communication difficulties, getting around safely and access to information.

The Coppersmith Matrix provides a visual representation of the intersections of sight and hearing impairment:

<table>
<tr><td></td><td>HEARING</td><td>HARD OF HEARING</td><td>DEAF</td></tr>
<tr><td>SIGHTED</td><td>Hearing and Sighted</td><td>Hard of hearing
"Normal" Vision</td><td>Deaf
"Normal" Vision</td></tr>
<tr><td>PARTIALLY SIGHTED</td><td>Partially sighted
"Normal" Vision</td><td colspan="2" rowspan="2">DUAL SENSORY IMPAIRED OR DEAFBLIND</td></tr>
<tr><td>BLIND</td><td>Blind
"Normal" Hearing</td></tr>
</table>

Those with dual sensory loss use many different communication methods dependent on the age of onset. Those deaf blind from birth or early childhood are more likely to use British sign language. The needs of those with dual sensory impairment cannot be met by services for single impairment

Deaf blindness can be due to several causes, such as Ushers Syndrome, Rubella (German measles) and problems caused by premature births.

[61] Annual Report of the Chief medical Officer, Surveillance Volume, 2012:On the State of the Public's Health (DH 2014)

The estimated prevalence of deafblind people is 40 per 100,000 population suggesting there are approximately 48 deafblind people (all age groups) in Halton with 30 aged over 18. This is thought to be a significant under estimate as the level of dual sensory impairment in the population is often masked by other physical and mental health conditions which can take precedence in statistical recording.

Children and Young People

There are 45,000 deaf children in the UK and around half are born deaf, and around the same amount acquire deafness during childhood. Estimates suggest that 1-2 children are born every year in Halton with permanent deafness[62]. 90% of deaf children are born to hearing parents with little or no experience of deafness or knowledge of how to communicate with a deaf person[63].

The incidence almost doubles by ten years of age because of acquired hearing loss from meningitis mumps, measles, trauma and other causes.

Halton's JSNA for Children estimates 76 children with permanent hearing loss and 26 experiencing severe or profound loss. 40% of deaf children have additional or complex needs: at least one other clinical or developmental problem and half of these children had at least two additional problems. The JSNA has further detail on prevalence of additional disabilities and identifies the following:

- Visual impairment
- Neurodevelopmental disorder
- Speech Language Disorder: range of prevalence
- Autistic Spectrum Disorder (ASD)
- Cerebral Palsy: range of prevalence
- Pervasive Developmental Disorder (PDD)

A major difficulty for deaf children and young people is language. Communication lies at the heart of a child's social, emotional and intellectual development. For example research suggests that:

a) deaf children and young people are 1.5 times more likely to experience mental health difficulties at a clinically identifiable level than hearing children

[62] Children with Disabilities and Complex Health Needs - Halton Joint Strategic Needs Assessment 2014
[63] http://www.ndcs.org.uk/about_us/ndcs/

b) they are more likely to be abused than hearing children (studies show they are at least twice as likely to experience abuse as hearing children, with one study identifying an incidence of abuse being 3.4 times that of hearing children[64])
c) their educational attainment is below that of hearing children[65]
d) they are more likely to be unemployed as young adults[66]

Thus there are good reasons for being concerned that deaf children may not achieve key outcomes, such as being healthy, keeping safe, educational success and economic well-being[67]

Adults of Working Age (18-65)

Around 3.7 million people aged 16-64 have a hearing loss and for 20% of those aged over 50 their hearing loss is moderate to profound. In Halton the projected number of people aged 18-64 with hearing loss by 2020 increases by only 1% in contrast to higher rises in the North West (6%) and England (8%). This is most likely explained by Halton's shrinking population rate which is faster than the regional prediction whilst for England there is a predicted increase in population.

Employment is often important to individuals' quality of life and those with hearing impairment are significantly less likely to be in employment. In the 18-64 age group those in full time employment without any sensory impairment is 53%; amongst the deaf community this figure is 38%. It is likely that other factors are involved such as the higher prevalence of comorbidities amongst those with sensory impairment.

Older People

An emerging issue is the numbers of people developing combined sight and hearing impairment after the age of 60. Dual sensory loss in this age group is often not labelled as 'deafblindness' or recognised as an identifiable disability. For some with a pre-existing sight or hearing impairment the development of impairment in the second sense places them within the deafblind continuum. The prevalence is difficult to quantify but estimated to be substantially higher than recorded numbers indicate.[68] Sensory impairment is generally assumed to be an inevitable and inescapable element of aging and for older people may be

[64] www.gscc.org.uk, Care Council for Wales - ccwales.org.uk, Northern Ireland Social Care Council - nisocialcarecouncil.org.uk, Scottish Social Services Council - sssc.uk.com
[65] www.ndcs.org.uk/closethegap
[66] Office for Disability Issues Annual Report 2008:
[67] http://www.teachingtimes.com/zone/every-child-matters.htm
[68] Identification of deafblind dual sensory impairment in older people SCIE Research Briefing 21 2007

overlooked as dual sensory impairment and a disability requiring investigation and possible intervention.

Dual sensory impairment can make a person more physically vulnerable in the environment in which they live, both domestic and social spaces, and is recognised as a clear underlying cause of falls in older people. Greater awareness of the challenges faced would lead to more preventative actions.

"A World of Silence"[69] summarises research undertaken with care home residents. Around 2/3rds of the care home residents experienced hearing loss. The report highlighted concerns that hearing loss was seen merely as a sign of aging and there was a significant level of unidentified hearing loss. In addition, care home staff could be more proactive in checking hearing aids and creating an environment which reduces background noise to improve their effectiveness. The report made three recommendations:

1. Intervene earlier in hearing loss
2. Meet communication needs in care homes
3. Improve hearing aid use and management in care homes

Tinnitus

Tinnitus is usually caused by a problem in the auditory pathway arising from ageing, hearing loss or noise exposure but can also be caused by head injury ear infection or emotional trauma, illness or stress.

Around 10% of the adult population has some form of tinnitus and for 1% the impact of their tinnitus affects their quality of life. It is associated with higher occurrences of depression and many sufferers will avoid visiting public places such as shops and restaurants as they know the background noise will trigger or worsen their tinnitus.

Noise induced hearing loss

Exposure to excessive noise can damage different types of cells in the ear. Exposure is cumulative and over time will lead to tinnitus and temporary or permanent hearing loss. The WHO classifies noise exposure as the major avoidable cause of permanent hearing impairment.

There are two groups at a higher risk of noise-induced hearing loss:

[69] A World of Silence – Action on hearing loss 2012

i. Armed forces personnel and the Police – this is now being mitigated as far as possible with the use of ear protection.

ii. Young People – due to exposure to loud music at venues and through personal music players.

Campaigning by Action on Hearing Loss is on ongoing to prevent noise-induced hearing damage among young people.

Social Impact of hearing loss

Hearing loss has a significant personal and social impact due to the communication barrier that it creates. This can lead to social isolation and exclusion as research shows that those with hearing loss withdraw from social activities involving large groups of people.[70]

Often a family member will intervene in communication with third parties which erodes the independence of the person with the hearing loss as they become dependent on others for information.

Stigma

Stigma relating to hearing loss is both real and perceived. It is a key factor in the delay in taking up hearing aids, and makes many people unwilling to tell others about their hearing loss. One element of stigma is the fear that people with hearing loss are seen as less capable [71]

Support for those with hearing loss

Following diagnosis people with hearing loss need a range of services and support from health and social care. Evidence demonstrates that appropriate support can have a substantial impact on the quality of life for those with sensory impairment[72].

Communication is the principal challenge and there are a range of services and assistive technology that can bridge this gap. Lack of awareness of what is available can hamper uptake and development.

Sensory impairment and people with a learning disability

[70] Hidden Crisis RNIS 2009
[71] RNID, Hidden Crisis, 2009
[72] Annual Report of the Chief Medical Officer (DH 2014)

People with a learning disability are more likely to have a hearing loss, and are 10 times more likely to have a sight loss than people in the wider community. This can have a profound impact on how they are understood and are able to interact with others, and people with challenging behaviour will be more likely to challenge if there is a limited understanding of any sensory loss that they may have.

Hidden and untreated sensory loss

Hidden and/or untreated sensory loss leads to a withdrawal from social interaction. To a person with dementia, for example, failure to recognise and respond to a sensory loss will result in greater isolation, will generate behaviours that can be misinterpreted as symptoms of advancing dementia, and will lead to a consequent failure to respond appropriately to basic physical needs.

Specifically, neurological sight loss, caused by injury or trauma to the brain, is often undiagnosed and can, therefore, remain untreated. Between 20% and 60% of people who have a brain injury from stroke or traumatic injury have associated neurological visual impairment.[6] This type of sight loss has a significant, detrimental impact on survivors of brain injury and their carers.

Sensory loss and other Long Term Conditions (LTC)

Based on the GP Patient Survey73 only 3% of those reporting no sight or hearing loss report 4 or more LTC's compared to 29% of those reporting hearing loss, 32% of those reporting sight loss and 69% of those reporting both sight and hearing loss. In the context of multi-morbidity, confidence in managing one's own health conditions is likely to be an important contributor to quality of life and influence long-term outcomes. Among those aged over 55 91% of those with neither sight or hearing loss feel confident in managing their own health compared to 84% among those with hearing loss and 72% of those with sight loss and 60% of those with both sight and hearing loss.

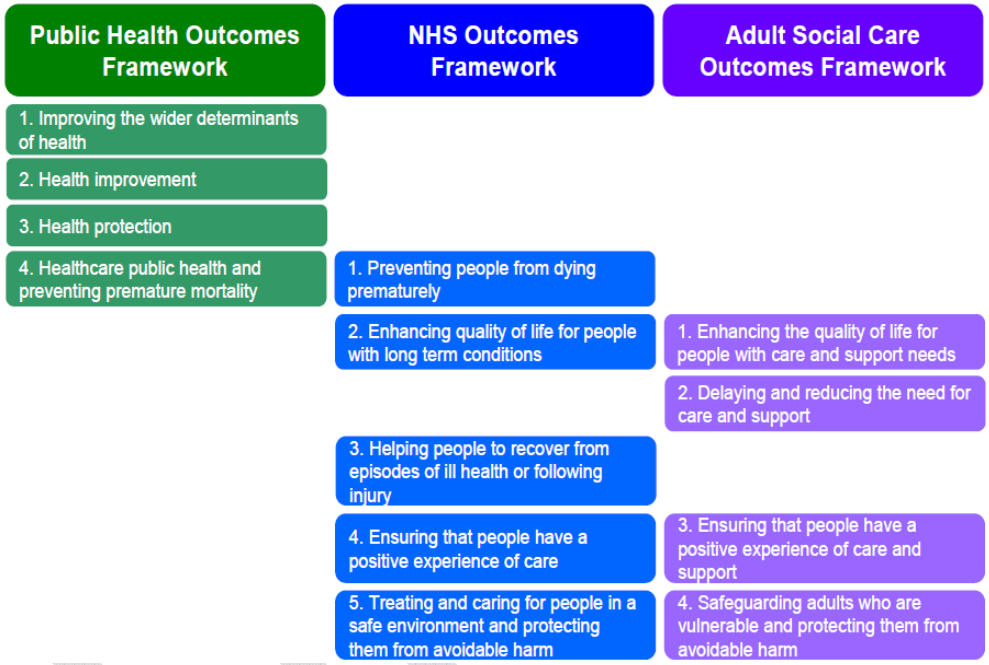
[73] Annual report of the Chief Medical Officer DH 2014

Part Five: Outcomes Frameworks

Outcomes Frameworks

Outcome measures provide a description of what a good social care and health system should aspire to achieve, as well as a method of checking progress in achieving these aims. All three of the National Outcome Frameworks – Public Health[74], NHS[75], and Adult Social Care[76] have been aligned so local partners across the health and care systems can identify the challenges for their population to determine local priorities for joint action.

The 3 outcomes frameworks 2013/14



[74] Available from: http://www.phoutcomes.info/
[75] Available from: https://www.gov.uk/government/publications/nhs---outcomes---framework---2013---to---2014
[76] Available from: https://www.gov.uk/government/publications/the---adult---social---care---outcomes---framework---2013---to---2014

The detailed indicators relating long term conditions are summarised below along with the outcome they contribute to.

Long term conditions indicators and outcomes framework domains

National Indicators	Adult Social Care	NHS	Public Health
Quality of life for people with long-term conditions	1.A	2.0	
Proportion of people who use services who have control over their daily life	1B		
To be revised from 2014/15: Proportion of people using social care who receive self-directed support, and those receiving direct payments	1C		
Carer reported quality of life	1D	2.4	
Proportion of people feeling supported to manage their condition		2.1	
Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services	1E	2.2	1.8
Proportion of people who use services and their carers, who reported that they had as much social contact as they would like.	1I		1.18
Permanent admissions to residential and nursing care homes,	2A		
Delayed transfers of care from hospital, and those which are attributable to adult social care	2C		
Reducing time spent in hospital by people with long-term conditions		2.3i/ii	
Overall satisfaction of people who use services with their care and support	3A		
Overall satisfaction of carers with social services	3B		
The proportion of carers who report that they have been included or consulted in discussions about the person they care for	3C		
The proportion of people who use services and carers who find it easy to find information about support	3D		
New placeholder 3E: Improving people's experience of integrated care	3E	4.9	
The proportion of people who use services who feel safe	4A		1.19
The proportion of people who use services that say those services have made them feel safe and secure	4B		
Mortality rate from causes considered preventable **		1A	4.3
Emergency readmissions within 30 days of discharge from hospital*		3B	4.11
Preventable sight loss			4.12

Part Six: Evidence based interventions

National Standards

NICE quality standards are a concise set of prioritised statements designed to drive measurable quality improvements within a particular area of health or care. They are central to supporting the Government's vision for a health and social care system focussed on delivering the best possible outcomes for people who use services, as detailed in the Health and Social Care Act (2012). NICE quality standards enable:

- **Health professionals and public health and social care practitioners** to make decisions about care based on the latest evidence and best practice.
- **People receiving health and social care services, their families and carers and the public** to find information about the quality of services and care they should expect from their health and social care provider.
- **Service providers** to quickly and easily examine the performance of their organisation and assess improvement in standards of care they provide.
- **Commissioners** to be confident that the services they are purchasing are high quality and cost effective and focussed on driving up quality.

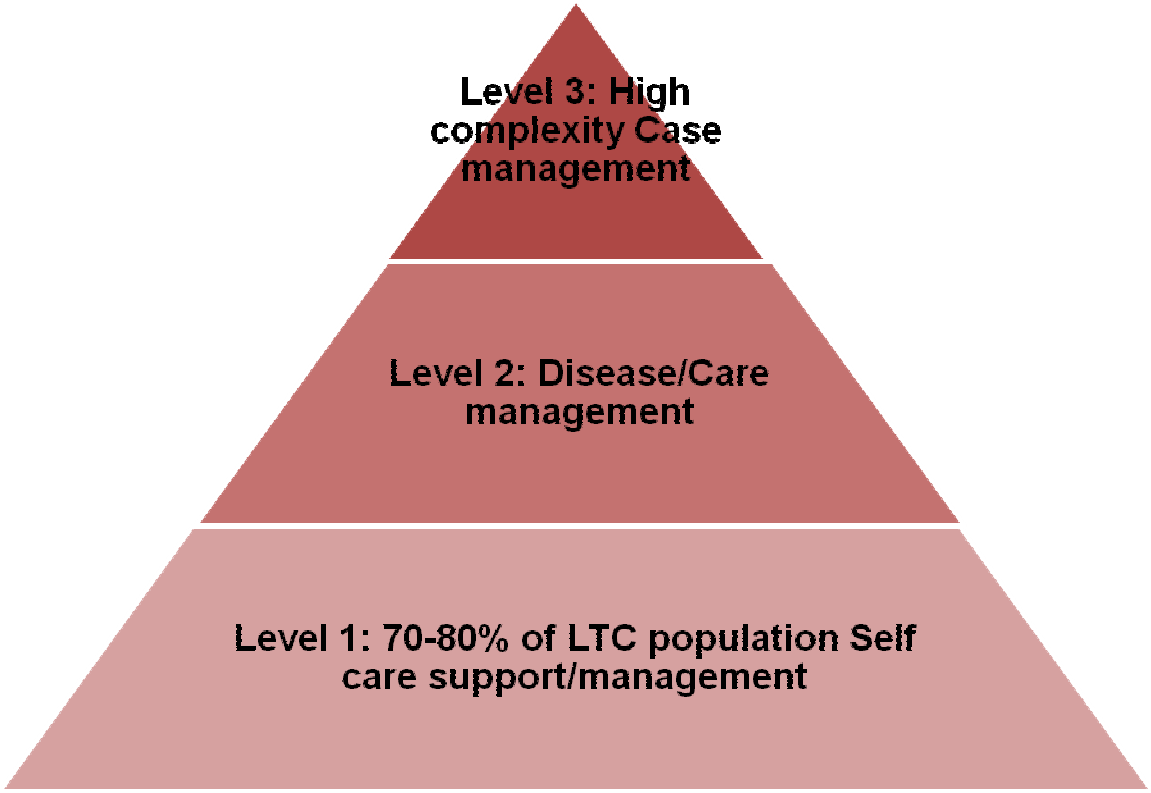
Supporting People with Long term Conditions[77] was published in 2005 to promote a model of health and care which aimed to:

- embed an effective, systematic approach to the care and management of patients with a long term condition.
- reduce the reliance on secondary care services and increase the provision of care in a primary, community or home environment.
- Ensure availability of high-quality, personalised care
- Promote a healthier future by ensuring that self care support is in place – particularly for those in disadvantaged groups and areas – to make healthier choices about diet, physical activity and lifestyle.

The recommended route and one which has been adopted in Halton is a systematic approach utilising multi-professional teams and integrated patient pathways to ensure closer integration between health and social care.

Different interventions should then be used for patients with different degrees of need. The NHS and Social Care Long Term Conditions Model sets out a delivery system that matches care with need.

[77] Supporting people with long term conditions: An NHS and social care model to support local innovation and integration (DH 2005)



(Based on the Kaiser Permanente triangle)

Level 3: Case management – requires the identification of the very high intensity users of unplanned secondary care. Care for these patients is to be managed using a community matron or other professional using a case management approach, to anticipate, co-ordinate and join up health and social care.

Level 2: Disease-specific care management – This involves providing people who have a complex single need or multiple conditions with responsive, specialist services using multi-disciplinary teams and disease-specific protocols and pathways, such as the National Service Frameworks and Quality and Outcomes Framework.

Level 1: Supported self-care – collaboratively helping individuals and their carers to develop the knowledge, skills and confidence to care for themselves and their condition effectively. Underpinned by promoting better health – building on the public's growing desire for a healthier future by ensuring that the self-care support is in place for people – particularly those in disadvantaged groups and areas – to make healthier choices about diet, physical activity and lifestyle, for example stopping smoking and reducing alcohol intake.

This is now being followed up with the development of a guideline on social care of older people with complex care needs and multiple long-term conditions. The link between ageing and long-term conditions and the discrimination that older people can experience

provides the rationale for focusing the guideline on this age group. The National Institute of Clinical Governance (NICE) is leading this work for the Department of Health and publication is anticipated in 2015.

NICE clinical guidelines are already in place for the diagnosis, treatment and management of MS, epilepsy and Parkinson's. These evidence based guidelines outline the range of care that should be available. These include providing specialist services, a system for rapid diagnosis, a seamless and responsive service, thorough problem assessment and self-referral after discharge. Full details of these recommendations are available at www.nice.org.uk.

In January 2014, following consultation, a further 5 topics relating to Adult Social Care have been identified for formal referral to NICE for development of guidance and standards in social care

- falls - regaining independence for older people who experience a fall
- care and support of older people - with learning disabilities
- medicines management - managing the use of medicines in community settings for people receiving social care
- regaining independence - short term interventions to help people to regain independence
- adult social care - service users and carers experience of adult social care

Using technology to manage long term conditions

Within the model illustrated above helping people to manage their own health condition as much as possible forms the foundation of the health and social care delivery system. Telehealth and Telecare services support this approach but what are they:

Telehealth (remote care) - Electronic sensors or equipment that monitor vital health signs remotely, e.g. in your own home or while on the move. These readings are automatically transmitted to an appropriately trained person who can monitor the health vital signs and make decisions about potential interventions in real time, without the patient needing to attend a clinic

Telecare - Personal and environmental sensors in the home that enable people to remain safe and independent in their own home for longer. 24 hour monitoring ensures that should an event occur the information is acted upon immediately and the most appropriate response put in train.

Research into the benefits of telehealth and telecare[78] in the management of long term conditions found that correct use of technology reduced:

- death rates by 45%
- visits to accident and emergency departments by 15%
- emergency admissions to hospital by 20%

National estimates suggest that at least 3 million people with long term conditions could benefit from using telehealth and telecare which has led to the NHS England Vision Statement on telehealth and telecare:

> *"3millionlives* is underpinned by the idea of service integration to improve patient care and outcomes. When different services and sectors work together, towards shared goals, patients get far more flexible, better, and more appropriate care. To achieve true service integration, we recognise that *3millionlives* needs to be delivered through a genuine partnership across NHS England – facilitating collaboration between clinicians, and empowering patients to better self-manage their conditions, with the use of technology. We also recognise that this cannot be achieved through technology alone – the key will be to deliver service transformation through realising the potential of that technology to support clinicians, patients and carers."
>
> http://3millionlives.co.uk/about-3ml

[78] Whole System Demonstrator Programme Headline Findings – DH December 2011

Part Seven: Paying for local services

Expenditure

The following financial breakdown is based upon direct expenditure in 2013/14 on funding for initiatives specific to disabled people. It does not reflect all of the wider universal and targeted activity that is commissioned locally. Expenditure, on areas such as Primary Care (GPs, etc.), general health promotion, weight management, equipment or voluntary and community sector activity, all have a direct impact upon the quality of life of disabled people but does not fall within the direct influence of this strategy and action plan.

In 2013/14 Resources were spent as follows:

Insert pie

In Halton 11% of the total spend on Adult Social Care supports those whose primary need arises from their physical or sensory disability. The table below summarises how this is spent[79]:

[79] Expenditure Report 2012-13 Halton (321) (Health and Social Care Information Centre 2013)

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

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

Percentage Local Authority Total Gross Spend Adults age 18-64 with physical disabilities by activity 2010-11 to 2012-13

2013/14 data not yet published

Figures are %	**2010/11**	**2011/12**	**2012/13**
Residential and Nursing	15	7	9
Day and Domiciliary#	48	51	54
Assessment and Care Management	37	42	36
# % of Day and Domiciliary Care spent on Direct Payments	40	31	37

Source: Expenditure Report 2012-13 Halton (321) NASCIS

These figures show the continuing shift from placements in residential and nursing care to supporting people to remain at home in line with local policy.

Halton Unit Costs and England Average Per person per week 2012-13 Adults of Working Age (18-64)

2013/14 data not yet published

SERVICE £ per person per week	NUMBER OF PEOPLE OR HOURS	HALTON £	ENGLAND £
Residential and Nursing placements	8	878	877
Home Care	75	279	199
Day Care – average hours per week	31 hours	205	188
Direct Payment	94	196	244
Meals	not available	4.10	5.40

Source: PSS-EX1

The cost of residential services to the Council is in line with the England average. However costs of home care and day care are somewhat higher. Most disabled adults accessing services receive more than 5 hours home care support per week

Range of weekly Home Care support for disabled people living at home

	Arranged by Directorate	Purchased via Direct Payment
Less Than 2 hours	6	3
More than 2 hours less than or equal to 5 hours	12	13
More than 5 hours less than or equal to 10 hours	15	23
More than 10 hours less than or equal to 20 hours	25	28
More than 20 hours	17	27

Source: RAP H1 2012-13 and Direct Payments database

The Council supports

Capital Investment Proposals 2014/15

	2014/15 Capital Programme Proposals £
Disabled Facilities Grants (incl. capitalised salaries)	500,000
Energy Promotion	6,000
Stair lifts	250,000
RSL Adaptations (Joint Funding)	175,000
Contribution to new build Bungalows for complex needs	400,000
TOTAL	**1,331,000**

Appendix A

Current Services

Access to information, advice and advocacy

Information and Advice

Halton Council's Direct Link offices and Contact Centre have trained advisors who can offer advice on a range of issues relating to council services or are able to sign post to more appropriate agencies. Referrals for Adult Social Care are received by the Initial Assessment Team (IAT).

The Council also has a web portal "Care and Support for You" which acts as a hub for people to find out what support is available whether they are eligible for social care or self-funding. This portal will be further developed to include a resource directory of service providers

Halton Disability Partnership (HDP) is a Disabled People User Led Organisation (DPULO) which works to improve the lives of disabled people by providing information and advice on a range of issues of concern to disabled people. HDP also provide an advice and support service for people in receipt of Direct Payments.

For those with sensory impairments Deafness Resource Centre and Vision Support are commissioned by the Council to offer information and support as well as advising on resources to assist with daily living and offering befriending services. There are other voluntary organisations in the Borough offering information to disabled people and through Halton Disability Forum have the opportunity to exchange information on their services which supports better signposting.

Maintaining Independence and Control

Initial Assessment Team

Within Adult Social Care the first point of contact for everyone is the Initial Assessment Team (IAT) consisting of Social Workers, Community Care Workers and Occupational Therapist Community Care Workers. This acts as a single point of access to all adults with adult social care needs providing universal advice, guidance and signposting to other services. For more complex support planning and care management the team refers on to the appropriate Complex Care Team.

Independent Living Services

It is important that people feel safer, more protected and independent in their own home and the Community Alarm Service facilitates this by offering a rapid response alarm service for vulnerable people aged 18+, available 24 hours a day, and seven days a week.

Specialist Equipment and Adaptations

Some people may be struggling at home due to their physical or sensory condition. This may be short term following hospital discharge or longer term. Adult Social Care offer assessments and may be able to assist through specialist equipment such as grab rails or can advise on adaptations to the property. For those living in the private rented sector or owning their own home assistance with the cost of any adaptations may be available through Disabled Facilities Grant.

Registered Provider protocol

Funding constraints have historically led to tenants of social housing having to wait longer for major adaptations. In 2008 the Council and Registered Providers put an agreement in place whereby the Council provides additional financial help to increase the number of tenants benefitting. This action significantly reduced waiting times and the agreement remains on-going subject to available resources.

Accessible Housing Service

The Accessible Housing Service works in partnership with all Registered Providers with stock in Halton to enable a better match for disabled applicants to accessible and adapted homes when they become available in the borough. Disabled applicants of any age from all property tenures are assessed when they have applied for housing to any of the providers, and available void adapted properties are also assessed to try and match applicants to the accommodation best suited to their needs. This service will be integrated with the IT system for the sub regional Property Pool Plus choice based lettings sytem.

Complex Care Teams

Complex Care Teams are based in Runcorn and Widnes and aligned with GP practices. The teams work with all adults age 18+ with complex needs (except mental health) regardless of age. For those young people identified as having complex needs, to facilitate the transition from children's' to adult services, care management assistance with planning is available from age 16+. The focus throughout all care management processes is on enablement, to promote independence and includes:

- Longer-term complex assessments and support planning
- Facilitating people to undertake assessments and support plans with limited social services input;
- Scheduled annual reviews
- Re-assessments and safeguarding vulnerable adult assessments (VAA)

Hospital DischargeTeam

Both Whiston and Warrington Integrated Hospital Discharge Teams provide care management support to inpatients in the hospitals to enable hospital discharge and avoid

delays. The teams work alongside staff of neighbouring authorities as well as health commissioners.

Therapy Services

Therapy services include physiotherapy, occupational therapy, speech and language, and psychology. Therapists are based within hospitals as well as community settings. Halton residents are also able to access a specialist neuro-rehabilitation team.

Independent Living Centre (ILC)

Located at Collier Street in Runcorn the ILC is a resource centre offering permanent displays of basic and specialist equipment for independent living. Agencies located here include Vision Support offering low level support for the visually impaired and Bridgewater Community Healthcare Trust Wheelchair and Mobility service.

Deafness Resource Centre

The Deafness Resource Centre provides services that aim to empower, support and enhance the quality of life of D/deaf people. Deafness Resource Centre is commissioned to complete technical assessments for equipment on behalf of the Council. Halton residents of all ages are able to access centre based activities in St Helens including a chapel. There are also regular signing social groups and drop in sessions located around Halton.

Social Integration and Community Contribution

The Council's Sure Start to Later Life services work with those aged 55+ and offer low level information provision and support for people to explore their interests and engage in community activities including volunteering. The Community Bridge Builders Service (CBB) works across all adult age groups and also supports disabled young people during their transition to Adult Services. As well as addressing social isolation CBB also strive to move people into volunteer placements with a view to long term employment.

Community Day Services

Day services offer disabled people a range of activities based at community and leisure centres, libraries and parks across the Borough, the aim is to develop skills, promote independence and ensure a community presence that is both meaningful and valued. There is a focus on enterprise which offers work experience and vocational qualifications to move people closer to the job market as well as giving something back to the community.

Shop Mobility

One of the enterprises run by Halton Day Services is Shop Mobility which offers members of the public mobility scooters and wheelchairs for hire. The service is available in both Widnes Town Centre and Halton Lea Shopping Centre from Monday to Saturday.

Safe In Town

Safe In Town is a scheme designed to ensure vulnerable residents feel safe when out and about in the community. Launched by Halton Borough Council working alongside Cheshire

Police and charity Halton Speak Out, Safe In Town is aimed at residents aged 60-plus and adults and young people who suffer from a learning or physical disability or have mental health issues.

A special Safe In Town logo is displayed in participating shops and businesses across the borough to show residents that the staff inside are fully equipped to help them should they feel vulnerable or in trouble at any time. In 2014 Halton CCG and the Cheshire Police and Crime Commissioner have taken over funding of the scheme and greater participation is being encouraged through venues such as libraries and community centres.

Maintaining Health and Wellbeing

Community Wellbeing Practice (see Appendix 3) model is delivers a range of health and wellbeing initiatives within general practice. A wider view is taken of the key determinants of health and wellbeing than purely medical aspects. Robust, integrated networks across voluntary and community settings are being established and staff empowered to promote and coordinate interventions within general practice settings. As this model evolves any gaps will be highlighted and a solution developed.

The Health Improvement Team is part of Bridgewater Community Healthcare NHS Trust and works in close partnership with Halton Borough Council to offer a wide range of local, tailored services and initiatives including weight loss and smoking cessation designed to improve the health and wellbeing of local people.

The team works with individuals and the community as a whole to understand what services are needed and how best to deliver them – be it in a community venue or through one-to-one visits. Support is also available for local businesses and organisations to provide education and training services to help local people make healthy choices.

Intermediate Care

RARS is a multi-disciplinary team of health and social care professionals providing initial and on-going assessment, admission to other Intermediate Care services and rehabilitation, treatment and care to people in their own homes, in a residential intermediate care unit (Oak Meadow) or in a sub-acute unit. Less than 9% of referrals for intermediate care are under age 65.

Residential/Nursing Care

Whilst all efforts are made to support people to remain in their homes and avoid admittance to long term care there comes a point for some people where residential or nursing care is appropriate. There are a number of residential and nursing homes across the Borough offering both short and long term care to adults under age 65.

The numbers of people with more specialist residential or nursing support needs is relatively low and these are met by specialist placements outside Halton. Currently there are three

people in such placements. For those with cerebral palsy SCOPE offers small residential units' located in both Widnes and Runcorn.

Bredon

Bredon Respite Unit though primarily for adults with learning disabilities is also registered for physically disabled adults and offers short stay residential respite care.

Adult Placement

Adult Placement offers flexible care in an Adult Placement Carer's own home from a few hours a day to overnight stays or longer. This can be an opportunity the care to have some respite or can help a person recovering following a hospital stay or illness. There are some restrictions in accessing this support as the carers homes may not be suitable for those with poor mobility or wheelchair users.

Ensuring safety and quality in local services

The Council also has a duty to monitor all residential and nursing homes in the Borough and there is an annual monitoring programme in place through the Quality Assurance Team (QAT). The team also monitors domiciliary care providers and supported living services purchased by the Council.

Agreements have been put in place with providers contracted to the Council which enable Direct Payment holders to purchase care from them at the same competitive hourly rates. This offers the person confidence they are purchasing quality support from a provider that is monitored by the Council and at a realistic rate.

Personal Assistants employed directly by a direct payment holder are not monitored but the Council has produced an information leaflet on employing PA's.

Compliments and Complaints

Analysis of compliments and complaints offers useful feedback to services on their performance and can help identify any underlying adverse trends to be addressed. There is also valued learning in how to replicate good practice as well as informing system changes to offer clients a more positive experience of their contact with the Directorate. Commissioners maintain an overview to identify any gaps in service provision or services that need development

All complaints received by the Communities Directorate are analysed by type and client group. Themes within recent complaints related to communication and information provision.

Appendix B

PSD Joint Commissioning Strategy 2007-2011 Action Plan Achievements

Adult Social Care Outcome	Service area/activity	Actions	Outcome	Progress
Improved Health	Rehabilitation	Develop a consistent approach to physical and psychological rehabilitation services and establish community based services and support groups. Identify how short-term neuro-rehab can be accessed. Ensure continuity of rehabilitation and follow up reviews.	Individuals learn strategies to help manage their condition and remain independent.	Halton residents have access to the Bridgewater NHS Trust Neuro-Rehabilitation team based at the Independent Living Centre. The team includes a Consultant Clinical Neuropsychologist and whilst not formally integrated with social care, strong links have been forged.
		Extend intermediate care to those aged under 65.		Both Intermediate Care and reablement services are available to all adults aged 18+. Falls Specialist Service is also available to anyone over age 18
Improved Quality of Life	Voluntary Sector contracts	Review contracts to identify gaps / improvements and develop action plans with agencies. Implement ongoing provider	Individuals will be able to access appropriate effective services	Health and social care funding of Vision Support is now an integrated contract. Monitoring is built into the quality Assurance Team annual work

Adult Social Care Outcome	Service area/activity	Actions	Outcome	Progress
		monitoring arrangements		programme
	Deaf/Blind Strategy	Checklist/mapping exercise leading to action plan	Individuals have access to specific support.	Scrutiny review completed and recommendations implemented. Service Specifications revised with emphasis on developing greater community presence. This is being delivered by Deafness Resource Centre
Improved Quality of Life	Transport	Replacement programme for HBC fleet and HCT vehicles will support modernisation of day activities. Offer travel training and improve information to enable individuals to access public transport. Improve frequency of public transport services. Encourage bus companies to replace remaining non-accessible vehicles.	Accessible transport available and passenger journey times reduced. Individuals are enabled to travel independently. Improve accessibility in areas of the Borough across the week and Bank Holidays. Accessible vehicles will be available on all public transport routes at all times.	HCT has accessed lottery funding to acquire a new bus in its fleet. This is available through the Community Bridge Builder Service Frequency is dependent on demand and monitored by the bus companies. Routes must be commercially viable. **This remains an issue for disabled adults** Most routes now have accessible vehicles. Halton Community Transport and

Adult Social Care Outcome	Service area/activity	Actions	Outcome	Progress
				Taxis offer alternatives to those with impaired mobility or who are vulnerable.
	Care management	Care plans will be person centred and specify measurable outcomes for individuals.	Services will focus on enablement and be able to demonstrate achievement	Individuals now complete their own supported assessment, reviews and care plans are all person centred.
Making a positive contribution	Service user/carer involvement	Formalise opportunities for involvement	Service provision will be informed by service users and their carers at both micro and macro levels of commissioning. Individuals can express their views and be heard.	Halton Disability Partnership represents disabled people and are working with the Council and CCG to influence service quality and development.
		Review access to Advocacy services	Implications of IMCA are addressed	Access to both generic advocacy and IMCA available through Advocacy Matters.
Exercise choice and Control	Individualised Budgets Independent Living Team	Pilot IB's for Adults with physical disabilities as part of the In Control project work. Care managers to encourage self-assessment and support planning Self-Assessment for equipment	IB's will be made available to all who want them. Individual sets the outcome they wish to achieve. Reduced waiting times and individuals are in control.	Systems in place to offer self-directed support across adult social care and offer all service users personal budgets. Individuals are supported to complete their own assessment of need. Smartassist available through HBC web portal to self-assess

Adult Social Care Outcome	Service area/activity	Actions	Outcome	Progress
	Carers Support	Ensure services are available to meet carers needs identified through assessment.	Carers will be supported to maintain their health and social networks.	equipment needs. Addressed through the Carers Action Plan and Halton Carers Centre
	Information	Explore opportunities to promote services/support and signpost individuals appropriately. Ensure people have full information about their condition and what this may mean for them.	Individuals will make informed choices.	Halton Direct Link and Contact Centre trained advisors offer this. A range of information leaflets are available to download through the website. Web portal "Care and Support for You" is a hub for people to find out what support is available
	Independent Living Centre	Re-establish vision/purpose	Effective use of building.	Considered in previous review of day services. This is now being revisited
	Equipment services	Scope of HICES Build capacity to expand HICES in response to aging population. Direct payments for equipment	Clarity around support for C&YP Equipment is available within time target. Greater choice for individuals	Service is meeting demand and n 7 day delivery target is being maintained
Freedom from discrimination and harassment	Diversity monitoring	Record diversity data in assessment, planning and review. Training to ensure diversity is addressed in care planning /	Individuals' cultural and religious needs are met.	Carefirst data shows ethnicity is recorded for 99% of clients. Supported assessment addresses diversity in planning to meet assessed need.

Adult Social Care Outcome	Service area/activity	Actions	Outcome	Progress
		service provision.		
Economic well-being	Life chances	Consider best use of Bridgewater Ensure Management Responsibility protocol is in place for all in-house services.	Available services will be designed to move people on. Council managers working alongside agency staff will ensure care plans are followed.	Bridgewater Centre closed and service users linked into community based activities as appropriate. In place.
	Employment	Develop support for maintenance of existing employment skills. Offer training to access employment	Individuals can continue or return to employment.	Picked up through Supported Employment in Children and Enterprise Directorate.
	Housing	Set up adapted housing register. Colleagues responsible for Housing elements of local development framework to sit on PSD LIT	Housing need will be quickly matched with suitable accommodation Need for an accessible environment compliant with both Lifetime Homes and Decent homes standards is promoted.	Completed. Now exploring management of this through the adapted housing register
	Community bridge building	All aspects of PSD services to link to the Bridge Building Service and ensure appropriate referrals are made	Opportunities for social integration and employment are identified and realised.	Now part of pathway.

Adult Social Care Outcome	Service area/activity	Actions	Outcome	Progress
	Cultural and Leisure services	Implement findings of accessibility review and actively promote mainstream services to people with disabilities.	Barriers that disable people will be removed.	Competed and has supported transfer of day activities to community venues.
Personal dignity and respect	Adult Protection	Safe Guard Vulnerable Adults in Line with Halton's *no secrets* Inter-Agency, Policy Procedures and Guidance	Vulnerable Adults are protected from abuse and their personal dignity and respect remain intact.	Now embedded into all service specifications. Integrated health and social care safe guarding unit established.
Leadership	Transition	Develop strategy for transition from Children's to Adult services.	Joint planning so young people experience a positive move into adulthood	Strategy and Protocol in place. Being reviewed following SEN reforms in September 2014
	PSD/OP Care Management	Review process for Adults approaching age 65	Continuity of care management will be maintained.	Revised care management structure 2012 and establishment of Complex Care teams based in Runcorn and Widnes has addressed this.
		Develop and implement clear and robust interface agreements across AOWA, OP and Children's services	Impact of service changes will be fully assessed and consulted on.	See above
	Primary Care Services	Build relationships with local clinicians to influence PBC and promote whole system working	Promote preventative services and early intervention.	Early Intervention and Prevention strategy implemented. Health and Wellbeing Strategy in place. Integrated working with Clinical Commissioning Group supported by Section 75 and pooled budget.

Adult Social Care Outcome	Service area/activity	Actions	Outcome	Progress
Commissioning and use of resources	HBC Independent Living Team/North Cheshire Hospital Trust /PCT	Whole system review of Therapy services	Effective utilisation of staff. Single assessment pre-hospital discharge	Integrated hospital discharge teams based in Whiston and Warrington Hospital Trusts linked to RARS and reablement support
	Independent Living Services	Whole system redesign of Equipment and Adaptations processes including safer handling. Modernisation of Halton major adaptations service.	Streamlined working practices creating capacity to respond to demand of aging population and maximising staff skills and resources	Completed - delays for adaptations minimised and equipment delivered in reasonable timescales
	Visual Impairment Service	Determine where this service is best situated.	Integrated, effective support available.	Scrutiny review of Sensory Services completed. HBC/CCG reviews of low vision services scheduled for 2014
	Providers	Ensure staff are appropriately trained.	Only skilled staff will provide care/support.	Service Specifications are kept under review and monitoring of services by Quality Assurance team ensures provider staff are appropriately skilled to meet changing demands.
		Incorporate person centred working practices into staff induction and ensure implemented.	Individuals will be in control of how and when they receive care and support.	Providers are adapting to market themselves at personal budget holders.
		Review specifications within contracts and SLA's to promote continuous	Commissioners will be able to monitor performance and know	All specifications are reviewed as contracts end to ensure they reflect current policy and offer

Adult Social Care Outcome	Service area/activity	Actions	Outcome	Progress
		improvement.	when intervention is required.	quality value for money services
	Joint Council/PCT Financial Strategy	Identify funding available over next three years and link service redesign to dis-investment / retraction	Re-focussed services within available resources	From April 2013 integrated commissioning across Public Health, Social Care and CCG supported by Section 75 and pooled budget has enabled health and social care transformation