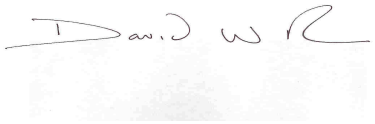
Public Document Pack

Health and Wellbeing Board

Wednesday, 12 March 2014 2.00 p.m.
Karalius Suite, Stobart Stadium, Widnes



Chief Executive

Please contact Gill Ferguson on 0151 511 8059 or e-mail gill.ferguson@halton.gov.uk for further information.
The next meeting of the Committee is on Wednesday, 7 May 2014

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

Part I

HEALTH AND WELLBEING BOARD

At a meeting of the Health and Wellbeing Board on Wednesday, 15 January 2014 at Karalius Suite, Stobart Stadium, Widnes

Present: Councillors Philbin, Polhill and Wright and G. Hayle, D. Johnson, T. Knight, A. McIntyre, A McNamara, E. O.Meara, D. Parr, M. Pickup, N. Sharpe, D. Sweeney, E. Sutton Thompson, I. Stewardson, J. Wilson and S. Yeoman.

Apologies for Absence: Audrey Williamson, Gerald Meehan and Dr David Lyon

Absence declared on Council business: Councillor Morley.

ITEM DEALT WITH
UNDER DUTIES
EXERCISABLE BY THE BOARD

Action

HWB47 MEETING DATES 2014

The following dates of Health and Wellbeing Board Meetings in 2014 were noted:

12th March 2014
7th May 2014
9th July 2014
17th September 2014
12th November 2014

All meetings will be held on a Wednesday at 2 pm in the Karalius Suite, Stobart Stadium, Widnes.

RESOLVED: That the meeting dates be noted.

HWB48 LOCAL GOVERNMENT DECLARATION ON TOBACCO CONTROL

The Board considered a report of the Director of Public Health, which advised that in May 2013, Newcastle City Council had passed a declaration setting their commitment to tackle the harm that smoking caused within our communities. This had become known as the Local Government Declaration on Tobacco Control. The Declaration committed Councils to:-

- reduce smoking prevalence and health inequalities;
- develop plans with partners and local communities;
- participate in local and regional networks;
- support Government action at national level;
- protect tobacco controlled work from the commercial and vested interests of the tobacco industry;
- monitor the progress of our plans; and
- join the Smoke Free Action Coalition.

RESOLVED: That the Declaration be supported (attached as Appendix 2).

Director of Public Health

HWB49 HALTON'S DEMENTIA STRATEGY

The Board considered a report of the Strategic Director, Communities, which presented Halton's Dementia Strategy.

The Board was advised that the Local Dementia Strategy had been completed in February 2010 and was a direct response to the National Dementia Strategy – Living Well with Dementia (Department of Health, February 2009). The Local Strategy adopted the national targets as well as developing a specific implementation plan to deliver a range of improvements for people diagnosed with dementia and their carers.

The Board was further advised that the revised Dementia Strategy, Living Well with Dementia in Halton (Appendix 1), and the associated Needs Paper (Appendix 2) looked at the progress that had been made since the original Strategy publication, as well as identifying key some key actions that needed to be completed over the next five years.

The Board noted the key achievements that had been made since the original Strategy and that the priorities for 2013 – 2018 focussed on the following areas:-

- prevention and Raising Awareness;
- early diagnosis, information and advice;
- living Well in the Community;
- end of Life;
- workforce Development; and
- links to other work streams.

In conclusion, it was reported that the 2013 – 2015 Strategy Implementation Plan outlined the key actions for future development in improving the outcomes for people

with a dementia diagnoses, their families and carers. The Implementation Plan could be found within the Living Well with Dementia in Halton Strategy document.

RESOLVED: That Halton's Dementia Strategy be noted.

HWB50 AUTISM SELF-ASSESSMENT FRAMEWORK 2013

The Board considered a report of the Strategic Director, Communities, which provided an update on the Autism Self-Assessment Framework (SAF) 2013. The purpose of the SAF was to:-

- assist Local Authorities and their partners in assessing progress in implementing the 2010 Adult Autism Strategy;
- see how much progress had been made since the baseline survey, as at February 2013; and
- provide evidence for examples of good progress made that could be shared and of remaining challenges.

The Board was advised that the Autism SAF was submitted to the Public Health England on the 30th September 2013. The submission had previously been presented to individuals with autism, The Autism Strategy Group and Learning Disability Partnership. It was noted that the submission would be joint owned by both the Local Authority and the Clinical Commissioning Group and would be monitored via Autism Strategy Group. A copy of the Autism Self-Assessment Framework which had been submitted was attached to the report.

RESOLVED: That the report be noted.

HWB51 FALLS UPDATE

The Board considered a report of the Strategic Director, Communities, which provided an update on the progress in relation to the implementation of the Halton Falls Strategy and Plans that were in place for the future. The Halton Falls Strategy covered 2013-2018 and aimed to address a number of issues that Halton faced including the level of falls, hospital admissions, re-admissions and fractures. The Strategy identified the following eight key deliverables that formed the basis of the Strategy, together with an update on the progress of each:

1) develop current workforce training;

2) develop a plan for awareness-raising with both the public and professionals;
3) improve partnership working;
4) set and deliver specific targets to reduce falls;
5) develop an Integrated Falls Pathway;
6) develop a Prevention of Falls Pathway;
7) identify gaps in funding of the Pathway; and
8) improve Governance arrangements to support falls.

RESOLVED: That the report be noted.

HWB52 HALTON CHILDREN'S TRUST STRUCTURES FROM 2014

The Board considered a report of the Strategic Director, Children and Enterprise, which outlined the proposed structures for Halton Children's Trust from April 2014 and provided an update on the work on the new Halton Children and Young People's Plan (CYPP) 2014 – 17.

In respect of the Halton Children's Trust, the Board had:-

- reached an agreement on the priorities for 2014;
- set up a Working Group to Develop the new CYPP; and
- established a new Halton Children's Trust Structure from April 2014.

With regard to the Halton CYPP, initial draft elements of the plan had been previously circulated to the Board. It was noted that a multi agency group was meeting fortnightly to discuss updates and two topics of focus for the plan. It was proposed that the CYPP would be available via a web version primarily with a limited number of printed copies.

RESOLVED: That

(1) the structures outlined in the report be noted; and

(2) the Board support the work on the Halton Children and Young People's Plan 2014 – 17 as outlined in the report.

HWB53 MENTAL HEALTH AND WELLBEING COMMISSIONING STRATEGY

The Board received a report of the Strategic Director, Communities, which sought approval for the adoption and implementation of Halton's Integrated Mental Health and Wellbeing Commissioning Strategy 2013 – 2018.

The Board was advised that the National Policy relating to mental health was set out in No Health Without Mental Health – GH2011 (NHWMH) and emphasised that Mental Health was everybody's business. The Policy set out six high level objectives with an emphasis on prevention and early intervention.

The Board was further advised that Mental Health problems were the single largest cause of ill-health and disability in the Borough. The Health and Wellbeing Board had recognised this by including prevention and early detection of Mental Health conditions as one of its five priorities. The Board's Health and Wellbeing Strategy 2013 – 16 included actions to begin addressing this and included the NHWMH six objectives as the framework to address the challenge of improving Mental Health and Wellbeing in the Borough.

It was reported that this was Halton's first Integrated Strategy for Mental Health and Wellbeing in the Borough and brought together commissioning intensions of Public Health, the Clinical Commissioning Group, Children's Services and Adults Social Care. It was complementary to the Health and Wellbeing Strategy and had been informed by feedback at public engagement events hosted by the CCG and Healthwatch, together with open consultation through a recent survey with those using services, carers, Halton residents and other key stakeholders.

Members were advised that the Mental Health and Wellbeing Strategy set out the strategic objectives and priorities for the next five years. An Action Plan was currently in development on how these would be achieved and resources required.

It was noted that the Strategy was considered by Health Policy and Performance Board on the 7th January and would be presented to Executive Board on the 23rd January. The overview of progress in implementing the Strategy would be through the Mental Health Strategic Commissioning Board which reported to the Health and Wellbeing Board.

RESOLVED: That

(1) the Mental Health and Wellbeing Commissioning Strategy 2013 – 2018 be endorsed; and — Strategic Director Communities

(2) the Board receive regular progress updates through the Mental Health Strategic Commissioning Board on

progress in delivering this Strategy Action Plan.

REPORT TO: Health and Wellbeing Board

DATE: 12th March 2014

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health and Wellbeing

SUBJECT: Approval of the draft Better Care Fund Submission

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To request that the Board approve the final draft Better Care Fund for submission to the Local Government Association and NHS England by 4th April 2014.

2.0 **RECOMMENDATION: That the Board**

1. **note the content of the report; and**

2. **approve the final draft Better Care Fund submission (Appendix 1).**

3.0 **SUPPORTING INFORMATION**

3.1 Members of the Board will recall that the initial draft Better Care Fund was submitted to the Local Government Association (LGA) and NHS England on 14th February, following approval by the Board.

3.2 Initial feedback has been received from NHS England through an assurance checklist and the Better Care Fund submission has been updated accordingly. The updated submission is attached at Appendix 1.

3.3 The final submission of the Better Care Fund is due on Friday 4th April 2014.

4.0 **POLICY IMPLICATIONS**

4.1 Nationally, the Public Health White Paper and the Health and Social Care Act both emphasise more preventative services that are focussed on delivering the best outcomes for local people. Locally, the Integrated Commissioning Framework sets out formally the joint arrangements for Commissioning. The joint Health and Wellbeing

Strategy includes shared priorities based on the Joint Strategic Needs Assessment and local consultation.

5.0 **FINANCIAL IMPLICATIONS**

5.1 Undertaking the recommendations within this report will ensure that the new pooled budget funding is accessible so that outcomes for people living within Halton can be improved further.

5.2 The breakdown of the financial overview for the Better Care Fund is described in the table below.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
Local Authority #1	Y	23,525	*6,917*	*25,488*
CCG #1	N	12,986	*3,208*	*15,579*
Contingency			*473*	*473*
BCF Total		**36,511**	**10,598**	**41,540**

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

6.1 **Children & Young People in Halton**

Effective arrangements for children's transition services will need to be in place.

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

Any long-term integration arrangements will need to focus upon staffing issues.

6.3 **A Healthy Halton**

Developing integration further between Halton Borough Council and the NHS Halton Clinical Commissioning Group will have a direct impact on improving the health of people living in Halton. The plan that is developed will be linked to the priorities identified in the Integrated Commissioning Framework.

6.4 **A Safer Halton**

None identified.

6.5 **Halton's Urban Renewal**

None identified.

7.0 **RISK ANALYSIS**

7.1 Halton Borough Council and the NHS Halton Clinical Commissioning Group may be at risk of losing funding if certain criteria/conditions described in this report are not met. To avoid this, it is vital that we work together to produce the "Plan" in line with the guidance that has been issued.

8.0 EQUALITY AND DIVERSITY ISSUES

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

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

None within the meaning of the Act.

Halton Clinical Commissioning Group

DRAFT

Better Care Fund

2014/15 to 2015/16

Between Halton Borough Council, the NHS Halton Clinical Commissioning Group and Stakeholders

Foreword

Social Care and Health services are already closely aligned in Halton with a high level of integration at strategic and operational levels. This has been strengthened this financial year by the introduction of the Public Health service into the council's structure. Public Health has the overall purpose to protect and improve health and reduce health inequalities through tackling the wider determinants of health while also improving the quality of healthcare services as such it is closely linked strategically to the wider council, but it also links to social care services and the clinical commissioning group, both of which it shares premises with.

By working together we can move toward full integration of health and social care for the benefit of the people of Halton to improve outcomes for both patients and people receiving health and social care services. We want to make a real and positive difference to the most vulnerable people in our community.

Many of the milestones and priorities within the Better Care Fund form the building blocks for the five year strategic plan for the NHS HCCG, and 70% of the actions are interlinked, moving us closer to full integration.

Dr Cliff Richards ***Chair*** ***NHS Halton Clinical Commissioning Group***		**Councillor Rob Polhill** ***Leader of the Council***
Simon Banks ***Chief Officer*** ***NHS Halton Clinical Commissioning Group***		**David Parr** ***Chief Executive*** ***Halton Borough Council***

1. Introduction and Vision

This plan sets out the shared vision of Halton Borough Council (HBC) and NHS Halton Clinical Commissioning Group (HCCG) for further improving health and social care services in the borough through the Better Care Fund (BCF).

Our joint vision is ***"to involve everybody in improving the health and wellbeing of the people of Halton".***

The BCF is described as a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and Local Authorities. This document demonstrates how the BCF will be used in Halton during 2014/15 and 2015/16.

2. Background

Having separate budgets for health and social care services has often been a barrier to joint working and addressing the needs of service users holistically. It often results in shifting costs from one organisation to another rather than encouraging them to act in partnership.

People's needs might be categorised as medical or social by agencies and their professionals, but in practice individuals' lives are often more complex. People do not fit neatly into organisational business units, hence the need for different service providers being required to collaborate.

The Government's reforms and the introduction of the Integrated Transformation Fund will introduce a more comprehensive approach to joint working. These will also increase the 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.

3. National Picture

The emphasis nationally for health and social care includes (Support, 2013):

- Outcomes, quality of care, reducing inequalities and efficiency
- Empowerment of patients, people who use services, carers and parents
- Local ownership (including close working between health and local government)
- Working in a proactive way with communities
- Professional leadership to drive change and enable innovation

There are various statutory duties when it comes to integrating health and social care and support and they are highlighted in the table below.

Statutory Body	Duty
NHS England and Monitor	To promote and enable integrated care
Local Authorities	To improve the public's health
Clinical Commissioning Groups and Health and Wellbeing Boards	To promote and encourage the delivery and advancement of integration with their local areas at scale and pace

The ***National Collaboration for Integrated Care and Support*** incorporates 13 organisations in association with National Voices, including the Association of Directors of Adult Social Services (ADASS), Care Quality Commission (CQC), Department of Health (DH), Local Government Association (LGA), Monitor, NHS England and Public Health England. In May 2013 they published "Integrated Care and Support: Our Shared Commitment".

"We must always remember that our efforts in this area and ultimate aspirations should be targeted at improving the experiences and outcomes of individuals and their communities, whilst allowing people to be true partners in their own care and support".

The diagram below is aligned with the statements from TLAPs Making It Real initiative around the personalisation of care and support.

Our ultimate aim is to improve the outcomes and experiences of individuals and communities

National Voices have co-developed a narrative of integrated care and support:

"I can plan my care with people who work together to understand me and my carers, allow me control and bring together services to achieve the outcomes important to me".

4. Legislation

The Government's White Paper *Caring for our future: reforming care and support* (July 2012) set out a long-term programme to reform care and support. At the centre of the White Paper is a 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 puts them in control of their lives so that they can pursue opportunities, including education and employment, to realise their potential.

The ***Care Bill 2013*** is a major step forward towards that vision and introduces legislation to provide protection and support to the people who need it most and to take forward elements of the government's initial response to the Francis Inquiry.

The Care Bill will give people peace of mind that they will be treated with compassion when in hospital, care homes or their own home. It highlights the importance of preventing and reducing needs, and putting people in control of their care and support.

The Bill is split into 3 parts:

- Reform of Care and Support;
- Response to the Francis Inquiry on failings at Mid-Staffordshire Hospital; and
- Health Education England and the Health Research Authority.

A strategic group has been established to look in more detail at the implications of the Care Bill, in particular focussing on the 11 elements of the bill:

- Prevention, Information and Market Shaping
- Who is entitled to public care and support?
- Assessments and Eligibility
- Personalising Care and Support Planning
- Charging and financial assessments
- Care and Support funding reforms
- Protecting adults from abuse or neglect
- The law for carers
- Continuity of care when moving between areas
- Market oversight and provider failure
- Transition for children to adult care and support services

These elements will all have implications for the delivery of health and social care services in terms of resources, finances, partnership working, policies and procedures and skilled and informed workforce.

5. Better Care Fund

The Government announced in their June 2013 spending review the introduction of the Better Care Fund to ensure a transformation in integrated health and social care. The Local Government Association (LGA) and NHS England have set out a planning vision for the fund for Local Authorities and Clinical Commissioning Groups to work more closely together on delivering health and social care.

5.1 Stakeholders

In addition to the endorsement of NHS HCCG Governing Body and HBC Executive Board, Halton's approach to integration has the full endorsement of the Health and Wellbeing Board. Chaired by the Leader of the Council, the Board is multi-agency and inclusive of executive colleagues (including Member involvement) from across key partner agencies, such as statutory health and social care services, independent, voluntary and community sectors, including HealthWatch Halton and the Chamber of Commerce.

On our journey towards full integration Halton has the required support from our local population and all political and clinical partners. Our highly developed joint collaborative approach with the general public has brokered trust and a real sense of openness. By listening to the voice of people who use our services this has led to the co-production of our local vision and strategy. At a recent public event, hosted by Health Watch, a member of the public fed back that:

> "our integrated approach has, for the first time, opened the doors to the ivory towers of both organisations"

By embracing the challenges set through recent health reforms and current financial pressures, Halton is proud to be seen at the forefront in its approach to health and wellbeing. This is achievable by not only having an integrated steer at a strategic level in all Partner organisations, but also the commitment of people who use our services and those who provide them.

5.2 Workforce

Organisational development is an important factor in the successful delivery of integrated health social care outlined within our submission. On-going evaluation of teams and skill mix will ensure the infrastructure and capacity to deliver the schemes identified.

Transformation and the integration of health and social care are on-going and the Better Care Fund provides the opportunity to accelerate this integration at pace and scale. A fundamental element of this will be developing the workforce and the aligning of resources across all partner agencies and providers to deliver integrated care with improved outcomes for service users and carers.

Workforce Plans will be established and worked through for each scheme we have identified as part of the Better Care Fund to ensure that we have the right people with the right skills, knowledge and experience in the right place.

Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Halton Borough Council**
Clinical Commissioning Groups	**NHS Halton CCG**
Boundary Differences	**N/A**
Date agreed at Health and Well-Being Board:	**15th January 2014**
Date submitted:	**14/02/2014**
Minimum required value of BCF pooled budget: 2014/15	**£3,945,000 (including capital)**
2015/16	**£10,598,000**
Total agreed value of pooled budget: 2014/15	**£36,511,000**
2015/16	**£41,540,000**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	
By	Simon Banks
Position	Chief Officer
Date	13/02/13

Signed on behalf of the Council	
By	David Parr
Position	Chief Executive
Date	13/02/14

Signed on behalf of the Health and Wellbeing Board	

By Chair of Health and Wellbeing Board	Rob Polhill
Date	13/02/14

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it.

Health and Social Care providers have been engaged in the development of the Better Care Funding Plan. At a senior level they are members of Halton's Health and Wellbeing Board represented by the Chief Executives of Halton and Warrington Hospital Trust, Knowsley and St Helens Hospital Trust, Bridgewater Community Trust, the Operational Director of Communities and Warrington and Halton Voluntary Action. Several discussions have taken place at this Board on the integration of health and social care and papers were submitted in July and November 2013 on the plan's development which they, along with the rest of Board, endorsed. There was also a BCF Workshop led by a facilitator from the LGA in January 2014. This enabled the Health and Wellbeing Board to look in depth at what changes are necessary to transform health and social care and improve health outcomes.

There has been considerable engagement on this plan with a range of provider stakeholders including 5 Borough Partnership Mental Health Trust, Halton GPs and the Urgent Care Group. There was also a specific meeting organised with the Chief Executive and Warrington and Halton NHS Foundation Trust, the Director of Service Modernisation at St Helens and Knowsley Teaching Hospitals NHS Trust, the Director of Community Services and Operational Director for Integrated Commissioning at Halton to discuss and plan the schemes. It has also been discussed at length with the operational adult social care team within the borough council. Providers have advised how pathways can be improved, teams reconfigured to increase quality and productivity, systems be more efficient and teams more integrated. These changes coupled with the introduction within care pathways of appropriate technology will enable people to live independently, avoid emergency admissions, benefit from reablement services if necessary and have a better patient experience.

In developing Halton's Market Position Statement we have undertaken on-going consultation with voluntary and independent sector providers.

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

On our journey towards full integration Halton has the required support from our local population and all political and clinical partners. Our highly developed joint collaborative approach with the general public has brokered trust and real sense of openness. By listening to the voice of people who use our services this has led to the co-production of our local vision and strategy. At a recent public event, hosted by Health Watch, a member of the public fed back that:

"our integrated approach has, for the first time, opened the doors to the ivory towers of both organisations".

Patients, service users and the public have been fully involved in the development of this plan through the Halton People's Health Forum (HPHF), a group of local people who meet regularly with NHS Halton Clinical Commissioning Group (CCG) to learn about health plans for the area and share their views and opinions on these plans and other health matters.

On 29 October, two HPHF events were held with hundreds of local people attending to learn about healthcare commissioning intentions for 2014-15 as well as have their say on the future of local health and social care services by taking part in a debate on NHS England's 'The NHS belongs to the people: a call to action' campaign, which is calling on patients and the public to talk about the future shape of the NHS,

so it can plan how best to deliver services, now and in the years ahead.

The Better Care Fund was also highlighted at these two events and our direction of travel was shared. In January 2014, the draft "plan" will be shared with the HPHF for their comment and input into the document. Feedback can also be seen at http://www.youtube.com/watch?v=_tLdKCxyk9s&feature=youtu.be

e) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Ref	Document title	Synopsis and links
D1	**Joint Strategic Needs Assessment (JSNA)**	Joint local authority and NHS HCCG assessments of the health needs of the local population in order to improve the physical and mental health and wellbeing of the people of Halton.
D2	**Future impact of demographic changes on unplanned hospital care in Halton**	This document identifies areas with a potential for increased demand over the next five years in relation to demographic changes in the borough. These potential areas for increased demand are reflected within our aims and objectives.
D3	**Halton Health and Wellbeing Strategy**	The Halton Health and Wellbeing Strategy sets out the priorities and actions which the Health and Wellbeing Board are planning to carry out during 2013 – 2016.
D4	**CCG 5 year strategic plan**	Detailed plans by the CCG delivery of services and associated performance measures and efficiency targets.
D5	**CCG 2 year operational plan**	Detailed plans by the CCG delivery of services and associated performance measures and efficiency targets.
D6	**Urgent Care Strategy**	The Urgent Care Strategy outlines the strategic direction for the delivery of urgent care in Halton over the next five years. The Strategy facilitates a common approach to provision and creates a framework within which care providers and commissioners can work to ensure seamless, high quality and appropriate care. It will help ensure that unplanned care becomes better planned and understood by the people of Halton, those responsible for managing urgent care services and the work force required to deliver them.
D7	**Falls Prevention Strategy**	This strategy proposes the development of an integrated falls care pathway with sufficient capacity to deliver an agreed model of care to older people in Halton who are at risk of falling. The model would build on an agreed model of care that is highlighted in the local prevention and early intervention strategy.
D8	**Market Position Statement (MPS)**	This statement provides a powerful signal to the market, summarising important intelligence and explaining how the local authority intends to strategically commission, and encourage the

		development of high quality provision to suit local populations.

VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- ***What changes will have been delivered in the pattern and configuration of services over the next five years?***
- ***What difference will this make to patient and service user outcomes?***

Our vision is "***to improve the health and wellbeing of Halton people so they live longer, healthier and happier lives".*** Within 5 years the commissioning and delivery of all aspects of health, social care and well-being will be transformed within the borough of Halton. Building on our innovative solutions and experiences the children, young people, adults, older people and communities of Halton will experience a fully integrated system that tailors its responses to their needs as individuals, members of families, carers and participants in their communities.

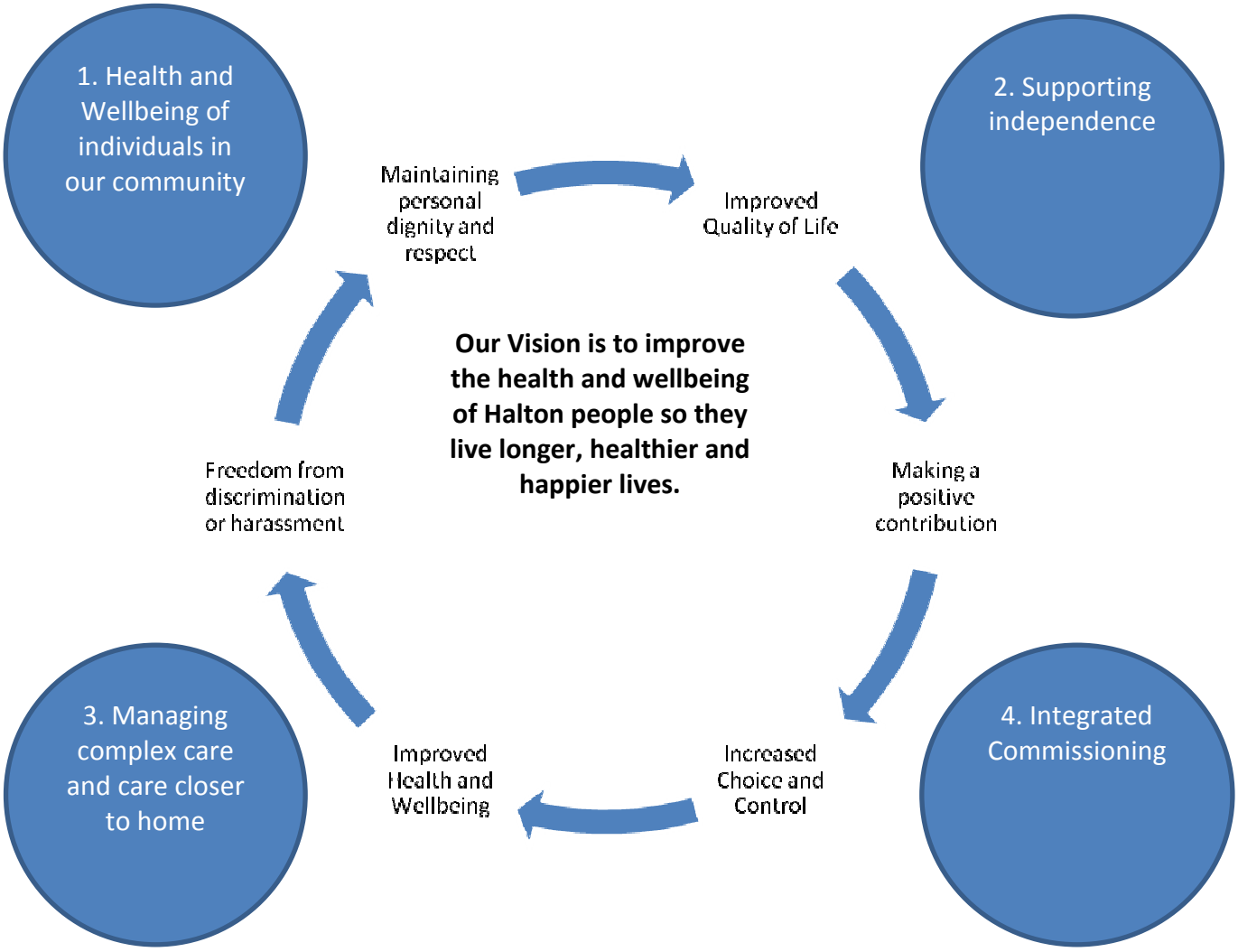
Pro-active prevention, health promotion and identifying people early when physical and / or mental health issues become evident will continue to be at the core of all our developments with the patient and service user outcome of a measurable improvement in our population's general health and wellbeing. We expect this to impact positively on people in the community whilst supporting secondary services to provide timely and appropriate care.

Choice, partnership and control will continue to be developed based on integrated approaches to needs assessment and utilising the diversity of mechanisms that enable individuals and communities to self-direct agreed health, social care and community resources.

We will ensure that we:

- Improve outcomes
- Improve health and wellbeing of individuals in our community
- Support independence
- Manage complex care and provide care closer to home
- Integrate our approach to commissioning
- Improve quality of care
- Intervene at an earlier stage to support people with mental health problems in the community

Figure 1 – Our Vision



b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- ***What are the aims and objectives of your integrated system?***
- ***How will you measure these aims and objectives?***
- ***What measures of health gain will you apply to your population?***

Halton is a borough in the North West of England. Our population of approximately 125,000 is centred on two towns with strong, supportive and active local communities. We have 17 GP practices with NHS Halton Clinical Commissioning Group (HCCG) co-terminus with Halton Borough Council (HBC). The two acute hospitals used by the population are out of borough with a single community health care provider and a separate mental health provider. We have a thriving domiciliary and residential care market and an active third, faith and voluntary sector. Whilst we have high levels of deprivation and challenging health outcomes we are seeing improvements in a number of key areas.

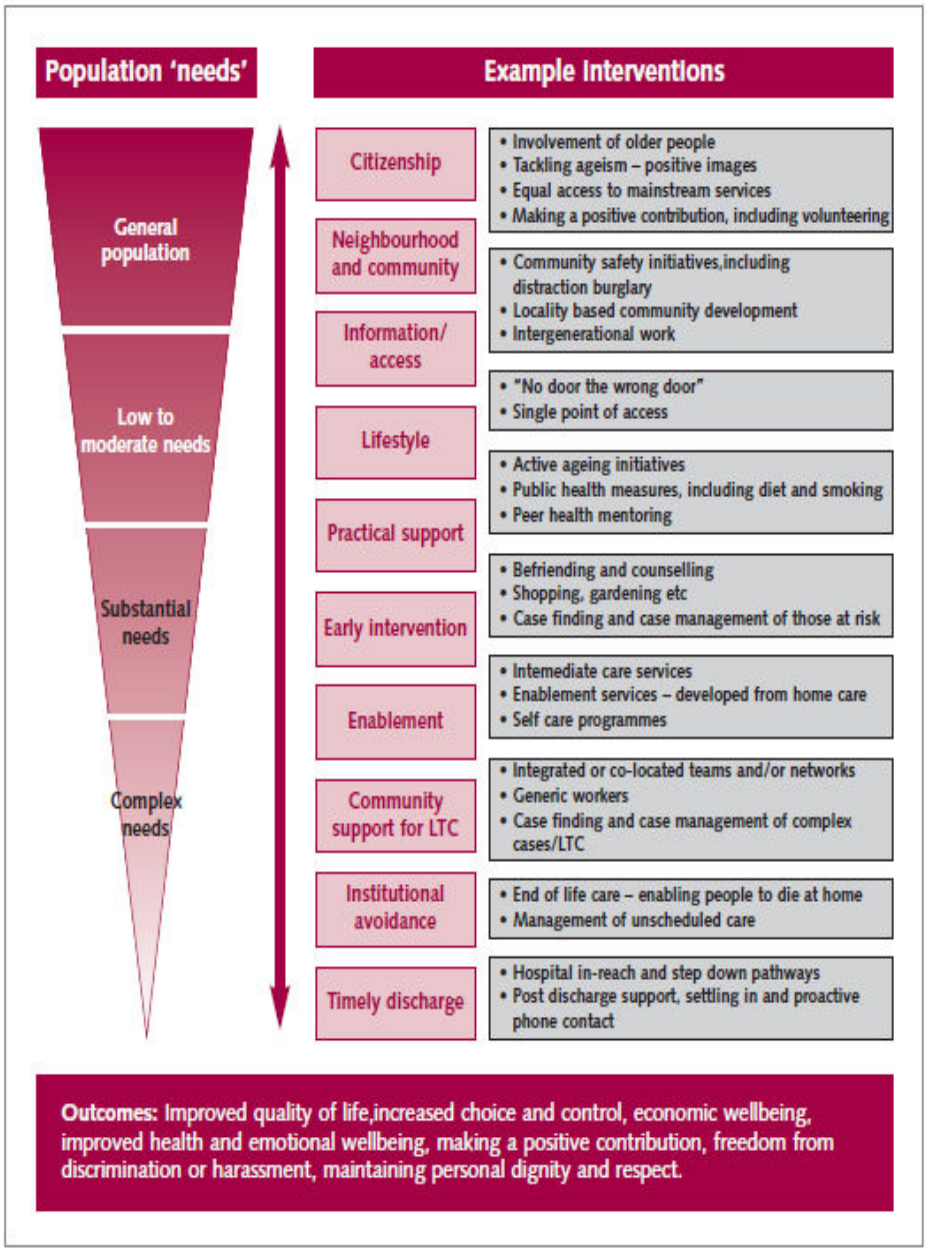
The changing landscape of health and social care provision over the past two years has enabled us to re-evaluate our overall approach to the commissioning and delivery of health and social care services and examine how we could do things differently to not only ensure value for money, but ensure that services

are affordable, sustainable and meet the needs, wants and aspirations of our community. There is a long tradition of working across organisational boundaries to achieve positive outcomes for local residents. The health and social care community is committed to taking current developments forward and knitting them into a coherent and integrated whole in order to achieve our vision of delivering person centre coordinated care within Halton. The HBC Public Health document "Future Impact of Demographic changes on unplanned hospital care in Halton" identifies areas with potential for increased demand over the next five years in relation to changes in demographics of the borough. These potential areas for increased demand are reflected within our aims and objectives, and outcomes and metrics.

With input and support from Partner Agencies across the Health and Social Care economy in Halton, HBC and NHS HCCG are moving forward at pace to deliver our shared vision of a whole system integrated approach to local health, care, support and well-being. The range of governance structures and boards bring together our two acute hospital providers, community healthcare and mental health providers, primary and social care and the independent and voluntary sectors. This ensures an alignment of the individual organisations' vision and priorities resulting in a borough focused approach. The Health and Wellbeing Board have been instrumental in the development of wellbeing areas, building on established Area Forums, to provide a springboard to an asset based community involvement and community led approaches to health and well-being. We see this approach as crucial to developing the sustainable approach to integrated care and support over the next five years.

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. This is described in the diagram below:

Figure 2 'Triangle Framework' showing the relationship between different levels of population need and a relevant range of intervention



To ensure delivery of our strategic approach, there are four strategic aims that should apply to our transformational plan and they include:

1. **Health and Wellbeing of individuals in our community**
2. **Supporting independence**
3. **Managing Complex Care and Care Closer to Home**
4. **Integrated Commissioning**

To deliver these key aims a number of objectives are required and this plan sets out the deliverables and schemes which include:

1. **Health and Wellbeing of individuals in our community**

The integration of commissioning, system realignment and multi-disciplinary teams provide Halton with the means to work effectively towards the overarching priority of improved health and emotional wellbeing.

This is led by Halton's JSNA and an in depth health needs assessment entitled ***The Future Impact of Demographic Changes on Unplanned Hospital Care in Halton 2013 to 2018*** which identifies areas and levels of increased hospital demand in the next 5 years in line with our ageing population.

Halton have developed a clear framework and rationale to support an increased shift to improving our approach to Health and Wellbeing.

The focus is on:

- Maintaining independence, good health and promoting wellbeing. Interventions include combating ageism, providing universal access to good quality information, supporting safer neighbourhoods, promoting health and active lifestyles, delivering practical services etc.
- Identifying people at risk and to halt or slow down any deterioration, and actively seek to improve their situation. Interventions include screening and case finding to identify individuals at risk of specific health conditions or events (such as strokes, or falls) or those that they have existing low level social care needs.
- Use of enabling technologies such as telecare and telehealth.

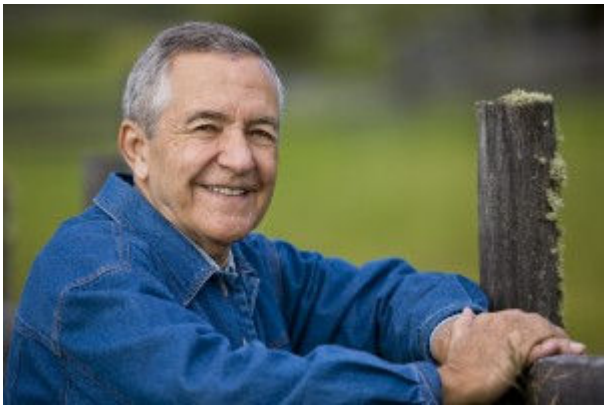
Halton have clearly defined our overall approach to health and wellbeing and can now begin to consider how addressing people's low-level needs and wants we can begin to shift service provision from high cost complex care to more cost effective low-level support.

A review of our Prevention and Early Intervention Strategy 2010 – 2015 has recently been undertaken and the initial mapping exercise has been completed which demonstrates the huge level of services that are being delivered in this area. However, the clear gap is the co-ordination/integration of these services. This approach sets out to address this and consider the benefits of developing a system of improved integration and increased navigation through the system to improve an individual's service experience/outcome.

There has been a significant and growing emphasis, in recent national strategy reports, on the need to change the way services are delivered in response to the demographic challenge of an ageing population, and on the need for a whole system response built around personalised services with increased emphasis on well-being. Community engagement with an assets based approach, prevention of illness and early detection will lead to more people having healthy disability free lives, being able to live independently and a reduction in emergency admissions.

A central objective of this approach is the development of an integrated wellness service following a review of current wellbeing services. A wellness service could be described as a service (or system of services) that specifically aim to promote and improve health and wellbeing, in its widest, most holistic definition, rather than diagnosis and treat illnesses or their direct cause. The service could include healthy lifestyles interventions and/or psychosocial interventions for an individual, for families or groups. The approach might involve a combination of services and interventions such as smoking cessation, weight management, physical activity, alcohol brief interventions, social prescribing/referral e.g. debt advice, welfare benefits, housing, legal advice, etc. psychological wellbeing interventions, e.g. mindfulness and stress management (or a range of any available services). Halton is also working with Primary Care to tackle health inequalities. This includes a proposal to use the National Support Team for Health

Inequalities priority actions based on best practice that could impact inequalities in mortality and life expectancy in the short term. Halton will run Master Classes, supported by NST Health Inequalities Workbooks, for GPs in driving up the quality and capacity of primary care to tackle specific chronic disease areas.



My name is Bob, I'm 65, from Norton and I've suffered from depression

"I knew I had to give up my stressful job when my mother-in-law became ill with Dementia.

It was an easy option to become a full-time carer as my job was affecting my own mental health and financially it made sense that I stay at home rather than my wife.

My new caring role meant I had no work structure, dropped contact with friends and my own personal skills were disappearing. This was the lowest I had ever been and I knew I had to get over this.

I made contact with the local Carers Centre and this opened up doors to lots of things to keep me busy and active that I didn't know about before. It was this that helped me overcome my depression and I've not looked back since!"

2. Supporting independence

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.

Diversity of organisations and service delivery will reflect the complexity and diversity of needs within our community. Integration will be around pathways of support, care and treatment utilising case management approaches as needed to support individuals, families and communities to take control of their health and well-being. Where it is appropriate then organisational integration will be encouraged to improve such pathways. This will result in appropriate admissions to the acute sector.

Technology will be central to supporting people to improve and maintain their health and well-being, offering a range of platforms and sophistication dependent on intensity of need and desired outcomes. Consultation, assessment and intervention work by a range of health, social care and community practitioners will be focused around General Practice and associated neighbourhoods providing quick access to multi-disciplinary and multi-agency teams as determined by presentation and need. These will support into other community settings such as schools, community centres and housing schemes. This means more people can live independently and there will be fewer people admitted to care and residential homes. Where hospital care is unavoidable people will be able to transfer home without delay.

The following schemes will be implemented:

i) Continue to develop the Integration of services and working together at all levels, such as the Multi-Disciplinary Team, Integrated Care in GP Practices, etc. Timely return to the Borough from acute and specialist services will be enabled through network approaches to case management. Proactive case finding, long term condition management, monitoring systems and a range of alternatives for urgent care needs will be in place. This will support the transformation of the acute hospital sector and associated demand management issues.

ii) Further develop our approach to Telecare and Telehealth interventions to support people to live as independently as possible within the community. Services will be tailored to individual needs and encourage a whole system/whole person approach to care.

iii) Continue with the development and implementation of an integrated approach to dementia care. This will allow a shift from traditional pathways and services that are rooted in an acute or clinical setting, to delivering a complete service from diagnosis in primary care to community and social care, voluntary sector and low-level health interventions.

iv) Progress the whole system Model of Care for Adults with Learning Disabilities. The Model is focused on a stepped care approach, from mainstream health and community services to more intensive specialist support. The most effective intervention is offered with the aim of supporting the person in their own home and not being overly restrictive or intrusive.

v) Develop our approach to Mental Health within primary care, enhancing the Council's Mental Health Outreach team by working directly with GP surgeries to identify people who may benefit from this service and therefore prevent relapse, a further priority will be extending the range of day services and work-related opportunities.

vi) Re-design of primary care.

These will be measured by existing performance data including:

- Maintaining lower level of care home admissions
- Preventing admissions and keeping people at home longer
- Early detection of conditions and prevention of deterioration

- Increase in number of extra care housing
- Equipment and adaptations
- Quality of provision – domiciliary care, housing

These will be measured by existing performance data. In Part 2, the plan identifies outcomes and metrics that support this aim and the corresponding objectives.

My name is Anne, I'm 78, from Ditton

and I used to feel lonely

"I lost my husband 3 years ago. It devastated me. I had never felt so lonely. We had plans for when I retired and I felt like my life had ended too. I was bad for a good few months, crying every day. I tried being normal, seeing my family and popping into the neighbour's but it was the evenings that I found the hardest.

Sitting at home on my own with no one to talk to, it was as if the world was passing by without me. I started to become really down and my daughter mentioned how tired and fed up I looked.

It took a while but one day I started to tell her how I felt and it all came out. We sat and hugged and she said I needed to get out more and start to build a new life with different things in it. I knew I had to do something, this couldn't go on. She found loads of dancing groups, Bingo and a flower arranging group. I was nervous at first but with my daughters help I went. I met quite a few new people, two had lost their husbands and also took it badly. But because I could see how they was coping, it gave me hope that feeling lost every day would eventually go.

That was eighteen months ago and now I am busy and have new friends to have a laugh with; which I never thought I would say. I no longer feel lonely and on my own."

3. Managing complex care and Care Closer to Home

The multiple pathways and processes associated with the provision of services to Adults with complex needs are often duplicated and fragmented across Health and Social Care organisational boundaries; this presents challenges in achieving a whole system co-ordinated approach to the assessment and provision of services. The development of new pathways in addition to a pooled budget arrangement for all community care, including Intermediate Care, equipment and Mental Health Services enables Practitioners to work more effectively across those organisational boundaries, utilising the flexibility within the pooled budget to commission holistic services and to improve health gains. This will result in reduced need for emergency bed days and a reduction in lengths of stay in hospital where admission is unavoidable. Acute and specialist services will only be utilised by those with acute and specialist needs. Timely return to the Borough from acute and specialist services will be enabled through network approaches to case management and discharge between the acute areas and community services – a combination of push and pull through the acute/specialist systems. Proactive case finding, long term condition management, monitoring systems and a range of alternatives for urgent care needs will be in place. This will support the transformation of the acute hospital sector and associated demand management issues.

To support this approach a number of schemes will be further developed:

i) Continue to develop the reconfiguration of both Adult Social Care and Community nursing teams, including aligning the teams around local GP communities to strengthen the capacity of the teams, and provide for greater opportunities to work more closely to deliver integrated care and better outcomes and health gains for people in the community.

ii) Continue to progress the Community Multi-disciplinary Teams project, for high intensity users with multiple conditions, specific teams and levels of support focussed around the individual.

iii) Develop the Integrated care home support teams, including a community geriatrician to improve the range of healthcare interventions and services that currently are not easily accessible to people who live in residential and nursing homes. This will result in the improved health and well-being of residents of care homes.

iv) Continue with the improvements in the Integrated Hospital Discharge Teams who provide assessment and care management to inpatients in two local hospitals and which reduces lengths of hospital stay. Proactive discharge planning takes place irrespective of whether the primary need could be described as a health or social care need.

v) Further develop the Integrated Safeguarding Unit to improve the delivery of a flexible and responsive multi-agency service, with a focus on the more complex cases within institutional settings.

vi) Re-design of mental health primary care. Reference has already been made to enhancing the role of the Mental Health Outreach Team in delivering focused interventions to people who may be at risk of being referred to secondary services. One social worker is already targeted at this group of people and the plan is to concentrate more resource in this area. This will enhance community based provision whilst supporting secondary care to focus on core service delivery.

vii) We have been working in conjunction with the 5boroughs NHS Foundation Trust to redesign pathways around acute services, which have now been in place for one year. The emphasis is on preventing admissions wherever possible and adopting a recovery model to support those with more serious mental health problems. The Council's Mental Health social workers are co-located with colleagues from the 5boroughs NHS Foundation Trust and there is a multi-agency Mental Health Strategic Commissioning Board (NHS HCCG, HBC, 5boroughs and others) which oversees strategic developments. Current pressures include those upon acute beds in line with the national position, and continuing pressure upon the community care budget. We therefore intend to connect this work with the re-design of mental health primary care.

These will be measured by existing performance data including urgent care targets and NHS planned care targets. In Part 2, the plan identifies outcomes and metrics that support this aim and the corresponding objectives.

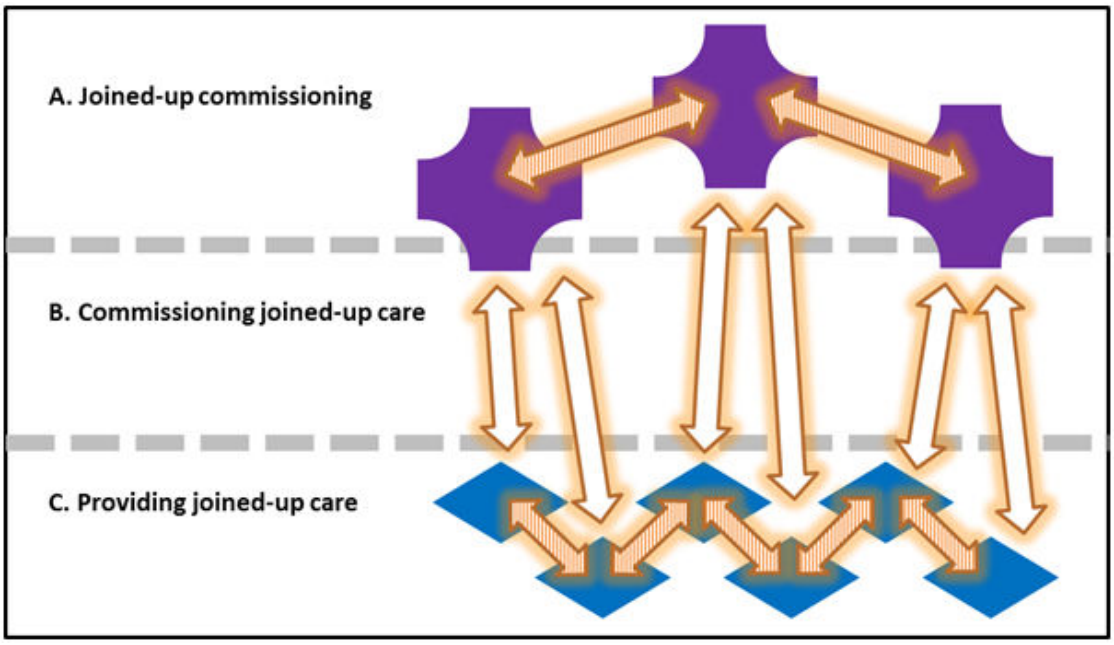
4. Integrated commissioning and clinical practice

Integrating Commissioning within Halton creates the three ***'foci of integration'*** which is necessary to achieve integration.

A. **Joined-up commissioning:** Commissioners within the Clinical Commissioning Group and the local authority develop shared vision, plans and budget. Although this can present challenges, it is necessary to ensure that the large gaps that may have previously been visible between health and social care planning and provision is addressed. Halton are able to clearly demonstrate the benefits of developing shared vision, plans and budgets between the Clinical Commissioning Group and Halton Borough Council.

B. **Commissioning joined-up care:** Commissioners across sectors collaborate with providers to design coherent, reliable and efficient patient pathways, and ensure the incentives are right for providers to provide interoperable services within these pathways. Engaging patients and carers is a vital part of designing better systems and pathways of care.

C. **Providing joined-up care:** Providers ensure reliable and timely transitions, supported by a culture of inter-team collaboration and modern information systems.



Halton's Integrated commissioning aligns commissioning plans, which avoids duplication, increases productivity and improves quality for patients and service providers. Added to this our focus will be on the joining up of expertise and lead roles with commissioners and practitioners. NHS HCCG Clinical Leads link directly with Champions from the Adult Social Care Assessment and Care Management Team therefore improving lines of communication and the sharing of information, as well as improving health gains.

The culture within and between organisations is focused on achieving real improvements in the health and well-being of our population through the delivery of high quality, effective and safe care. This approach recognises both the centrality of supporting people to have control over their health and well-being and the inter-dependency across the systems and organisations to achieve this. This is facilitated through existing and developing mechanisms to incentivise and performance manage providers of services. This is underpinned by a letter of intent which informally binds the organisations to joint working. A formal Section 75 agreement is being developed to take this process to the next stage and drive structural, patient-centred, fully integrated service change.

Within five years the commissioning and delivery of all aspects of health, social care and well-being will be transformed within the borough of Halton. Building on our innovative solutions. The communities of Halton will have a fully integrated system that tailors its responses to their needs as individuals, members of families, carers and participants in their communities.

The following will be the performance areas:

- Integration journey
- Performance Improvement
- Procurement efficiencies
- Quality, Access and Clinical pathways,
- Innovation and Value for Money

- Commissioning for Outcomes

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- ***The key success factors including an outline of processes, end points and time frames for delivery***
- ***How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care.***

Our Integration aims and objectives set out the four main priorities for integration. The planned changes build on what we have already achieved within these areas, and ultimately, moving towards full integration. These include:

- Quality Board linking in to the Overview and Scrutiny Committee, Safeguarding Adults Board and the restructure of the sub groups underneath this;
- Quality and Performance – the development of Integrated dashboards so the monitoring can be streamlined;
- Full integration of the Health and Wellbeing Services; and
- Mainstreaming our overarching approach to delivering health and social care, e.g. locality-based integrated working (Multi-Disciplinary Teams) in conjunction with GP practices.
- We will ensure that all related activity will align with the JHWS, CCG commissioning plan/s and Local Authority plan/s for social care**.**

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

Implications for the Acute Sector with the implementation of the Better Care Fund include:

- Reduction in emergency admissions
- Reduction in A&E admissions
- Appropriate admissions into the acute sector
- Reduction in the need for emergency bed days
- Reduction in the lengths of stay (Integrated Hospital Discharge Team)

If the focus is on prevention and reducing pressure on complex services, and the above implications are realised, the funding capacity achieved from the above will then be directed to sustain improvements within the community (see Figure 1).

By investing £2.7M in urgent care facilities across Runcorn and Widnes NHS Halton CCG aim to reduce inappropriate A&E attendances by 15% across 2 years (14/15 – 15/16) The financial impact of A&E reduction in year 1 is £240k and Year 2 £480k.

The aim is to reduce inappropriate non elective admissions into secondary care by moving emergency activity closer to home, increasing diagnostic activity in urgent care centre – this will impact non elective admission by 15% over 3 years. The financial impact of the reduction of Secondary care non elective admissions in year 1 amounts to £677,500 with an additional saving of £240,000 in relation to the reduction in A&E Activity. Over a three year period this is expected to generate a net saving £2.074m. This will allow the CCG to re-invest in planned care closer to home.

The above estimates are based on a foundation of solid contractual oversight, strong financial management and a governance structure dedicated to improving quality. However it is never a guarantee that outside influences or further pressure will not arise during this process. This in mind the integrated commissioning process is drawing in a clinical lead and economist to work through the activity of all our provider trusts. This work will determine further efficiencies (if required) by determining the activity that brings best value. Activity below the criteria of significant impact may need to stop to achieve the 15%. These actions will need close and careful consideration.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes.

Halton's Health and Wellbeing Board will monitor and review progress and evaluate with the BCF on a regular basis. Governance arrangements and accountability structures for integrated health and social care report into the Board. It has adopted a membership that adequately reflects its key responsibility of providing an integrated response to local needs, which has early intervention and prevention at the forefront. The structure attached indicates the current governance structure, along with how the Board links to other strategic partnerships and operational delivery. **Governance Structure attached at Appendix 1.**

We also recognise that we need to focus our transformation upon prevention and avoid hospital admissions and support people to remain independent. Our focus upon urgent care is therefore fundamental.

In addition to the above governance structure, Halton's approach to Urgent Care, via the establishment of the Urgent Care Working Group, demonstrates a significant level of trust and confidence in shared governance structures and a shared commitment to improving outcomes for service users and patients and their carers making effective and efficient use of public resources. This group is responsible for overseeing all significant service changes required to deliver Urgent Care across the whole of the Halton Health Community, and also addresses developments that may impact in neighbouring local health and social care economies e.g. Warrington. A whole system framework has been developed collaboratively with neighbouring CCGs and Local Authorities, clinicians, practitioners and commissioners to ensure the delivery of seamless, high quality and appropriate care. This framework is easily accessed and understood by the public. It removes duplication, improves efficiency and builds on the strong relationships between social care, health services, self-care services and the third sector. We have recently seen reductions in non-elective admissions, readmissions, lengths of stay, delayed transfers of care and we continue to participate in the North West AQuA benchmarking to support improved performance. Our ambition to reduce A&E attendances and non-elective admissions by 17% will move our performance to better than the national average.

2) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services.

Adult Social Care services in Halton are provided in accordance with relevant legislation. This includes:

- NHS and Community Care Act 1990 and associated regulations
- The Care Bill 2013 that meet the assessed eligible social care needs of people who are ordinarily resident in Halton

Services are available to all eligible adults over the age of 18 and for young people in transition to Adult Services from the age of 16.

The BCF will help to protect these services by:

- Enabling/maintaining continued provision
- Supporting the development of preventative services
- Facilitating the development of integrated services which deliver better outcomes for individuals and improved efficiency for commissioners and providers.

Please explain how local social care services will be protected within your plans.

Plans will help to protect the present level of social care services by:

- Supporting improvements in quality and efficiency of existing services through the developments of integrated initiatives such as the integrated wellness model, data sharing agreement and use of the NHS number as the primary identifier
- Developing preventative services to decrease pressure on complex services
- Developing integrated 7 day services to reduce discharge
- Allowing additional capacity to develop services and improve efficiency

Maintaining eligibility rather than waiting for crisis to happen is important and requires funding to enable us to carry out the Health and Wellbeing services, intermediate care services and reduced duplication. Currently the eligibility criteria at Halton Borough Council is set at substantial (although we do provide some moderate services)which is in line with the plans within the Government's Care Bill for all Local Authorities to set a substantial level by April 2015. A project is currently underway looking at the implications of increased assessments and how this might impact upon the Initial Assessment Team, reviewing existing policies and guidance in this area and establishing a register of all Mental Health assessments, sight impaired and severely impaired adults, adults with a disability and adults with a

diagnosis of dementia.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

7 day access to health and social care services currently exists within the borough for hospital discharges and for people in the community (both assessment for and the provision of services). The capacity and demand in the acute sector at weekends is being reviewed and developed alongside the developments in 7 day working in our local acute trusts. The development of integrated community health and social care teams will further support a consistent approach to treatment, rehabilitation, care and support throughout the whole week.

The development of the Urgent Care Centres in both towns, the on-going work with the out of hours GP provider, the developments through the GP contract and the continued development of IT infrastructure will enable our local population to access timely and informed primary medical care 7 days a week.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

From a CCG perspective, the NHS Number is used as the primary identifier for all correspondence. The Local Authority does not, at present, use the NHS Number as the primary identifier.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by.

In terms of the Local Authority, a project is currently underway, working in conjunction with the NHS Halton CCG to enable the matching of data between both organisations so that the NHS Number can be used by everyone as the primary identifier. This project will be progressed during 2014/15 and will include the development of a data-sharing agreement.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

There is an ever increasing need for interoperability; the ability to share information between multiple systems and service providers to facilitate and enable new and improved patient pathways. In addition, the need to achieve more efficient working practices through the quality agenda is driving healthcare providers to look for opportunities to improve processes, reduce administration and the 'paper chase'.

With this in mind, HBC and the NHS HCCG propose to embark on a dynamic interoperability programme which will have far reaching benefits for patients and the wider health economy in Halton. Through the sharing of clinical views from detailed care records and associated clinical documentation via a secure data exchange, clinicians will have access to accurate, timely information that supports patient care and

joins up health provision in an unprecedented way. This will be facilitated through the utilisation of the Medical Interoperability Gateway (MIG).

We will continue to develop a programme of work to further enable information sharing across care settings including:

- Sharing of clinical views between primary care and community services;
- Sharing of clinical views and discharge summaries between acute and primary care services;
- Sharing of electronic discharge summaries between Acute(s) and Mental health trusts through to primary care; and
- Sharing notifications and support plans from adult social care to primary and community services.

The NHS Halton CCG currently use the COIN network system and NHS.UK and are committed to continuing to adopt these systems that are based upon Open APIs and Open Standards. The Local Authority is also committed to using the GCSX secure standard (Government Connect Secure Extranet) for moving data externally. The Local Authority has clear guidance in place for this, and are committed to adopting Interoperability which is being progressed during 2014/15 as described above.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

The NHS HCCG have all of the appropriate IG controls in place. The Local Authority has been compliant from last year and is currently awaiting approval for this year. Caldicott 2 has just been released and the Local Authority is working through the document to ensure compliance.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

HBC, the NHS HCCG and Bridgewater Community Trust are leading the development of an integrated health and social care programme which supports individuals to remain at home and avoid unnecessary hospital admissions. The PRISM risk stratification tool is used in the locality alongside softer intelligence to identify those at risk of deterioration and increased service utilisation (including hospital care). The model divides the patient population into 3 distinct tiers according to their increasing level of service need, as below:

PRISM Level 1 and 2 – These individuals are at medium to low risk of hospital admission and constitute approximately 70-80% of the long-term condition population. They can self- manage their health.

PRISM Level 3 –These individuals are an increased risk of hospital admission and very often have diagnosed diseases and require a care management approach.

PRISM Level 4-These individuals (approx. 5% of the population) have highly complex conditions and at greatest risk of hospital admission, and require active case management.

The risk stratified data is used by General Practice through a multi-agency meeting to discuss patients, agree an assessment and joint care planning approach and identify an appropriate lead GP and professional. All those at level 3 and 4 have a joint care plan. Some of those at level 1 and 2 may be identified as requiring some lower level prevention and support intervention

This has been in operation for 3 months and will be further strengthened by the planned changes to the GP contract in 2014 in relation to named GP.

3) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

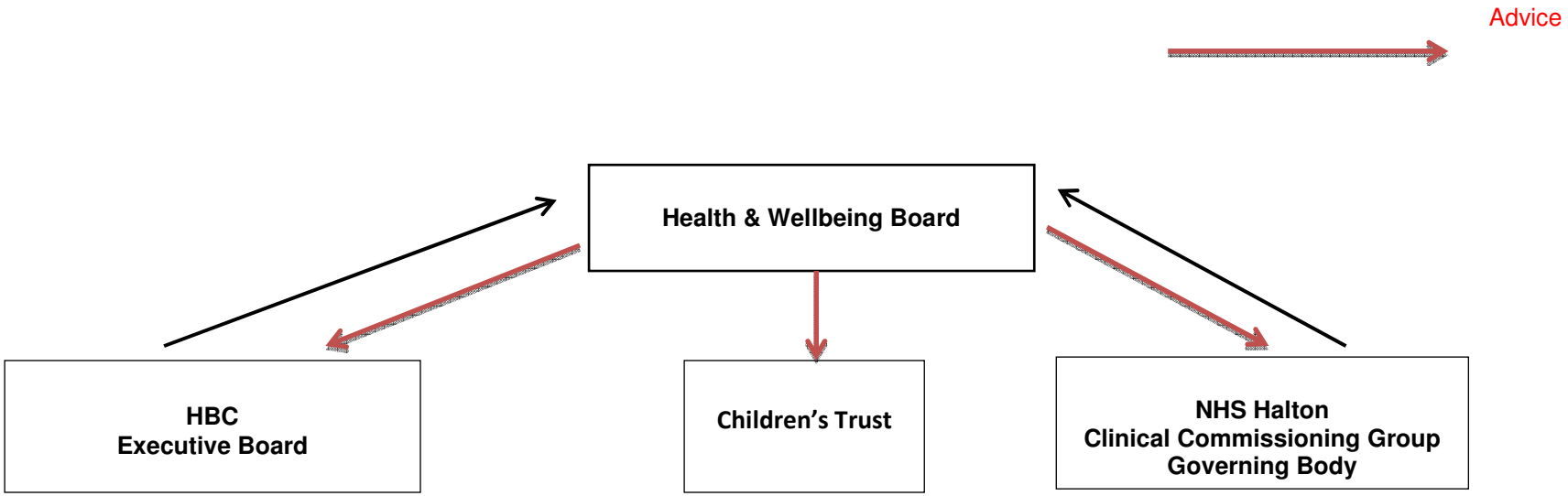
Between HBC and the NHS HCCG there are a number of areas of focus on quality and safety to ensure that gaps are reduced and issues are dealt with as a whole. Some examples include: NHS HCCG have a Quality Committee which is closely aligned to the HBC Safeguarding Adults Board. It is anticipated that this Committee become the main Quality Board for both health and social care. To support this approach, the CCG and Local Authority have developed processes through which member practices of the CCG can raise issues of service quality in any service commissioned by the CCG and LA. The CCG/LA can then utilise this information to identify service/quality issues and take appropriate commissioning action. HBC also has a provider monitoring system which links into the Quality Assurance Team.

The table below identifies a number of high level risks that we have identified as being the most significant to the BCF and to integration as a whole.

Risk	Risk rating	Mitigating Actions
Improvements in the quality of care and in preventative services will fail to translate into the required reductions in the acute sector by 2015/16, impacting the overall funding available to support core services and future schemes.	High	Our integrated commissioning process is drawing in a clinical lead and economist to work through the activity of all our provider trusts. This work will highlight further efficiencies (if required) by determining the activity that brings best value. Activity below the criteria of significant impact may need to stop to achieve this.
The introduction of the Care Bill 2013 will have implications in the cost of care provision, partnership working, policies and procedures and skilled and informed workforce.	High	Strategic Group was established in October 2013 to begin to identify the implications of each element of the Care Bill.
Financial fragility	High	Work on-going to forecast financial situation and continue to identify efficiencies across both organisations.
Legal Challenge	High	Robust consultation processes in place, clear application of eligibility criteria, with policies and procedures in place to support decision-makers.
Failure to identify and deal with cultural issues across the HBC and NHS Halton CCG could result	High	Building trust through effective communication, shared values, equal opportunities and effective leadership is crucial

in staff feeling isolated; anxious and worried; and a reduction in job performance.		to the successful development of integrated teams.
Shifting of resources to fund new joint interventions and schemes will destabilise current service providers, particularly in the acute sector.	High	Our current plans are based on the strategies we have in place covering all service areas and linking in to the priorities of the Joint Health and Wellbeing Strategy and Joint Strategic Needs Assessment.
A lack of detailed baseline data and the need to rely on current assumptions means that our financial and performance targets for 2015/16 onwards are unachievable.	High	We are investing specifically in areas such as data management to ensure that we have up-to-date information around which we will adapt and tailor our plans throughout the next 2 years. This includes moving forward with data-sharing and developing a joint performance framework across all areas.
Operational pressures will restrict the ability of our workforce to deliver the required investment and associated schemes to make the vision of care outlined in our BCF submission a reality.	High	Organisational development is an important factor in the successful delivery of adult social care outlined in our BCF submission. On-going evaluation of teams and skill mix will ensure the infrastructure and capacity to deliver the schemes identified.
Communication	Medium	• Joint Local Authority and NHS HCCG commissioning team meetings take place on a bi-monthly basis communicating the vision and plans for the future and involving staff at the outset. • Communication and media tools have been identified as a future scheme to ensure the public are fully aware and involved in all aspects of the BCF and integration.

Governance Arrangements for Integrated Transformation Fund



Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
Local Authority #1	Y	23,525	*6,917*	*25,488*
CCG #1	N	12,986	*3,208*	*15,579*
Contingency			*473*	*473*
BCF Total		**36,511**	**10,598**	**41,540**

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

Better Care Fund schemes in 2014/15 will be funded through the s.256 transfer from NHS England to Halton Borough Council and non-recurrent expenditure to transform services and help manage the transition to new patterns of provision.

Contingency plan:		2015/16	Ongoing
Outcome 1	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		
Outcome 2	Planned savings (if targets fully achieved)	N/A	
	Maximum support needed for other services (if targets not achieved)		

REPORT TO: Health and Wellbeing Board

DATE: 12th March 2014

REPORTING OFFICER: Operational Director, Integrated Care
Halton Clinical Commissioning Group

PORTFOLIO: Health & Wellbeing

SUBJECT: NHS Halton CCG 2 Year Operational Plan

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To provide information to the Board to enable the Board to reach a decision to review the NHS Halton CCG 2-year Operational Plan required by NHS England.

2.0 **RECOMMENDATION: That the Board review the NHS Halton CCG 2-year Operational Plan.**

3.0 **SUPPORTING INFORMATION**

3.1 Copy of NHS Halton CCG 2 Year Operational Plan attached.

4.0 **POLICY IMPLICATIONS**

4.1 None identified

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 The plan identifies in detail the finances and level of savings required over the next 2 to 5 years and the actions to be undertaken to provide sustainable quality services to improve the health and wellbeing of the people of Halton.

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

This is inline with the high level priorities set by the HWBB and evidenced within the Better Care Fund. (BCF)

6.1 **Children & Young People in Halton**

Specific commissioning intentions have been identified in Appendix A page 77 to page 85 highlighting the integrated work to be undertaken between the CCG and the Council in providing services to children and young people as part of the 2-year operational plan

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

None identified.

6.3 **A Healthy Halton**

The Operational Plan priority areas identified in the plan (page 27 to page 45) highlight the areas in which NHS Halton CCG will focus efforts to improve the health and wellbeing of the people of Halton.

6.4 **A Safer Halton**

Specific Actions have been identified in the Operational Plan which will have a direct impact on safety of Halton Residents in receipt of healthcare, these are summarised on pages 9 to 11 and 20 to 21.

6.5 **Halton's Urban Renewal**

None identified.

7.0 **RISK ANALYSIS**

7.1 None identified.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None identified.

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

There are none within the meaning of the Act.

NHS
Halton Clinical Commissioning Group

NHS Halton CCG

2 Year Operational Plan

26/02/2014

Contents

1. System vision

NHS Halton CCG and Halton Borough Council are driven by a burning ambition to make Halton a healthier place to live and work. We are committed to ensuring that local people get the right care and support at the right time and in the right place. We will continue to uphold the rights of people under the NHS Constitution and positively push the boundaries of quality standards and patient experience. Our

vision is to involve everyone in improving the health and wellbeing of Halton. We want people to live longer, healthier and happier lives. We are acutely aware that we are working within scarce resources, it is a well known fact that 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 over the next five years, beginning with a robust 2 years operational delivery plan.

By redesigning primary care access we aim to enable 7 day GP access same day appointments. Integrating Acute and Community services we aim to align clinical pathways enabling a seamless approach to patient care. Focusing on the vulnerable through multi-disciplinary teams will allow for significant efficiencies.

Evidence gathered from our residents and Acute hospitals indicated that 23% of the A&E attendances did not warrant acute care. In 2014/15 we plan to bolster our Urgent care centres in Widnes and Runcorn to provide real alternatives to A&E. Utilising GP and Consultant oversight will offer a central location for 7 day GP access, speedy diagnostics and one stop approach to minor illness and injury. Aligning this with the North West Ambulance Service NHS Trust (NWAS) pathfinder scheme will give a triage option to ambulances that would ordinarily be heading to an acute setting.

By pump priming £2.7m into urgent care we aim to significantly reduce A&E and non-elective activity bringing a 4 year net saving of £2.1m.

The overall NHS Halton CCG financial pressure is a reduction in spend of around £9m therefore additional tightening of contracts and better use resources will drive the 5 year plan.

Building on these innovative solutions and experiences the people of Halton will experience a fully integrated system that puts people at the heart of decision making about their care.

Pro-active prevention, health promotion and identifying at risk people early when physical and / or mental health issues become evident will be at the core of all our developments with the outcome of a measurable improvement in our population's general health and wellbeing.

Choice, partnership and control will continue to be developed based on integrated approaches to needs assessment. With bringing care out of acute settings and closer to home an essential part of providing health and social care over the next five years.

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.

1) Maintain and improve Quality standards

NHS Halton CCG is committed to maintaining and wherever possible improving the quality of the care provided. Quality standards will not be allowed to slip despite the strain on the budget

2) Fully integrated commissioning and delivery of services across Health & Social care

NHS Halton CCG will drive Collaborative Commissioning with joint strategy, planning and collaborative commissioning with NHS England and Halton Borough Council, ensuring there is alignment of our commissioning towards outcomes and how each party works to lead on pathways of care.

3) Proactive prevention, health promotion and identifying people at risk early

Pro-active prevention, health promotion and identifying people early when physical and / or mental issues become evident will continue to be at the core of all our developments with the outcome of a measurable improvement in our population's general health and wellbeing.

Halton Borough Council's Mental Health Outreach team is currently piloting work with GP surgeries in order to identify people who may benefit from this service and prevent relapse.

4) Harnessing transformational technologies

Strategically, NHS Halton CGG are working with NHS Warrington CCG on a whole system IT transformation, which will allow data to flow across all systems, this will reduce the need for bulky/expensive back office functions. Technology will be central to supporting people to improve and maintain their health and well-being, offering a range of platforms and sophistication dependent on intensity of need and desired outcomes.

5) Reducing health inequalities

Halton's Health and Wellbeing service brings together the Health Improvement Team, the Wellbeing GP Practices Team and the Adult Social care Early intervention and Prevention team. This is a new approach that combines and aligns expertise from Public Health, Primary Care and Adult Social Care. This will be developed further over the next five years to continue the good results already seen and reduce the health gap between Halton and the England average.

6) **Acute and specialist services will only be utilised by those with acute and specialist needs.**

Timely return to the Borough from acute and specialist services will be enabled through network approaches to case management. Proactive case finding, long term condition management, monitoring systems and a range of alternatives for urgent care needs will be in place. This will support the transformation of the acute hospital sector and associated demand management issues.

7) **Enhancing practice based services around specialisms**

Consolidation of service providers, fewer but larger practices, development of integrated services centres, rationalisation of acute service providers.

8) **Providers working together across inter-dependencies to achieve real improvements in the health and wellbeing of our population.**

NHS Halton CCG will investigate the implementation of Prime Contractor arrangements for a whole pathway of care or model of care, enabling alignment of incentives and accountability for quality improvement and capacity management.

NHS Halton CCG will work with the Operational Delivery Networks to ensure that outcomes and quality standards are improved and that evidence based networked patient paths are agreed.

2. Integration & Innovation

2.1 Integration

NHS Halton CCG is currently moving towards a fully integrated commissioning unit. Focusing on commissioning, contracting & quality. This commissioning for outcomes approach will bring full system / operational delivery. NHS Halton CCG and Halton

Borough Council have harnessed the recent reforms in health and social care to create the platform for a fully integrated approach to commissioning. This whole system ensures we meet the political directions whilst providing services that are affordable, sustainable and meet the needs, wants and aspirations of our community.

With input and support from partner agencies across the health and social care economy in Halton, Halton Borough Council and NHS Halton CCG are moving forward at pace to deliver our vision of a whole system integrated approach to local health, care, support and wellbeing. Utilising the expertise of our integrated Public Health Team all of the 2014/15 commissioning intentions will be scrutinised to ensure a robust outcome driven evidence base.

We aim to continue our innovative approach to health and wellbeing, building the nationally recognised Community Well Being Practice Model. This approach will be in all 17 practices by midyear 2014. An economic analysis will be implemented early 2014 to indicate a fiscal return on this approach.

Under the Public Services (Social Value) Act (2012), social value will drive every commissioning decision, every piece of work and procured service will be tested under a social value lens ensuring the Borough of Halton benefits from a wider approach to community resilience. A social value charter will be completed in March 2014 in readiness for the new contractual round. Each contract will contain reference to social value and the added value providers can bring to reducing inequality etc.

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

1) Integrated Commissioning Function

NHS Halton CCG is co-located alongside Halton Borough Council Social Care and Public Health and we have already seen the positive impact this has had on breaking down organisational, professional and cultural barriers. Halton's approach to urgent care, via the establishment of the urgent care partnership board, demonstrates the

shared commitment to improving outcomes for service users/patients and their carers whilst making the most efficient use of public resources.

2) Health and Wellbeing of individuals in our community

Health inequalities in Halton are reducing and there have been significant improvements in rate of Cardio Vascular Disease (CVD), Smoking prevalence, Child obesity and Chronic Obstructive Pulmonary Disorder (COPD). However, challenges remain if we are to close the gap between Halton and the national average. Integrated senior management teams, commissioning meetings and planning meetings with staff from a range of backgrounds ensures a joined up approach to improving health inequalities.

Halton's Health and wellbeing service brings together the Health Improvement Team, the wellbeing GP Practices Team and the Adult Social care early intervention and Prevention team. This is a new approach that combines and aligns expertise from Public Health, Primary Care and Adult Social Care.

3) Supporting Independence

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.

Technology will be central to supporting people to improve and maintain their health and wellbeing, offering a range of platforms (such as Telecare and Telehealth) and sophistication dependent on intensity of needs and desired outcomes.

4) Managing complex care and Care closer to home

The development of new pathways in addition to a pooled budget arrangement for all community care, including intermediate care, equipment and mental health services enables practitioners to work more effectively across organisational boundaries, utilising the flexibility within the pooled budget to commission holistic services and to improve health gains.

2.2 Innovation

2.2.1 Innovation in Mental Health Practice

Mental Health services across Halton will be delivered in a way that values the expertise of users enabling them to make their own contribution and be part of a shared decision making process about their treatment and care.

NHS Halton CCG plans to commission services that support a multi-disciplinary team response that is integrated across primary and secondary care, this will include a seamless stepped model to improve access to psychological therapies.

Further innovation will be developed across AED liaison services and developing a street triage model to respond to Section 136 Crisis calls that diverts people away from AED and reduced potential Section 136 assessments under the Mental Health Act 1983. Following a successful pilot running from December to February 2014 which (as of 6th Jan) showed a 72% reduction in the number of Sections under Section 136.

3. Quality Improvement

With regard to the 7 ambitions highlighted by NHS England, NHS Halton CCG has the following services and improvement programmes in place.

1) Securing additional years of life for the people of Halton with treatable mental and physical health conditions

As part of NHS Halton CCG's work with its partners and providers there are several areas where specific work is being done to secure additional years of life. This includes working the Mental Health Provider, 5 Boroughs Partnership NHS Foundation Trust, with regards to reducing the harm from suicide and lessons learnt and physical health checks of people with mental health problems. Working with the community services provider, Bridgewater Community Healthcare NHS Trust, in increasing the number of people with learning disabilities who have had a physical health check.

Work is being done with the acute providers (Warrington & Halton Hospitals NHS Foundation Trust and St Helens & Knowsley Hospitals NHS Trust) to improve the reported hospital mortality figures Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI).

2) Improving the health related quality of life with one or more long term conditions, including mental health conditions

NHS Halton CCG has worked with Bridgewater Community Healthcare NHS Trust to develop a screening programme for the over 65's, this will identify conditions sooner, enable treatment to start earlier and provider the best outcomes for both the patient and the health economy.

NHS Halton CCG has one of the best dementia diagnosis rates in the country (currently 63%) however we are not complacent and are committed to reaching the target of 67% by 2014/15.

The successful Multi-Disciplinary Team (MDT) programme is in the process of developing a Quality of Life survey which will enable us to quantify the amount of difference to a person's quality of life the involvement of the MDT has been able to make.

3) **Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital**

The development of the urgent care centres will have a significant impact on the number of people attending hospital avoidably; this is quantified as a 2.5% reduction in 2014/15 with a 15% reduction seen by 2017/18.

The Multi-Disciplinary Teams are promoting self-care to enable people to manage their own care at home.

The planned Practice Nursing audit will also highlight what training needs may be required to ensure that the highest standards for competence are maintained.

4) **Increasing the proportion of older people living independently at home following discharge from hospital**

The use of pooled budgets between Social Care and Health, the reablement team, Multi-disciplinary team and the review of stroke services will enable 70% of older people to remain at home 91 days after discharge from hospital into reablement.

5) **Increasing the number of people having a positive experience of hospital care**

NHS Halton CCG will continue to monitor the levels of complaints with regard to its two acute services providers, with particular focus on the response times to complaints and whether or not the complainant was comfortable with the response. NHS Halton CCG will also ensure that the providers have mechanisms in place to learn from the complaints that are received.

6) **Increasing the number of people with mental and physical conditions having a positive experience of care outside hospital, in general practice and in the community**

NHS Halton CCG will work towards improving the patient experience of their GP surgery with the aim of increasing the percentage of people answering 'good' or 'very

good' in the GP Patient survey with regards to their experience of the GP surgery to exceed the national average.

Bridgewater Community Healthcare NHS Trust has already begun a local Friends and Family test as part of commissioning for quality and innovation payment which will provide focus around improving a person's experience of care.

7) **Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.**

NHS Halton CCG is involved in several initiatives to reduce the amount of harm related to problems in care. These include the Safer Care Collaborative; One area of focus of this group is Medicines Management. Another initiative is the Mid-Mersey Health Care Acquired Infection (HCAI) taskforce which is looking at providing a consistency of approach with regard to HCAI's across the Mid-Mersey footprint.

NHS Halton CCG has to-date had no HCAI incidences of MRSA and is committed to maintaining this level of performance. Halton is also forecast to have a low reported incidence of clostridium difficile for 2013/14 which we aim to improve upon for 2014/15

3.1 Quality in Mental Health

NHS Halton CCG will continue to support recovery focussed mental health support services that are integrated across health, social care and the criminal justice system.

Services will be supported to develop innovation through organisational change and be commissioned to ensure meaningful outcomes are achieved such as:

- Reduce stigma and discrimination
- Reduce waiting times and ensure parity across services that will in turn support an integrated provision across cluster pathways
- Improve access
- Increases the level of involvement of services users in the quality agendas within the Trust – Such as serious untoward incident panels
- Sustaining and supporting Bridgewater Community Healthcare NHS Trust to be a pilot area for the Mental Health Friend and Family Test and continuing to support the Trust in the advancing quality agenda.

4. Sustainability

NHS Halton CCG faces a 'do nothing' 5 year finance gap of £46 Million. For the health economy to be sustainable the goals are;

- All organisations within the health economy are financially viable in 2015/16
- Operational plan objectives are met
- Reduction seen in A&E activity at the Acute providers
- Reduction seen in inappropriate non-elective admissions into secondary care

4.1 Demographics

The population structure of Halton is projected to change in the next 5 years to 2018. Office for National Statistics predict that there will be an increase of 6.8% in the population aged 0-15 and 23.8% in those aged 65+. Conversely, it is estimated that there will be a decrease in those aged 16-24 by 13.6% and in 25-64 year olds by 2.3%

4.2 Activity

It is likely that there will be more demand on unplanned hospital care over the next 5 years from those living and registered with GPs in Halton, particularly in relation to these younger and older age groups.

Areas identified with a potential for increased demand, due to population changes, are;[1]

Emergency admissions for:

- Falls in those aged 65 and over
- Injuries to the body, particularly in those aged 65+
- Dementia (aged 65+)
- Respiratory conditions (infections and asthma 0-15; flu, pneumonia and chronic obstructive pulmonary disease in 65+)
- Digestive conditions (65+)
- Circulatory conditions (heart disease and stroke aged 65+)

Emergency re-admissions within 28 days, for those aged 65+

A&E attendances in those aged 65+

Analysis of activity demands on Halton Health economy

[1] Future impact of demographic changes on unplanned hospital care in Halton

Older people 65+[2]	2012	2014	2016	2018	2020
People aged 65+ with a limiting long-term illness	10782	11419	12185	12675	13300
People aged 65+ predicted to have dementia	1229	1256	1314	1421	1518
People aged 65+ predicted to have a longstanding health condition caused by a heart attack	948	1018	1073	1116	1166
People aged 65+ predicted to have a longstanding health condition caused by a stroke	444	473	501	528	551
People aged 65+ predicted to have severe depression	523	554	591	606	636
People aged 65+ predicted to have a fall	5048	5363	5665	5921	6206
People aged 65+ with a BMI of 30 or more	5191	5585	5906	6127	6359
People aged 65+ predicted to have diabetes	2430	2605	2755	2895	3017
Adults 18-64[3]	2012	2014	2016	2018	2020
People age 18-64 predicted to have a learning disability	1901	1878	1858	1841	1824
People aged 18-64 predicted to have a common mental disorder	12608	12499	12365	12269	12172
People aged 18-64 predicted to have a moderate physical disability	6267	6190	6154	6136	6109
People aged 18-64 predicted to have a serious physical disability	1878	1852	1842	1844	1845
People aged 18-64 predicted to have diabetes	2625	2603	2584	2594	2585

Contribution of Health and Wellbeing priority areas to emergency admissions in 2011/12[4]

[2] http://www.poppi.org.uk
[3] http://www.pansi.org.uk

		Number	Percentage of all emergency admissions	Change since 2010/11	
Falls	Falls in ages 65+	934	6.2%	7.1%	↑
Alcohol	Alcohol specific	864	5.7%	7.9%	↑
Mental Health	Mental and behavioural disorders	631	4.1%	-0.5%	↔
	Dementia (primary or secondary cause)	563	3.7%	-28.6%	↓
	Self-harm	362	2.4%	-15.6%	↓
Cancer	Cancer	291	1.9%	-19.8%	↓

Of those Health and Wellbeing priority areas that have an impact on hospital admissions, the emergency activity relating to falls and alcohol has increased from 2010/11 to 2011/12.

The number of falls over the last three years in those aged 65+ has increased each year

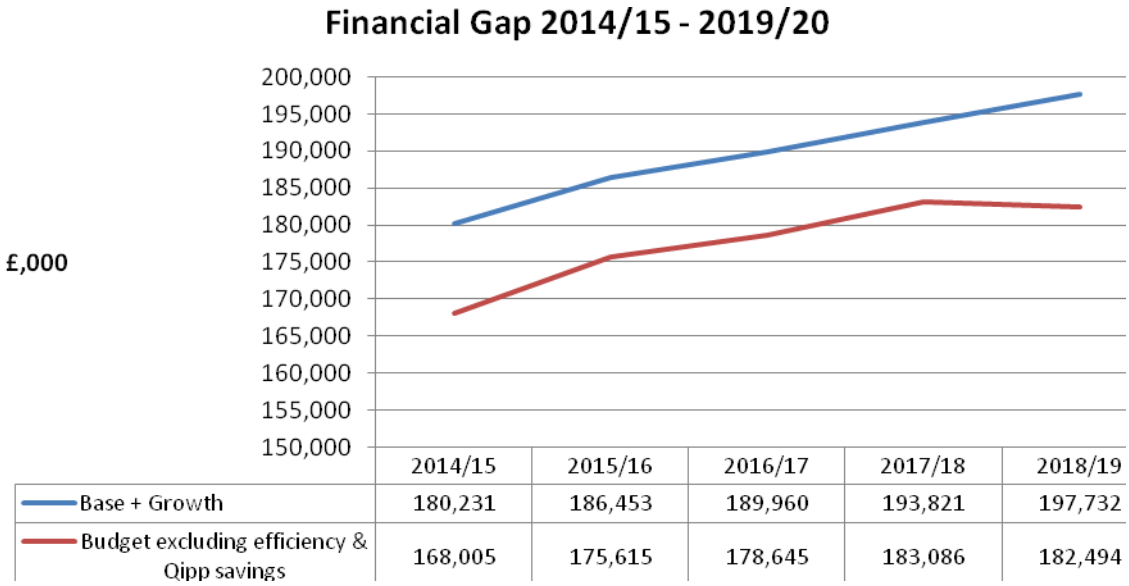
	2009/10	2010/11	2011/12	% change 2009/10 to 2011/12	
Number of admissions for falls[5]	740	872	934	26.2%	↑

- Left unchecked this increase is likely to continue, as the number of falls in people aged 65+ is projected to rise from 5048 in 2012 to 5665 in 2016[6]

4.3 Finances

[4] Source: Future impact of demographic changes on unplanned hospital care in Halton
[5] Source: SUS data (commissioning Support Unit) as reported in 'Future impact of demographic changes on unplanned hospital care in Halton'
[6] Source: POPPI.org.uk

4.3.1 Overall financial position & do nothing position



CCG Programme Budget Allocation					
£'000's	2014/15	2015/16	2016/17	2017/18	2018/19
Halton CCG base + growth	180,231	186,453	189,960	193,821	197,732
Application less savings	168,005	175,615	178,645	183,086	182,494
Savings required	10,450	8,734	8,541	7,297	11,124
Surplus required	1,776	2,104	2,773	3,439	4,116

The table and chart above show a summary of the overall financial position of NHS Halton CCG for the next five financial years. Taking anticipated growth into account £10.45M of savings need to be found in 2014/15. The cumulative effect of the 'do nothing position' would be a shortfall of £46.15M over the five year period. Savings are required to be found in each of the next five years with the largest gap being seen in 2018/19 where a saving of £11.1M will need to be found to achieve a balanced budget.

A full financial plan is available in the NHS Halton CCG 5-year financial plan

4.3.2 Investments in Urgent Care

Investments in Urgent Care

Recurrent investments	£000's
Urgent Care centre	600
Enhanced service primary care	400
Telehealth	100
£5 per head strategic framework GP	646
Total Recurrent	1,746
Non Recurrent investment	
Urgent care centre	500
Redesign of discharge team	100
Extension to hospital at home scheme	65
Development X-ray facility in urgent care centre	300
Total non-recurrent	965
Total investment	2,711

4.3.2.1 Reduction on A&E Activity

By investing £2.7M in urgent care facilities across Runcorn and Widnes NHS Halton CCG aim to reduce inappropriate A&E attendances by 15% across 4 years (14/15 – 17/18) The financial impact of A&E reduction in year 1 is £240k and Year 2 £480k

4.3.2.2 Reduction on Non elective Admissions

The aim is to reduce inappropriate non elective admissions into secondary care by moving emergency activity closer to home and increasing diagnostic activity in urgent care centres. This will impact non elective admission by 15% over 4 years. The financial impact of the reduction of secondary care non elective admissions in year 1 amounts to £0.65m with an additional saving of £1.35m in year 2 and year 3. And a year 4 saving of £0.65m, an overall saving of £4.7m (across both A&E and non-elective admissions). Giving a net saving £2.074m

This will allow the CCG to re-invest in planned care closer to home.

4.3.3 Planned application of funds

The funds available to NHS Halton CCG (Base allocation + growth + prior year surplus less required programme surplus) have been calculated for the next five years and shown in the table below.

NHS
Halton Clinical Commissioning Group

Planned Application of Funds – NHS Halton CCG

	2014/15			2015/16			2016/17			2017/18			2018/19		
	Recurrent £'000	Non recurrent £'000	Total £'000	Recurrent £'000	Non recurrent £'000	Total £'000	Recurrent £'000	Non recurrent £'000	Total £'000	Recurrent £'000	Non recurrent £'000	Total £'000	Recurrent £'000	Non recurrent £'000	Total £'000
Planned application of funds															
Halton Acute Health Expenditure	89,715	2,743	92,458	88,638	2,416	91,054	87,106	2,178	89,284	87,280	2,182	89,462	87,804	2,195	89,999
Halton Community Expenditure	21,455	901	22,356	20,820	621	21,441	20,811	520	21,332	20,961	524	21,485	21,297	532	21,829
Halton Mental Health Expenditure	14,583	415	14,998	14,964	974	15,939	14,993	575	15,567	15,263	382	15,645	15,352	384	15,736
Halton Continuing Care Expenditure	11,720	0	11,720	11,231	0	11,231	11,253	0	11,253	11,388	0	11,388	11,571	0	11,571
Halton Prescribing Expenditure	21,259	0	21,259	21,472	0	21,472	21,687	0	21,687	21,904	0	21,904	22,123	0	22,123
Halton Other Primary Care Expenditure	5,453	550	6,003	4,523	700	5,223	4,435	50	4,485	4,470	0	4,470	840	0	840
Halton Other Costs Expenditure	4,692	1,212	5,904	3,855	215	4,070	17,597	1,627	19,224	21,821	1,909	23,730	23,976	1,942	25,918
Halton Future DH Mandate Investments	200	3,557	3,757	13,920	0	13,920	4,355	0	4,355	2,300	0	2,300	5,600	0	5,600
Total NHS Halton CCG Expenditure	169,078	9,377	178,455	179,424	4,926	184,349	182,237	4,950	187,186	185,386	4,997	190,383	188,563	5,053	193,616

4.3.4 Savings / Investments from other operational plan schemes (from Appendix A)

For full details of the individual schemes please see Appendix A.

4.3.4.1 Recurring expenditure development projects £'000

Scheme name	Scheme ref	14/15	15/16	16/17	17/18	18/19
Wellbeing practice initiative	PCI 5 (13/14)	435				
Urgent care centre development	MHUC141514	600	300			
Enhanced Service	PCI141503	400	50			
PICU Beds increase		15	15	15		
Telemed	PCI141510	100	100			
Redesign care pathway – mental health children	WCF141508	50	100	150	200	
Midwifery PBR redesign	WCF141504	500	100			
Autistic diagnosis	WCF141502	85	17	20		
Health Assessment team LAC		50				
AQP future projects		200	100	100		
Mental Health initiatives	MHUC141502		200	100	150	100
Alcohol Misuse			200	100	150	100
Access weekend and evenings	PCI141506		200	100	100	100
Social care national pooled budget	ADD141509/08		6522			
0.5% contingency plan		892				
Clairs House Hospice		15				
Community orthoptics movement to tariff	WCF141503	66				
£5 per head GP strategy	PCI141506/05/01	646				
Spirometry service	PC141501					
Liverpool care pathway training	PC141507	10				
Hospital at home community nursing	WCF141510	60				
Care home projects – existing and mental health 5BP	PCI141504/07	200				
Integrated IM&T	PCI141510		10			
Implement health needs assessment for LD	MHUC141507					

Improved access to grants	ADD141507	68				
Gynae Physio services	PC141516	10	20			
Lymphoedema	PC141519		30			
Future Mandate requirements			3250	6800	4700	2500

4.3.4.2 Non-recurring development projects

Scheme name	Scheme ref	14/15	15/16	16/17	17/18	18/19
Urgent Care Centre development	MHUC141514	500	200			
Redesign of discharge team, joint working		100				
Mental Health initiatives			300	100		
Alcohol misuse			300	100		
Access weekend and evening	PCI141506		300	50		
Telemed	PCU141510		500			
Hospital at home extension of pilot	WCF141510	65				
X-ray development		300				
Integrated IM&T	PCI141510	50	100			
Alternative employment vulnerable groups	MHUC141508	50				

4.3.4.3 Recurring quip schemes

Scheme name	Scheme ref	14/15	15/16	16/17	17/18	18/19
Running cost challenge		(128)	(115)	(115)	(115)	(72)
Enhanced service	PCI141503		(100)			
Telemed	PCI141510		(200)			
Redesign care pathway mental health children	WCF141508		(50)			
Autistic diagnosis	WCF141502	(85)	(17)	(20)		
Mental Health Initiatives			(200)			
Alcohol Misuse			(200)			
Access weekend and evenings	PCI141506		(200)			
Ophthalmic procurement		(125)				
Asthma care provision	PC14154					
Urology follow ups – Prostate	PC141509					
Foot health pathway re	PC141513					

amputations						
Reduction in NEL activity (2.5% 14/15, 5%15/16, 5% 16/17, 2.5% 17/18)	PCI141503	(677)	(1355)	(1355)	(677)	
Reduction in A&E activity (2.5% 14/15, 5% 15/16, 5% 16/17, 2.5% 17/18)	PCI141503	(120)	(240)	(240)	(120)	
Community Paediatrics		(50)				
Speech & Language therapy	WCF141505	(50)				
Other Primary Care		(1150)	(900)	(1000)	(1000)	(3700)

4.3.5 Running costs

One of the challenges facing NHS Halton CCG is in relation to the running costs. NHS Halton CCG covers a relatively small population and its Running Cost Allowance is proportionate to this, however some of the demands placed upon CCG's are the same regardless of size. The current running cost allowance is £3.1M there is no uplift in 2014/15 and a 10% real terms cut in 2015/16 to £2.87M

5. Improvement Interventions

The eight priority areas identified through extensive consultation with partners are expected to provide real improvements in the health and wellbeing of the people of Halton. These improvements are highlighted below with some of the key actions to be undertaken over the next two years. A more complete list of intentions is shown in Appendix A. These have been cross referenced in brackets ()

1 – Maintain and improve quality standards.

- Specific targets have been written in the quality schedule of the Community healthcare provider to increase the rate of medication error reporting as this has been highlighted as below the national average.
- The quality of services will be reported at GP practice level at as near to real-time as possible. (ADD141503)
- The Friends and Family test will be piloted with GP practices and rolled out to the Mental Health and community care providers (ADD141504)
- CQUINs developed with the providers to implement the commissioning outcomes of both the Francis report and the government response. Reviewing performance against last year and against Cavendish review, 'patients first' government response and Berwick re patient safety collaborative. This will be supported by evidence of duty of candour, quality strategy, and training programmes including mandatory training. (ADD141505)

- Quality standards improved in the acute sector providers by appropriate use of SHMI and HSMR mortality figures to identify areas for further investigation and evidence of improvement actions taken where appropriate. (ADD141506)
- Investigate the reasons behind the number of people who do not attend appointments (DNA's) review practices and develop methods for reduction (ADD141501)
- Develop clear and transparent process for applying for grants from the CCG (ADD141507)

2 – Fully integrated commissioning and delivery of services across health and social care.

- Better Care Fund plan actions are implemented (ADD141509)
- Further develop integrated services between the NHS and Local Authorities for people with complex needs (ADD141508)
- Develop an integrated approach with Halton Borough Council with community pharmacies (ADD141512)
- Deliver single specification with the Local Authority to deliver Children's speech and language services (WCF141505)
- Deliver revised integrated Tier 2 CAMHS specification as a joint project with the Local Authority (WCF141508)
- Secure provision of community services from 2015, VfM contract to reflect the needs of the population supporting more integrated care (PCI141514)

3 – Proactive prevention, health promotion and identifying people at risk early

- Examining the evidence to introduce a targeted screening programme to increase early detection rates of lung cancer (PC141505)
- To work with the NHS England Merseyside area team in the shared pursuit of improving uptake and early diagnosis of bowel, breast and cervical cancers (Public Health Commissioning Intentions 2014/15 – Merseyside Area Team)
- To review access to lifestyles service for patients with cancer, for example breast cancer weight loss and exercise programme (PC141508)
- Review provision of services for people with diabetes who have developed foot problems with the desired outcome of reducing the number of complications associated with foot problems in people with diabetes (PC141513)
- Securing 1 day service provision for people who have had a TIA (PC141510)
- Strengthen the GP's role at the heart of out of hospital care by identifying people at risk of hospital admission and introducing named accountable clinician (PCI141501)
- Explore the potential for introduction of a programme of care for Familial hypercholesterolemia. (PCI141512)
- Roll out learning disabilities physical health checks to under 16s (MHUC141510)
- Delivery Direct Enhanced Service for dementia within general practice, to increase awareness and screening for dementia (MHUC141511)
- Reduce the level of antibiotic prescribing (ADD141510)

4 – Harnessing transformational technologies

- Consider the use of technology to manage sleep apnoea in the community (PC141501)
- Implement the EPACCs IT system – Improve the use of special patient notes in end of life care (PC141506)
- Develop an integrated Health & Social care IM&T strategy & work plan (PCI141510)

5 – Reducing health inequalities

- Reviewing the phlebotomy and pathology provision to increase the equity of provision (PC141520)
- Increase access to and equity of provision of community gynae services (PC141517)
- Improve outcomes for people experiencing domestic violence with a review of the Halton Women's centre (WCF141511)
- Supporting NHS England in ensuring quality in primary care, reducing the variation seen across membership practices. (PCI141508)
- Develop local services to reduce suicide attempts (MHUC141501)
- Review the AED liaison psychiatry model, ensuring that acute and emergency care for people in mental health crisis is as accessible and high quality as for physical health emergencies (MHUC141502)
- Develop and launch 'safe in town' initiative across Halton to increase the number of people in vulnerable groups feeling safe in their communities. (MHUC141503)
- Work with other North West CCG's to secure provision of an IAPT service for military veterans (MHUC141504)
- Review current eating disorder service to improve outcomes for patients (MHUC141506)
- Implement the action plan from the Health Needs Assessment for Learning Disabilities (MHUC141507)
- Develop alternative employment opportunities for vulnerable groups to improve the emotional wellbeing and support individual personal development (MHUC141508)
- Develop mechanisms to ensure we listen to the whole population, including young people and BME communities (ADD141502)

6 – Acute and specialist services will only be used by those with acute and specialist needs

- Procurement of community paediatric consultant service (WCF141502)
- Expand community provision for special schools orthoptic service (WCF141503)
- Review possible procurement of community midwifery service (WCF141504)
- Evaluate the Mersey QIPP pilot for children's community nursing service (WCF141510)
- Amend existing asthma care provision to divert emergency admissions and A&E presentations to the new Urgent care centres (WCF141512)
- Support the regional procurement of NHS 111 (MHUC141513)
- Implement the Urgent Care redesign preferred model to reduce inappropriate A&E attendances and subsequent admissions (MHUC141514)

7 – Enhancing practice based services around specialisms

- To support GP practices to deliver services over above their core contractual responsibilities (PCI141505)
- Develop the strategy for sustainable general practice in Halton (PCI141506)

8 – Providers working together across inter-dependencies to achieve real improvements in the health and wellbeing of our population

- Review pathways for patients with cancer attending hospital to explore alternative models of follow up i.e. telephone follow up or GP led. (PC141509)
- Increase integration in the musculoskeletal (MSK) pathway (PC141515)
- Review the design of community services to focus on outcome based services (PCI141503)
- Establish a single supplementary specialist service for dementia patients that's able to effectively respond and meet the multiple and complex needs of a care home population through the provision of enhanced support (MHUC141515)

6. Contracting & Governance Overview

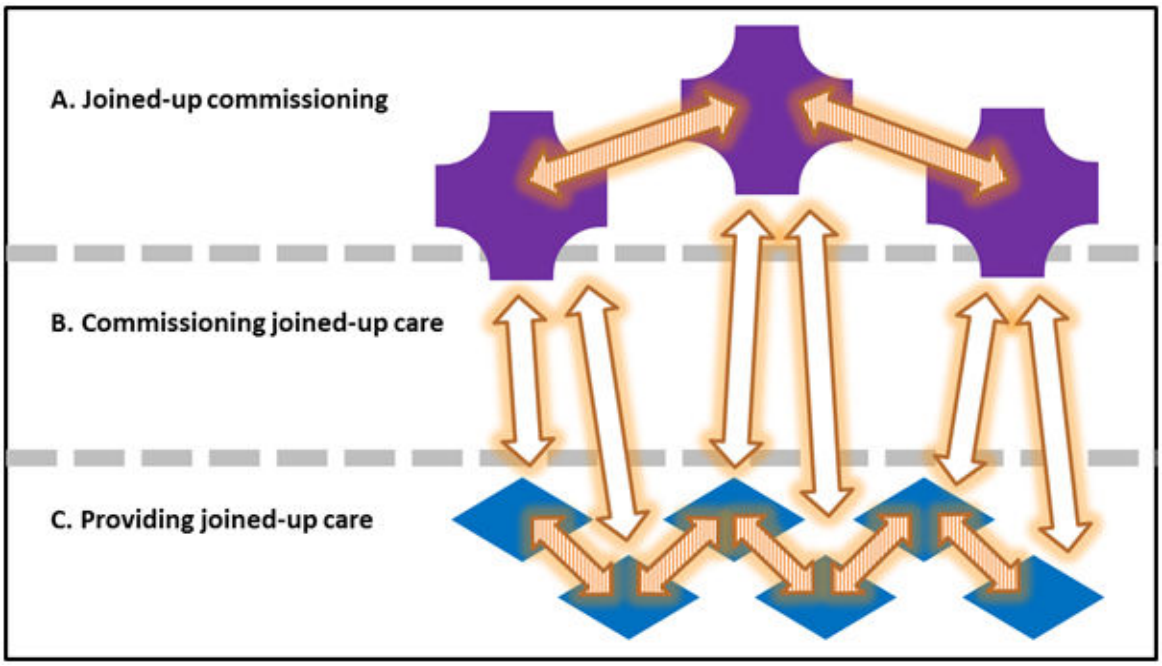
Success will be measured by NHS Halton CCG meeting its financial responsibilities, achieving service improvement and the move of activity away from acute settings and into the community. This will be measured by the views of the local population, providers, clinicians and the metrics highlighted both here and in the Better Care Fund Plan.

6.1 Contracting

Integrating commissioning within Halton creates the three *'foci of integration'* which is necessary to achieve integration.

A. Joined-up commissioning: Commissioners within the Clinical Commissioning Group and the local authority develop shared vision, plans and budget. Although this can present challenges, it is necessary to ensure that the large gaps that may have previously been visible between health and social care planning and provision is addressed. Halton are able to clearly demonstrate the benefits of developing shared vision, plans and budgets between the Clinical Commissioning Group and Halton Borough Council.
B. Commissioning joined-up care: Commissioners across sectors collaborate with providers to design coherent, reliable and efficient patient pathways, and ensure the incentives are right for providers to provide interoperable services within these pathways. Engaging patients and carers is a vital part of designing better systems and pathways of care.

C. Providing joined-up care: Providers ensure reliable and timely transitions, supported by a culture of inter-team collaboration and modern information systems.



Halton's integrated commissioning aligns commissioning plans, which avoids duplication, increases productivity and improves quality for patients and service providers. Added to this our focus will be on the joining up of expertise and lead roles with commissioners and practitioners. NHS Halton CCG Clinical Leads link directly with Champions from the Adult Social Care Assessment and Care Management Team therefore improving lines of communication and the sharing of information, as well as improving health gains.

The culture within and between organisations will be focused on achieving real improvements in the health and well-being of our population through the delivery of high quality, effective and safe care that recognises both the centrality of supporting people to have control over their health and well-being and the inter-dependency across the systems and organisations to achieve this. This will be facilitated through existing and developing mechanisms to incentivise and performance manage providers of services. This is underpinned by a letter of intent which informally binds the organisations to joint working. A formal section 75 is being developed to take this process to the next stage and drive structural, integrated change to the challenging landscape.

Within 5 years the commissioning and delivery of all aspects of health, social care and well-being will be transformed within the borough of Halton. Building on our innovative solutions. The communities of Halton will have a fully integrated system that tailors its responses to their needs as individuals, members of families, carers and participants in their communities.

6.2 Managing Performance

Performance against the key milestones identified against each project will be reported in a performance dashboard. Regular review of this dashboard will allow effective and timely responses to manage situations as they arise.

In addition an early warning dashboard will provide an at-a-glance view of performance against a series of measures including, infection control, quality, risk and safety measures, these will provide effective early markers of possible provider problems or service failure and more can be added as and when appropriate.

Actions identified will also report to an oversight group or be part of a new or existing programme of work. Where this is the case the performance will be reviewed by this oversight group.

6.3 Risk Assessment & Mitigation

The Governing body has considered the potential risk that NHS Halton CCG may be unable to deliver the duties and/or financial requirements set by NHS England. The main reasons this might occur include:

- Unanticipated activity growth
- Activity growth for services subject to cost and volume payment systems, e.g. payment by results (PbR) and continuing health care (CHC)
- Changes in the specialised commissioning allocation.
- The delay or failure of QIPP schemes to deliver planned savings
- Unexpected cost pressures or allocation reductions
- Capacity and capability within provider organisations

Controls to mitigate against these risks fall into three categories.

6.3.1 Financial systems – Sound financial systems and procedures, including a robust ledger and budgetary control system. Expertise in forecasting and budget-setting are key skills which NHS Halton CCG has acquired through its shared finance team arrangements.

6.3.2 Internal governance – These arrangements are intended to ensure that decisions are properly considered and approved and that all the members of NHS Halton CCG can be assured that risks are being properly managed. These include the performance management arrangements described earlier. Other elements are the Audit Committee, Finance and Performance Committee and meetings of the Governing Body and membership; internal and external auditors will test the

robustness of NHS Halton CCG's internal controls and systems. The Board Assurance Framework and Risk Register are well developed and highlight the controls and assurance in place for the identified risks.

6.3.3 Relationships and risk sharing – Examples of this include the creation of the pooled budget arrangements between NHS Halton CCG and Halton Borough Council for adults continuing health and social care cases. Each party agrees to shares risk of costs jointly.

Should NHS Halton CCG still be faced with significant financial pressures despite the controls outlined above then options to deliver short-term financial balance would be considered.

7. Key Values and Principles

The Key values and principles at the heart of our work are:

Partnership – we will work collaboratively with our practices, local people, communities and with other organisations with whom we share a common purpose.

Openness – We will undertake to deliver all business within the public domain unless there is a legitimate reason for us not to do so

Caring – We will place local people, patients, carers and their families at the heart of everything that we do.

Honesty – We will be clear in what we are able to do and what we are not able to do as a commissioning organisation

Leadership – We will be role models and champions for health in the local community.

Quality – We will commission the services we ourselves would want to access

Transformation – We will work to deliver improvement and real change in care.

8. Operational Plan Outcome measures & targets

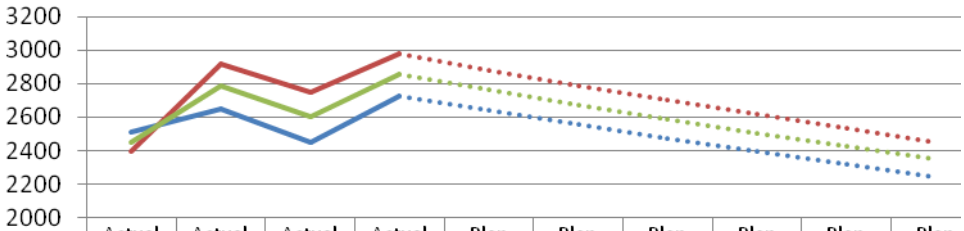
8.1 Securing additional years of life for the people of Halton with treatable mental and physical health conditions

Based on national and local intelligence NHS Halton CCG has developed a number of schemes for implementation over the next 2 years which have the intention of securing additional years of life for the people of Halton. Overall this improvement has been set at 3.2% in both 14/15 and 15/16 for both males and females.
The schemes identified for implementation are;

Reference	Description
PC141505	Review pathway around cancer presentations. This will look at the evidence across all pathways, and will include examining the evidence to introduce a targeted screening programme to increase early detection rates of lung cancer
PC141510	Develop a Cardiovascular strategy for Halton and implement actions arising from the strategy. To include 1) Securing 1 day service provision for people who have had a TIA
PCI141512	Explore the potential for introduction of a programme of care for Familial hypercholesterolemia
MHUC141501	Develop local services to reduce suicide attempts

For full details of the individual schemes please see appendix A.

C1.1 Potential years of life lost from causes amenable to health care in Halton



	Actual 2009	Actual 2010	Actual 2011	Actual 2012	Plan 2013	Plan 2014	Plan 2015	Plan 2016	Plan 2017	Plan 2018
Females	2509	2649	2449	2727	2639	2555	2473	2394	2317	2243
Males	2396	2920	2750	2977	2882	2790	2700	2614	2530	2449
Both	2452	2784	2599	2852	2761	2672	2587	2504	2424	2346

Source Data: http://ccgtools.england.nhs.uk/opa/flash/atlas.html on 09/01/2014

This measure has been selected as a 2014/15 Quality Premium Measure with a nationally set target for the calendar year 2014 of a 3.2% reduction based on the directly standardised rate from a 2013 baseline. This target is ambitious and needs to be agreed with both the Health & Wellbeing Board and the NHS England Area

Team The 2013 baseline will be available in the Summer of 2014, the figure used in this report is the 2012 baseline. For figures post 2014 a further 3.2% has been applied to each year, however targets post 2014 have not been specified by NHS England.

By continuing a year on year reduction of 3.2% on the potential years of life lost (PYLL) this would bring NHS Halton CCG's figure for PYLL from causes amenable to health care to the 4th Quintile nationally from the 5th currently (based on 2012 quintile boundaries). And the 2nd Quintile in the NHS Merseyside Area team. (Where the 1st quintile is the best performing 20% of CCG's)

8.2. Improving the health related quality of life of the people of Halton with one or more long-term conditions, including mental health conditions

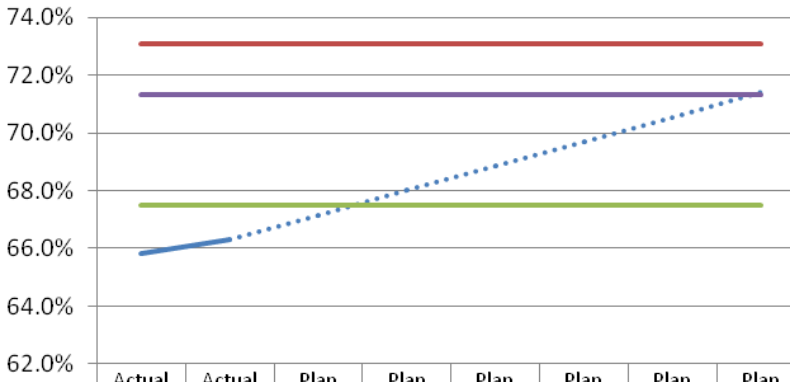
Based on national and local intelligence NHS Halton CCG has developed a number of schemes for implementation over the next 2 years which have the intention of improving the health related quality of life of the people of Halton with one or more long term conditions.

The schemes identified are;

Reference	Description
PC141508	To review access to lifestyles services for patients with cancer, for example breast cancer weight loss and exercise programme
PC141514	Review the scope of the community diabetes provision
PCI141503	Review the design of community services to focus on outcome based services
MHUC141504	Work with other North West CCGs to secure provision of an IAPT service for military veterans
MHUC141506	Review and redesign current eating disorder service
MHUC141507	Implement the action plan from the Health Needs Assessment for Learning Disabilities
MHUC141508	Develop alternative employment opportunities for vulnerable groups
MHUC141510	Roll out of learning disabilities health checks to under 16s
MHUC141511	Delivery of Direct Enhanced Service for Dementia within general practice, to increase awareness and screening for dementia

For full details of the individual schemes please see appendix A.

C2.1 Enhancing quality of life for people with long-term conditions

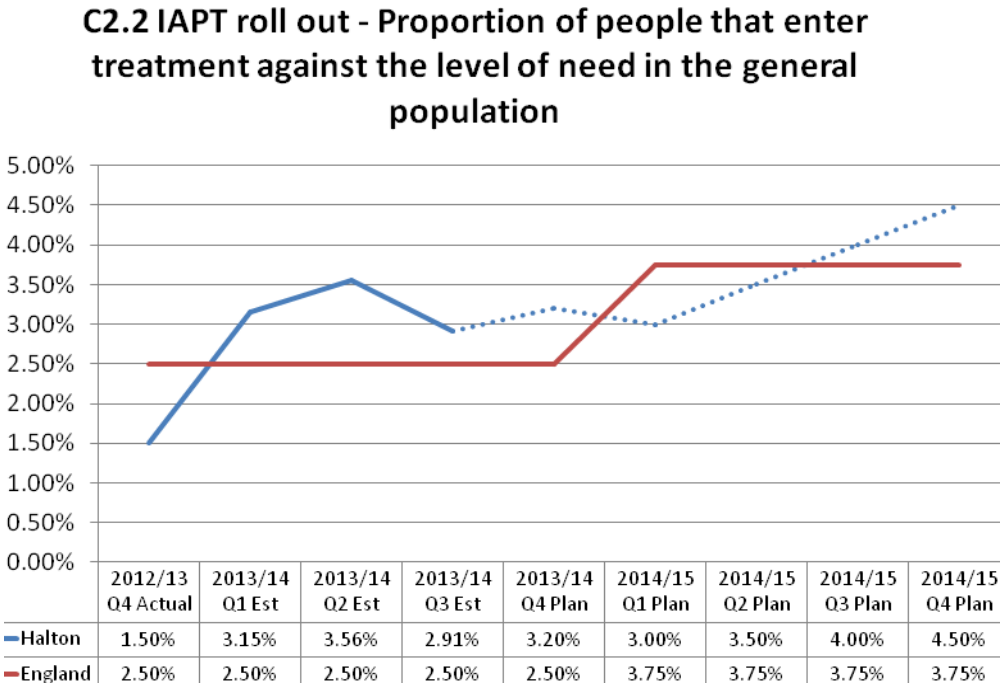


	Actual 2011	Actual 2012	Plan 2013	Plan 2014	Plan 2015	Plan 2016	Plan 2017	Plan 2018
Halton Average health status (EQ5D) score	65.8%	66.3%	67.2%	68.0%	68.9%	69.7%	70.6%	71.4%
England Average (2012)	73.1%	73.1%	73.1%	73.1%	73.1%	73.1%	73.1%	73.1%
NHS Merseyside 2012 (4th Quintile)	67.5%	67.5%	67.5%	67.5%	67.5%	67.5%	67.5%	67.5%
NHS Merseyside 2012 (5th Quintile)	71.3%	71.3%	71.3%	71.3%	71.3%	71.3%	71.3%	71.3%

Source Data: http://ccgtools.england.nhs.uk/opa/flash/atlas.html on 09/01/2014

The graph above shows the average health status (EQ-5D) score for individuals who identify themselves as having a long-term condition,

A 0.5% increase has been seen in the average health status score between 2011 and 2012 in Halton. This places Halton in the lowest quintile nationally but the 3rd (middle) quintile when looking at the NHS Merseyside area team CCG's. Given the rate of improvement need to reach the England 2012 Average score by 2015/16 this looks unrealistic. A more realistic target of a 0.8% Year on Year improvement is both stretching given historical rates of improvement and achievable given the improvement schemes being put into place. This level of improvement would place Halton in the 4th Quintile in the NHS Merseyside Area team (where high is good) by 2015/16 and the 5th Quintile by 2018/19 with a score of 71.4%. This would represent a statistically significant level of improvement on the 2012/13 figure regardless of regional or national improvements.



	2012/13 Q4 Actual	2013/14 Q1 Est	2013/14 Q2 Est	2013/14 Q3 Est	2013/14 Q4 Plan	2014/15 Q1 Plan	2014/15 Q2 Plan	2014/15 Q3 Plan	2014/15 Q4 Plan
Halton	1.50%	3.15%	3.56%	2.91%	3.20%	3.00%	3.50%	4.00%	4.50%
England	2.50%	2.50%	2.50%	2.50%	2.50%	3.75%	3.75%	3.75%	3.75%

Source Data 2012/13 Q4 Actual: *http://www.hscic.gov.uk/catalogue/PUB11365* on 09/01/2014

2014/15 Quality Premium Measure

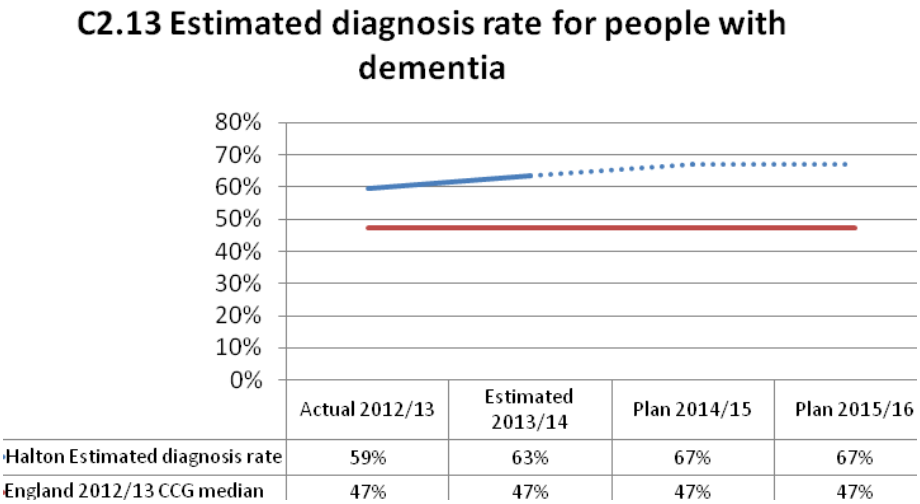
The 2012/13 Q4 Actual performance is based on the Halton & St Helens PCT figure, There are two IAPT providers in Halton, Self Help and Bridgwater Community Health Care Trust. Due to data quality issues the Bridgewater values are estimated for Q1 to Q3

To achieve the 2014/15 Quality Premium NHS Halton CCG will need to achieve an Improving Access to Psychological Therapies (IAPT) annual access level of at least 15% by 31/03/2015
Halton's historical performance with St Helens has been below the England average, however the plans highlighted in the table above and in Appendix A will have a significant impact on the number of people accessing IAPT services.

The current estimated performance for 2013/14 is 12.82%

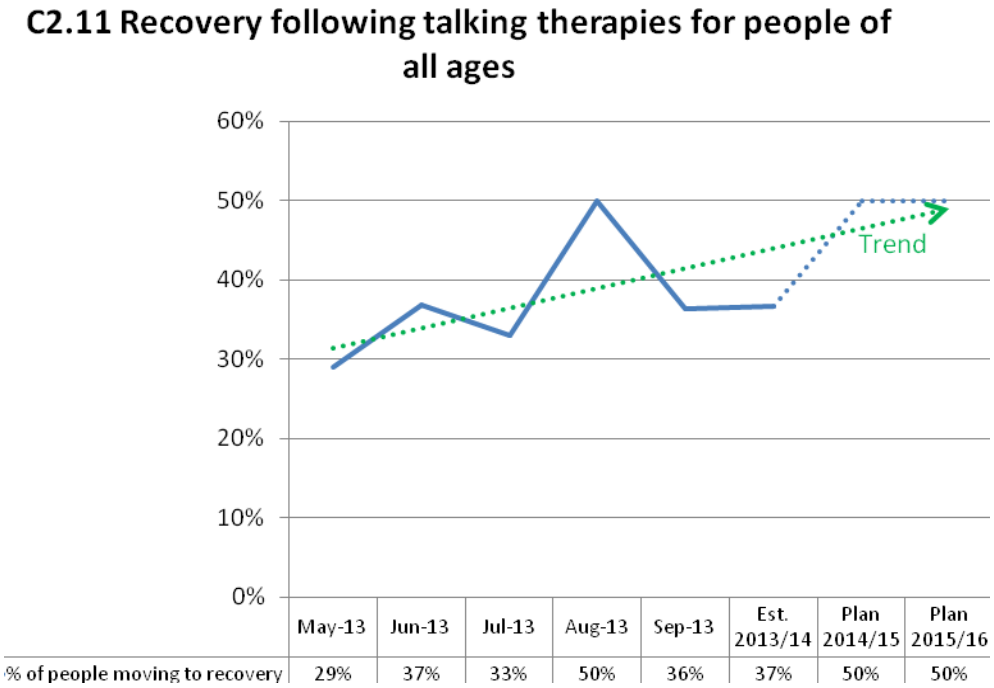
The trajectory set in chart C2.2 above demonstrates the quarterly planned figures to achieve this 15% annual figure.

For 2015/16 the intention is to maintain an annual 15% IAPT access level. This is equal to 2460 people based on a Halton prevalence of 16401.



Source Data: http://dementiachallenge.dh.gov.uk/see-the-data/ on 09/01/2014

NHS Halton CCG estimated diagnosis rate for 2012/13 was 59.3% this is the 12th highest rate in the country (out of 210 CCG's) and the 2nd highest in the North West. The provisional in-year results for 2013/14 showed a further improvement and an estimated final year position of 63.3%. The plan is to reach the nationally set target of 67% by 31 March 2015 and to at least maintain that level of performance for 2015/16.



A significant restructure of how IAPT services are offered from 2014/15 onwards will have a significant impact on the recovery rates recorded. The move to a single provider of the service will enable best practice across the whole population with the expectation of achieving the 50% IAPT recovery rate.

8.3. Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.

Based on national and local intelligence NHS Halton CCG has developed a number of schemes for implementation over the next 2 years which have the intention of reducing the amount of time people spend avoidably in hospital.

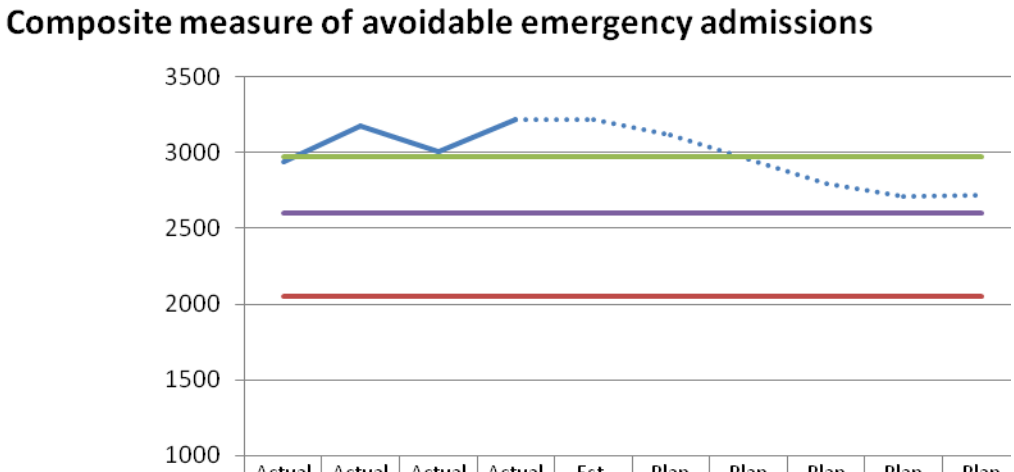
The schemes identified are;

Reference	Description
PC141501	Develop a respiratory strategy for Halton and implement actions from the strategy. To include: 1) reviewing the pathway for people with sleep apnoea. This will include the possibility of using technology to manage sleep apnoea in the community, and considering whether weight management is part of the pathway 2) Reviewing the provision of spirometry services in Halton
PC141506	Implement tools to improve the sharing of information at the end of life: - Work towards implementing the EPACCs IT system - Improve the use of special patient notes in end of life care
PCI141501	Strengthen the GPs role at the heart of out of hospital care and supporting people to stay healthy by identifying people at risk of hospital admission including the introduction of a named accountable clinician
PCI141505	To support GP practices and other providers where appropriate to deliver services over and above their core contractual responsibilities (Local Commissioning Schemes – previously known as Enhanced Services)
PCI141506	A strategy for sustainable general practice services in Halton
PCI141508	Support NHS England in ensuring quality in primary care
PCI141510	Develop an Integration Health & Social Care IM&T Strategy & work plan to include; 1) exploring ways for clinicians and carers to have access to the same information regardless of setting, 2) explore opportunities for OOH providers to have access to primary care record OOH, 3) use of Telehealth and telemedicine to improve patient care, 4) identify the benefits and possibly introduction of Map of Medicine and 5) extending the uptake and use of Choose & Book to improve pathways to hospital and patient choice
PCI141514	Secure provision of community services from 2015
WCF141504	Continue to review with possible procurement community midwifery service
WCF141510	Evaluate the Mersey QIPP pilot for children's community nursing service.
WCF141512	Amend existing care provision for children to build on work done

	currently to divert emergency admissions and A&E presentations to the new Urgent care centre
MHUC141514	Implement the Urgent Care redesign preferred model

For full details of the individual schemes please see appendix A.

8.3.1 Annual Composite Measure



	Actual 09/10	Actual 10/11	Actual 11/12	Actual 12/13	Est. 13/14	Plan 14/15	Plan 15/16	Plan 16/17	Plan 17/18	Plan 18/19
Halton Annual	2936	3179	3007	3215	3215	3114	2953	2793	2712	2717
NHS England 2012/13 Average	2054	2054	2054	2054	2054	2054	2054	2054	2054	2054
Merseyside Area CCG's 20/13 3rd Quintile	2969	2969	2969	2969	2969	2969	2969	2969	2969	2969
Merseyside Area CCG's 12/13 2nd Quintile	2603	2603	2603	2603	2603	2603	2603	2603	2603	2603

Source data: http://ccgtools.england.nhs.uk/loa/flash/atlas.html on 10/01/2014

Source data for 2013/14 Estimated: http://ccgtools.england.nhs.uk/opa/flash/atlas.html on 10/01/2014

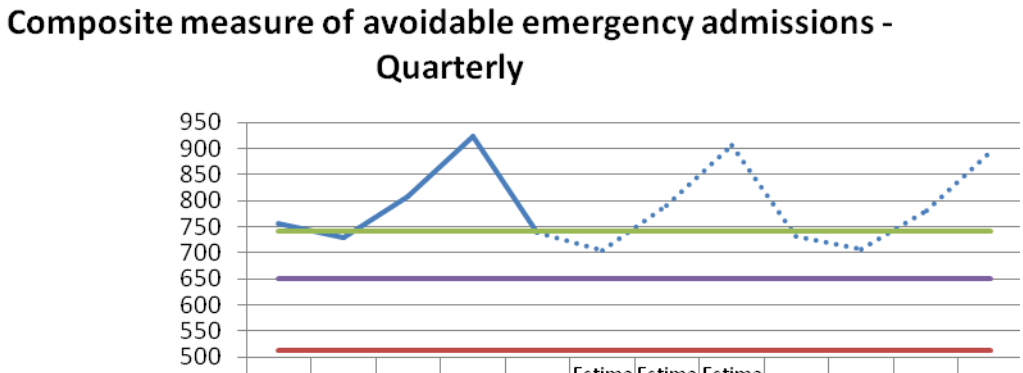
This measure has been identified as a quality premium measure. A reduction or zero percent change is required to earn this portion of the quality premium.

There is a requirement for NHS Halton CCG to achieve 15% of savings over the next five years. The schemes identified in 8.3 will contribute towards this saving. The plan is to reduce the number of avoidable emergency admissions by this 15%. This will be achieved in part by the development of the urgent care centre however this will only become fully operational part way through 2014/15. A 2.5% reduction is planned (currently on the 12/13 baseline) for 2014/15, this would reduce the number of emergency admissions per 100,000 to 3134; however this is within the 95% Confidence Interval. For a reduction to be statistically significant a value of 3114 is needed, this is close to the 2.5% reduction. Further 5% reductions (on the 12/13 baseline) are expected to be seen in both 15/16 and 16/17

Beyond 16/17 the current expectation is that there will be continued innovation and development of the service and a further 2.5% reduction is anticipated. Beyond 2017/18 an age standardised demographic increase of 0.17% is expected, however development in services over the next four years may impact on this forecast.-

The 14/15 Quality premium is based on a reduction being seen between 13/14 and 14/15 or a rate below 1,000 per 100,000. The Baseline data for 2013/14 will not be available until summer 2014 the figures above are based on the 2012/13 actual

8.3.2 Quarterly composite measure



	Actual 12/13 Q1	Actual 12/13 Q2	Actual 12/13 Q3	Actual 12/13 Q4	Actual 13/14 Q1	Estimated 13/14 Q2	Estimated 13/14 Q3	Estimated 13/14 Q4	Plan 14/15 Q1	Plan 14/15 Q2	Plan 14/15 Q3	Plan 14/15 Q4
Halton per 100,000 indirectly standardised	755	730	807	923	738	704	791	905	732	708	781	893
NHS England 12/13 Average	513	513	513	513	513	513	513	513	513	513	513	513
Merseyside Area CCG 12/13 3rd Quintile	742	742	742	742	742	742	742	742	742	742	742	742
Merseyside Area CCG 12/13 2nd Quintile	651	651	651	651	651	651	651	651	651	651	651	651

Source Data: http://ccgtools.england.nhs.uk/opa/flash/atlas.html on 10/01/2014

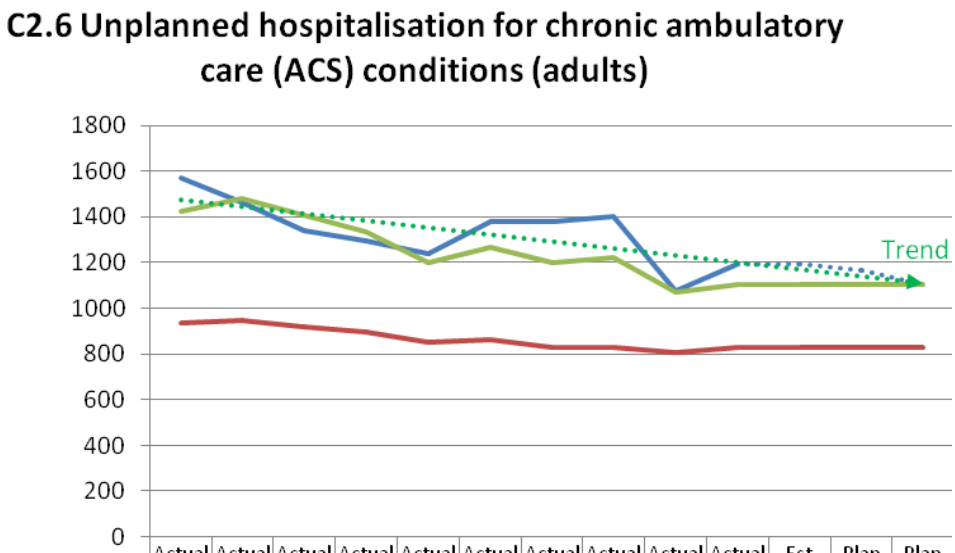
This measure is a composite of four separate measures. These are;

- Unplanned hospitalisation for chronic ambulatory care sensitive conditions
- Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s
- Emergency admissions for acute conditions that should not usually require hospital admission
- Emergency admissions for children with lower respiratory tract infections (LRTI)

Separate plans have been made of each of these measures. For the composite measure quarterly plans are required for 14/15, the figures based in the chart above

are based on the 2.5% reduction on the 12/13 baseline. This have been split across the year based on the seasonal pattern seen in both 12/13 and 13/14 YTD

This is a statistically significant reduction on the 12/13 baseline.



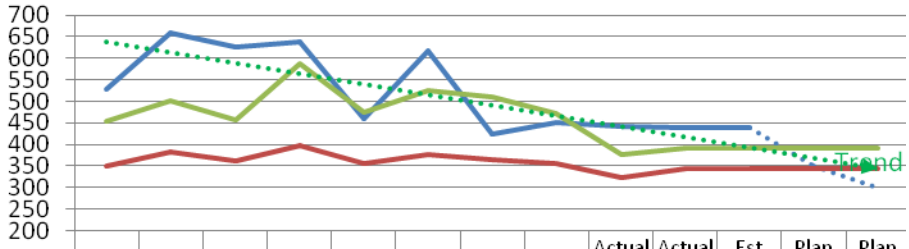
	Actual 03/04	Actual 04/05	Actual 05/06	Actual 06/07	Actual 07/08	Actual 08/09	Actual 09/10	Actual 10/11	Actual 11/12	Actual 12/13	Est 13/14	Plan 14/15	Plan 15/16
Halton per 100,000	1572	1466	1338	1295	1237	1379	1378	1401	1078	1193	1193	1163	1103
England	937	945	918	896	852	860	829	831	808	827	827	827	827
Northwest	1425	1478	1406	1332	1200	1269	1198	1224	1068	1105	1105	1105	1105

Source data: http://ccgtools.england.nhs.uk/loa/flash/atlas.html on 10/01/2014

This is one of the measures included in the composite measure on emergency admissions

For 2014/15 a 2.5% reduction has been planned based on 12/13 Actuals. 13/14 baseline is not yet known. A further 5% reduction on the 12/13 baseline is planned for 2015/16. This is a statistically significant reduction, would bring Halton's performance below the Northwest 12/13 baseline and is in line with the long-term historical trend from 2003.

C2.7 Unplanned hospitalisation for Asthma, diabetes and epilepsy (under 19's)



	Actual 03/04	Actual 04/05	Actual 05/06	Actual 06/07	Actual 07/08	Actual 08/09	Actual 09/10	Actual 10/11	Actual 2011/12	Actual 2012/13	Est 2013/14	Plan 2014/15	Plan 2015/16
Halton (per 100,000)	529	658	626	637	458	617	424	451	443	439	439	350	300
England	350	383	361	396	357	375	364	356	322	343	343	343	343
North west (2nd Quintile)	454	501	458	588	474	525	510	473	377	390	390	390	390

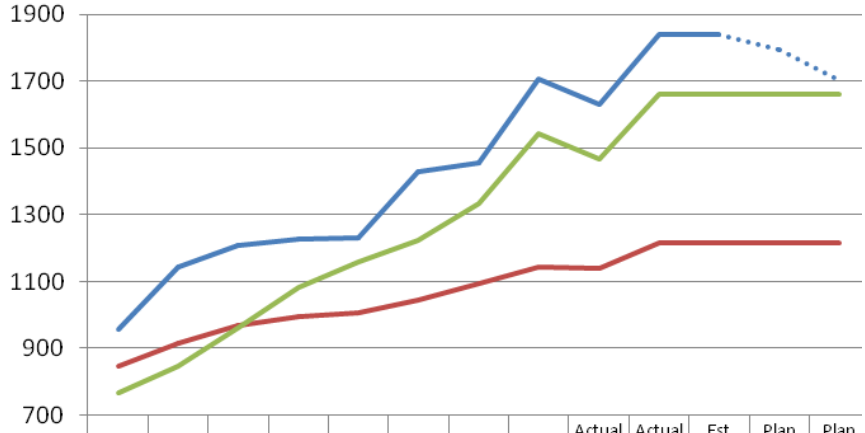
Source data: http://ccgtools.england.nhs.uk/loa/flash/atlas.html on 10/01/2014

This is one of the measures included in the composite measure on emergency admissions

Significant progress has been made with regard to unplanned hospitalisation for asthma, diabetes and epilepsy. It is expected that 2013/14 will be lower than 2012/13. Based on trend forecasting a reduction to 350 per 100,000 is expected by 2014/15 this is a statistically significant reduction below the Lower level confidence interval of the 2012/13 baseline. Further improvements are expected in 2015/16 which will bring the number of admissions down to 300 per 100,000 which will be below the England 12/13 average.

Based on current intelligence if current improvements in performance can be maintained an out-turn rate of 300 is predicted for 2015/16

C3.1 Emergency admissions for acute conditions that should not usually require hospital admission



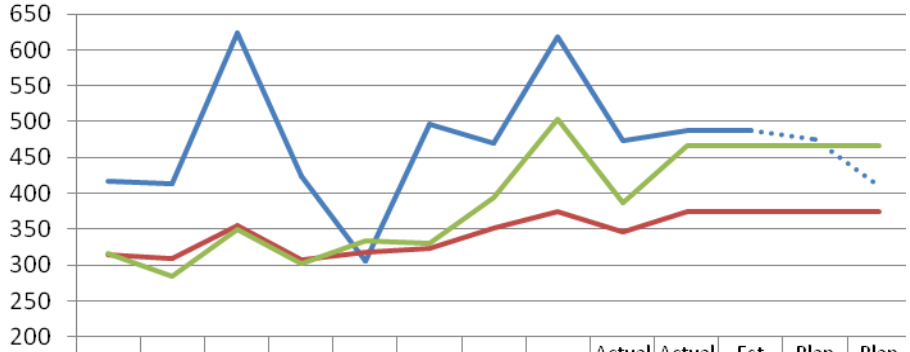
	Actual 03/04	Actual 04/05	Actual 05/06	Actual 06/07	Actual 07/08	Actual 08/09	Actual 09/10	Actual 10/11	Actual 2011/12	Actual 2012/13	Est 2013/14	Plan 2014/15	Plan 2015/16
Halton (per 100,000)	955	1143	1209	1228	1231	1428	1457	1707	1632	1840	1840	1794	1702
England	847	915	968	993	1008	1044	1092	1142	1139	1214	1214	1214	1214
North west (3rd Quintile)	768	845	962	1084	1159	1225	1333	1542	1466	1660	1660	1660	1660

Source Data: http://ccgtools.england.nhs.uk/loa/flash/atlas.html on 10/01/2014

This is one of the measures included in the composite measure on emergency admissions

The plan over the next two years is through transformation of services to make a statistically significant reduction in the number of these admissions with a 2.5% reduction on the 12/13 baseline in 2014/15 and a further 5% on the 12/13 baseline by 2015/16. This will also bring NHS Halton CCG close to the North West 2012/13 3rd Quintile boundary.

C3.4 Emergency admissions for children with lower respiratory tract infections (LRTI's)



	Actual 03/04	Actual 04/05	Actual 05/06	Actual 06/07	Actual 07/08	Actual 08/09	Actual 09/10	Actual 10/11	Actual 2011/12	Actual 2012/13	Est 2013/14	Plan 2014/15	Plan 2015/16
Halton (per 100,000)	416	413	623	424	306	497	469	618	473	488	488	476	410
England	314	309	355	307	317	323	351	375	347	374	374	374	374
North west (2nd Quintile)	316	285	350	302	334	330	394	504	386	467	467	467	467

Source data: http://ccgtools.england.nhs.uk/loa/flash/atlas.html on 10/01/2014

This is one of the measures included in the composite measure on emergency admissions

Targets have been set for a 2.5% reduction on the 12/13 baseline for 2014/15 and a further reduction to 410 per 100,000 for 2015/16.

The 410 per 100,000 target has been chosen as slightly higher level of improvement than other types of emergency admissions to allow for this level of improvement to be proven to be statistically significant.

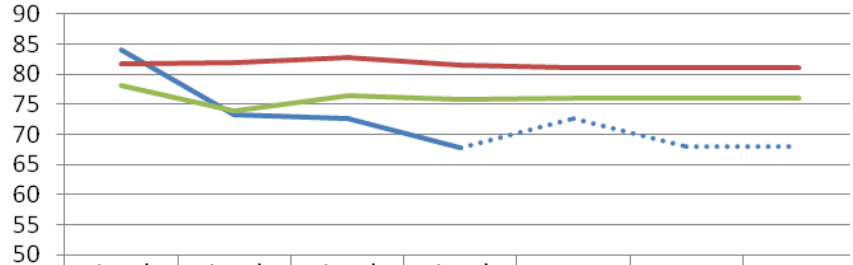
Paediatric attendance at A&E

NHS Halton CCG aim to reduce the utilisation of A&E by children by 16% over 2 years by ensuring that there are paediatric specific services, using agreed care pathways available within the community at the two Urgent Care centres to be established within Halton, for the most common conditions which cause children to present at A&E. These services will be underpinned by the availability of appropriate diagnostic/facilities e.g. cold room to ensure the services can deal with a range of children's conditions effectively. It is also expected that the reduction in the number of A&E attendances will also result in a reduction in the number of emergency admissions, especially in St Helens. This has been calculated at between 3% and 5%.

8.4. Increasing the proportion of older people living independently at home following discharge from Hospital

NHS Halton CCG has worked in partnership with Halton Borough Council in the development of the Better Care Fund plan. Full details of the schemes in place and planned improvements to increase the proportion of older people living independently at home following discharge from hospital are available in this plan.

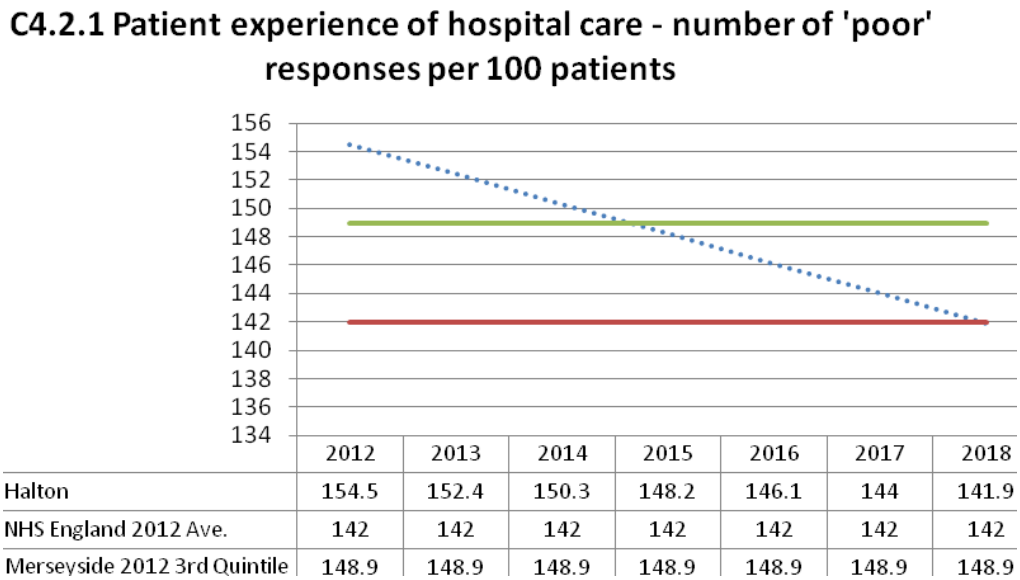
ASCOF 2B - Proportion of older people (65 and over) who were still at home 91 days after dischsrge from hospital into reablement / rehabilitation services



	Actual 09/10	Actual 10/11	Actual 11/12	Actual 12/13	Est 13/14	Plan 14/15	Plan 15/16
Halton	84	73	73	68	73	68	68
England	82	82	83	81	81	81	81
North West 2nd Quintile	78	74	76	76	76	76	76

Data Source: http://ccgtools.england.nhs.uk/loa/flash/atlas.html on 10/01/2014

8.5. Increasing the number of people having a positive experience of hospital care



Source Data: http://ccgtools.england.nhs.uk/loa/flash/atlas.html on 10/01/2014

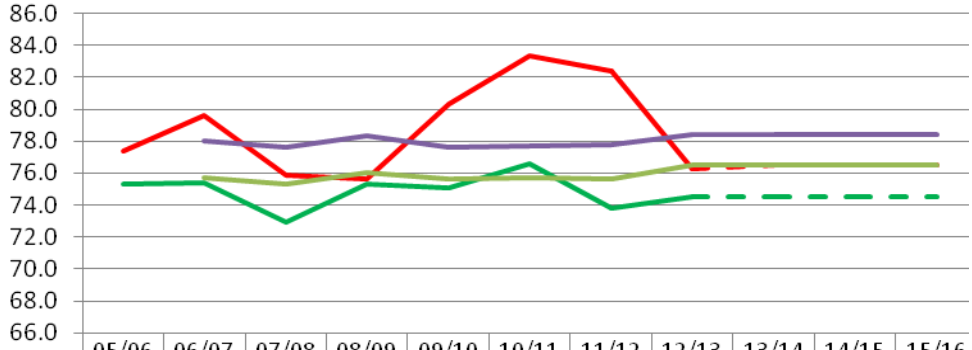
Data is only available for 2012. This shows NHS Halton CCG with a performance of 154.5 'poor' responses per 100 patients, however the lower level 95% confidence interval is 142.0. Co-incidentally this is also the 2012 England average. In order to demonstrate a statistically significant improvement a figure of 141.9 must be achieved. This has been set as the plan for 2018/19

8.5.1 Patient experience of inpatient care (C4.2)[7]

The data below relate to the Care Quality Commissions (CQC) annual Inpatient survey, this is split by the two main acute providers of inpatient services for Halton GP registered patients. Warrington & Halton Hospitals NHS Foundation Trust and St Helens & Knowsley NHS Trust.

[7] http://www.nhssurveys.org/

C4.2 Inpatient experience of hospital care (By Trust)



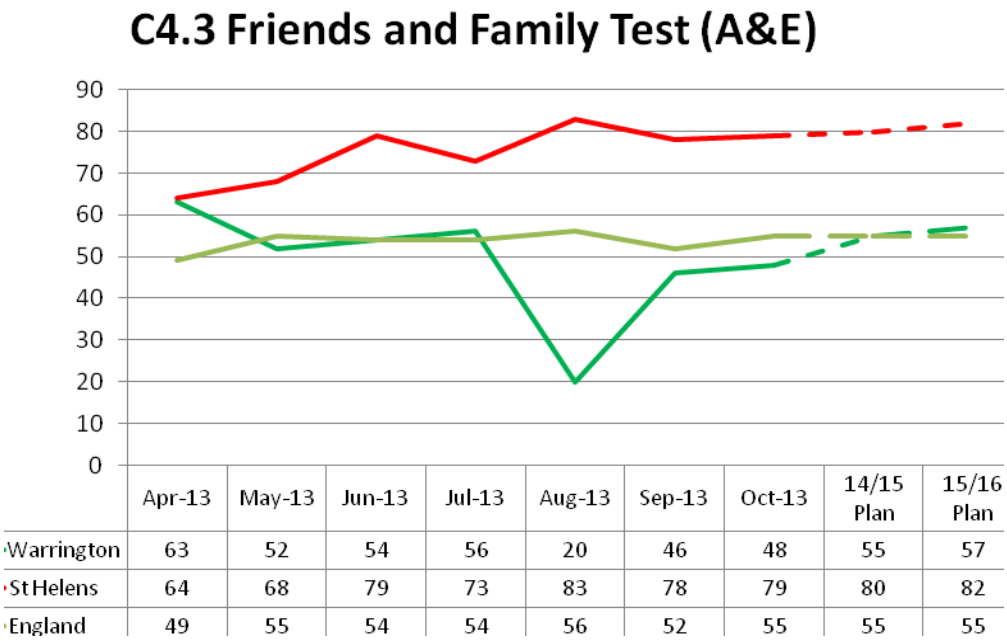
	05/06	06/07	07/08	08/09	09/10	10/11	11/12	12/13	13/14	14/15	15/16
Warrington	75.3	75.4	72.9	75.3	75.1	76.6	73.8	74.5	74.5	74.5	74.5
St Helens	77.4	79.6	75.9	75.6	80.3	83.3	82.4	76.3	76.5	76.5	76.5
England Average		75.7	75.3	76.0	75.6	75.7	75.6	76.5	76.5	76.5	76.5
80th Centile		78.0	77.6	78.3	77.6	77.7	77.8	78.4	78.4	78.4	78.4

Warrington & Halton Hospitals NHS foundation Trust has consistently performed below the England average for patient experience of hospital care. The plan for the next two years is to increase this performance in line with the current (12/13) England Average.

St Helens & Knowsley NHS Trust has reported more variable performance over the last 8 years, reporting figures both below the England average but also above the 80th Percentile. The most recent performance is just below the England average. The plan is to increase performance to the England (12/13) average for 13/14 and to at least maintain this performance for the next two years.

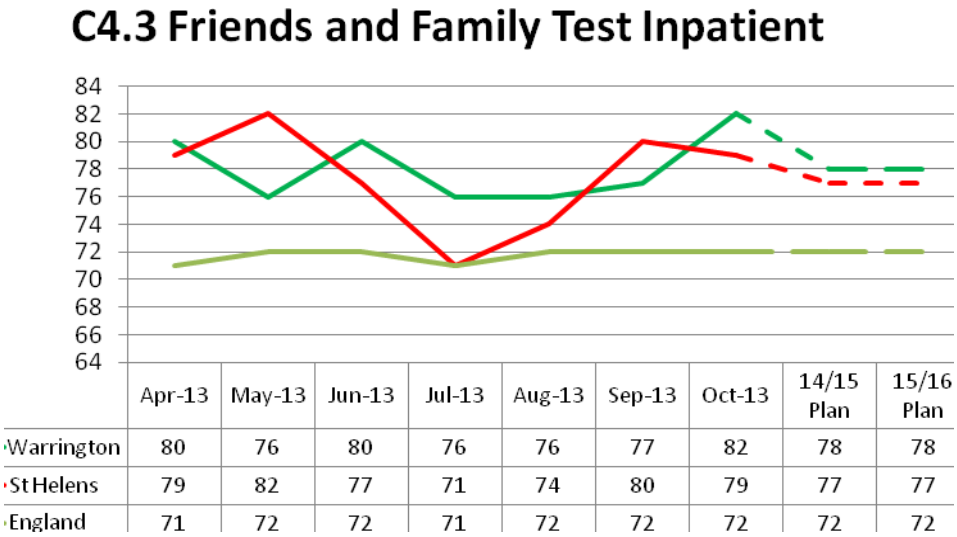
The plan for the next two years is to bring the overall patient experience to meet and exceed the 12/13 England average.

8.5.2 Friends and family test. (C4.3)



There are significant differences in performance in the Friends and Family test (A&E) between St Helens & Knowsley NHS Trust and Warrington & Halton Hospitals NHS Foundation Trust.

The plan is to improve performance in both Trusts. For Warrington & Halton Hospitals NHS Foundation Trust the plan is to bring performance in line with the England average by 2014/15 and a further improvement to exceed England average by 2015/16. For St Helens & Knowsley NHS Trust the plan for 14/15 and 15/16 is for continuous improvement based on a linear trend forecast.



With regards to the friends and family test (inpatient) both Warrington & Halton Hospitals NHS Foundation Trust and St Helens & Knowsley NHS Trust perform significantly above the England average. The plan for 14/15 and 15/16 are to maintain this excellent level of performance at the average of the period April 13 to Oct 13.

8.6. Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community

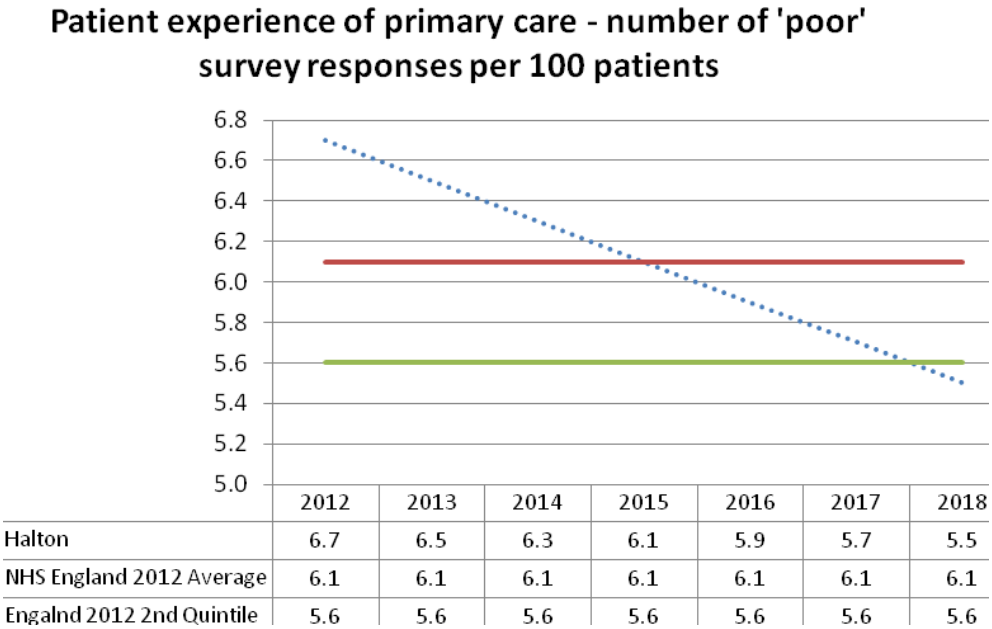
Based on national and local intelligence NHS Halton CCG has developed a number of schemes for implementation over the next two years which have the intention of increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.

The schemes identified are;

Reference	Description
WCF141503	Move to local community tariff basis for special schools orthoptic service and expand community provision on a tariff basis
WCF141505	Undertake joint review of Children's Speech & Language services with LA to deliver single specification and single budget through 'pooled' arrangements with subsequent procurement during 2014/15
WCF141508	To support delivery of the Halton's mental Health Strategy in relation to young people including; 1) Continue review of emotional wellbeing and psychological pathway for young people with a view to delivering revised Integrated Tier 2 CAMHS specification as a joint project with the LA and procurement during 2014/15
WCF141511	Review of the Halton Women's centre
ADD141503	Work towards reporting on the quality of services at GP practice level and also at the level of consultant-led teams for a number of specific specialties
ADD141504	Extend the friends and family test in line with national timescales, including Mental Health and Community based services from April

For full details of the individual schemes please see appendix A.

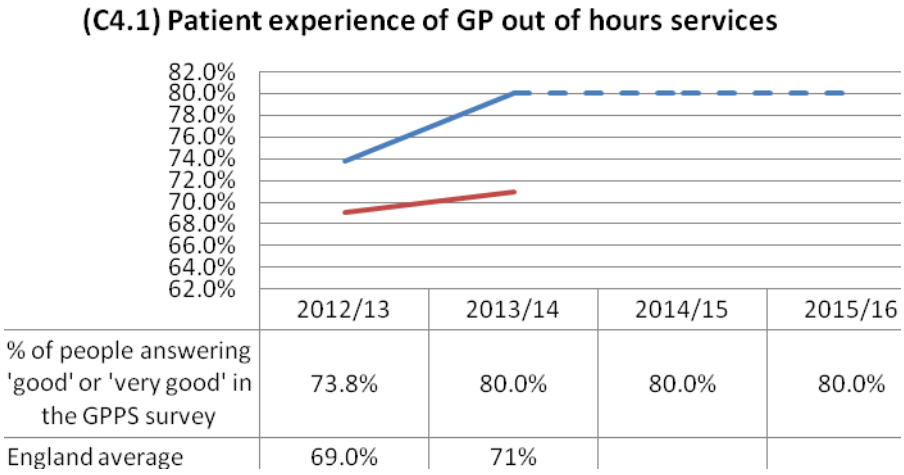
Composite indicator of i) GP Services and ii) GP out-of hours services



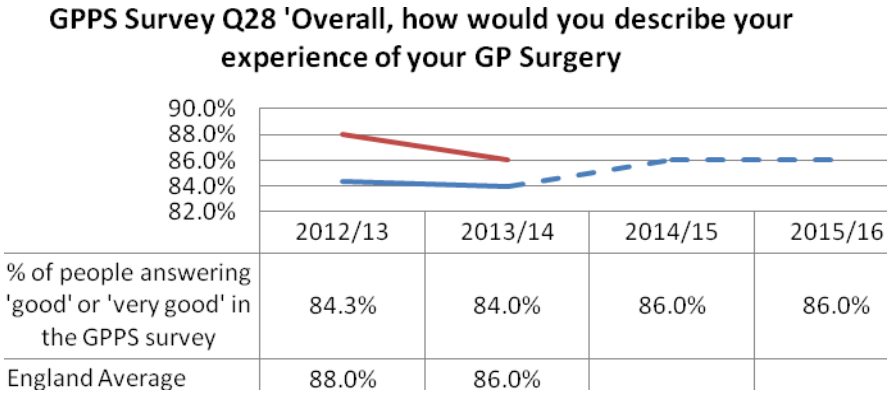
Source Data: http://ccgtools.england.nhs.uk/loa/flash/atlas.html on 10/01/2014

The data above is a composite indicator of results from both GP services and GP out of hours services. In 2012 Halton's performance of 6.7 'poor' survey responses per 100 patients was higher than the England average, however the 95% confidence interval of this result is such that to achieve a statistically significant improvement in performance a result of 5.6 would need to be achieved. This is also the England 2012 2nd Quintile upper limit. This has been set as the target for 2018/19. With interim targets of 6.3 for 2014/15 and 6.1 for 2015/16

8.6.1 GP Out of Hours (C4.1)



NHS Halton CCG's performance in the GPPS survey for patient experience of GP out of hours services is significantly higher than the England average. The plan for 2014/15 and 15/16 is to maintain this high level of performance.



Current performance across Halton practices has remained constant from the Oct-March 13 results to the Jul-Sept results at 84% for those patients answering 'fairly good' or 'very good' to their experience of the GP surgery. NHS Halton CCG are committed to not reducing the quality of services for its residents and wish to bring the overall satisfaction to GP practices to at least the England average of 86% by 2014/15 and maintaining at least this level of quality for 2015/16.

8.7 Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

Based on national and local intelligence NHS Halton CCG has developed a number of schemes for implementation over the next 2 years which have the intention making significant progress towards eliminating avoidable deaths in hospital caused by problems in care.

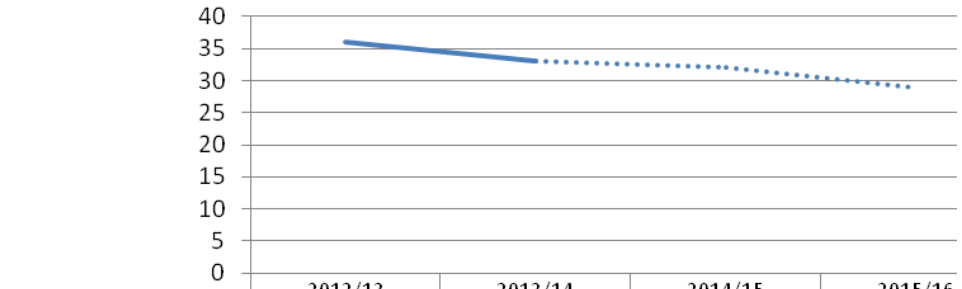
The schemes identified are;

Reference	Description
ADD141505	Implement the commissioning outcomes of both the Francis report and the government response
ADD141506	Develop process to monitor and improve SHMI and HSMR mortality figures in secondary care
ADD141510	Ensure appropriate prescribing of antibacterials

8.7.1 MRSA Zero tolerance (C5.3)

NHS Halton CCG has a zero tolerance approach to MRSA (meticillin-resistant staphylococcus aureus). In the period April to December 2013 there have been no HCAI reported incidences of MRSA for Halton GP registered patients. NHS Halton CCG is committed to maintaining this level of performance for 2014/15 and 2015/16

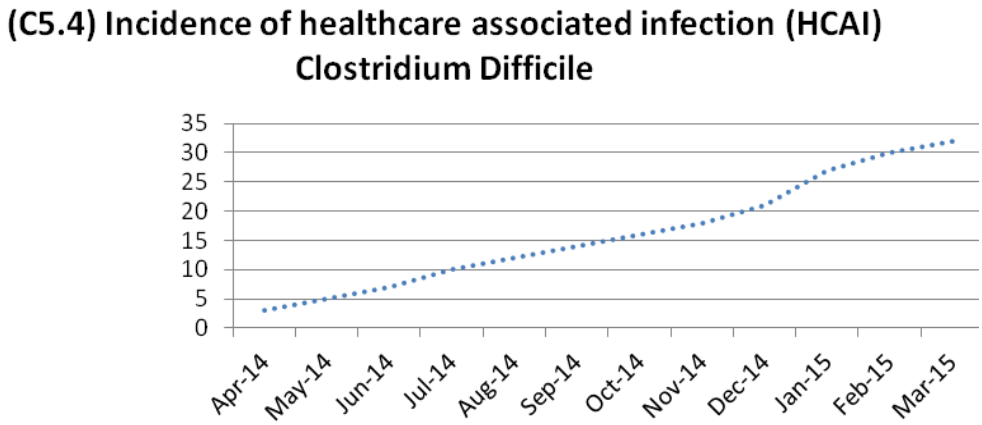
8.7.2 Clostridium Difficile annual plan (C5.4)



	2012/13 Actual	2013/14 Target	2014/15 Plan	2015/16 Plan
The number of C.difficile infections reported in people aged 2 and over	36	33	32	29

Based on initial feedback from the NHS Merseyside area team a reduction of 1 has been factored into the plan for 2014/15 this is a holding position until the exact level of performance required is announced by NHS England. A reduction of 10% has been planned for 2015/16

8.7.3 Clostridium Difficile quarterly plan (C5.4)



	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
C-diff cases (cumulative)	3	5	7	10	12	14	16	18	21	27	30	32

NHS Halton CCG has been making excellent progress in reducing the numbers of people the HCAI C-difficile, and is on target to achieve target set for 2013/14 of 33 cases.

2014/15 and 2015/16 targets are nationally set and these figures are not yet available. The figures above are based on a reduction of 1 from the 2012/13 planned

baseline. However these are subject to change dependant on the outcome of the NHS England review of the approach to setting C difficile objectives.

The seasonal variation of Difficile infections has been taken into account when planning monthly figures for 2014/15.

The percentages applied are 33% of cases expected between Jan to March, with the peak for infections being in January, 27% for April to June, 20% for July to September and 20% for October to December. These estimates were taken from 'English voluntary surveillance scheme for C. Difficile infections'[8]

9.0 Operational plan NHS Constitution measures

For the next two years NHS Halton CCG has set the following targets to meet or exceed the NHS constitution measures

Description	Standard	Halton 14/15 Target	Halton 15/16 Target
Referral to Treatment waiting times for non-urgent consultant –led treatment			
Admitted patients to start treatment within a maximum of 18 weeks from referral	90%	90%	90%
Non-admitted patients to start treatment within a maximum of 18 weeks from referral	95%	95%	95%
Patients of incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral	92%	92%	92%
Diagnostic test waiting times			
Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral	99%	99%	99%
A&E Waits			
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department	95%	95%	95%
Cancer waits – 2 week wait			
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93%	93%	93%
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer not initially suspected)	93%	93%	93%
Cancer waits – 31 days			
Maximum one month (31 day) wait from diagnosis to first definitive treatment for all cancers	96%	96%	96%
Maximum 31-day wait for subsequent treatment where that treatment is surgery	94%	94%	94%

[8] http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317132089343

Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	98%	98%	98%
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	94%	94%	94%
Cancer waits – 62 days			
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer	85%	85%	85%
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	90%	90%	90%
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set	n/a	90%	90%
Category A ambulance calls			
Category A calls resulting in an emergency response arriving within 8 minutes (Red 1)	75%	75%	75%
Category A calls resulting in an emergency response arriving within 8 minutes (Red 2)	75%	75%	75%
Category A calls resulting in an ambulance arriving at the scene within 19 minutes	96%	95%	95%

NHS Halton CCG is committed to maintaining its excellent performance against the NHS constitution measures and achieving or exceeding the standards set.

In addition NHS Halton CCG is committed to the NHS constitution support measures

9.1 NHS Constitution support measures

Description	Standard	Halton 14/15 Target	Halton 15/16 Target
Mixed Sex Accommodation Breaches[9]			
Minimise breaches (rate per 1,000 FCEs)	0.1	0.1	0.1
Cancelled Operations			
All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patients treatment to be funded at the time and hospital of the patient's choice	100%	100%	100%
Mental Health			
Care Programme Approach (CPA): the proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period	95%	95%	95%
Referral to Treatment waiting times for non-urgent consultant-led treatment			
Zero tolerance of over 52 week waiters	0	0	0
A&E waits			
No waits from decision to admit to admission (trolley waits) over 12 hours	0	0	0
Cancelled Operations			
No urgent operation to be cancelled for a 2nd time	0	0	0
Ambulance Handovers			
All handovers between ambulance and A&E must take place within 15 minutes and crews should be ready to accept new calls within a further 15 minutes. Financial penalties, in both cases, for delays over 30 minutes and over an hour.	0	0	0

Mixed sex accommodation breaches – NHS Halton CCG usually has a very good record with regards to mixed sex accommodation breaches, with no breaches at all recorded between April and August 2013. However 2 breaches were reported in September and 3 in October (rate of 0.7 per 1000 FCE's) this has since returned back to 0 in November. The plan is to minimise the number of breaches to at least the national average and ultimately zero.

Ambulance Handovers – NHS Halton CCG recognises that this national standard is an ambitious target to achieve, however we aspire to meet this standard and will work with the Acute Trusts and the North West Ambulance Service NHS Trust (NWAS) to move towards this.

[9] http://www.england.nhs.uk/statistics/statistical-work-areas/mixed-sex-accommodation/msa-data/

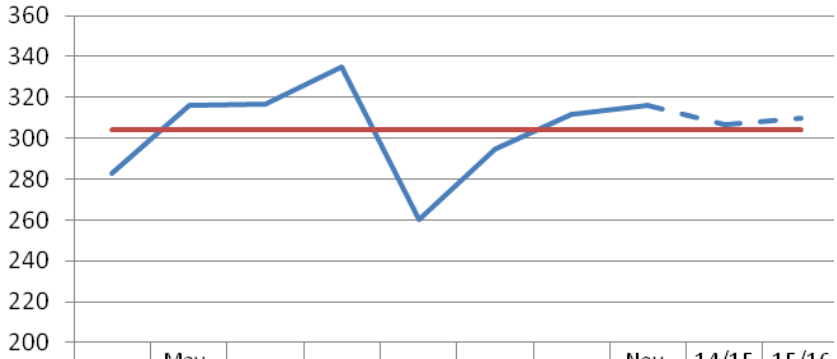
10 Operational Plan Activity

The charts below show actual and projected activity for a range of measures as highlighted in the NHS England Planning guidance.

10.1 Elective[10]

10.1.1 Elective G&A Ordinary Admissions (FFCEs)

10.1.1 Monthly activity data - Elective G&A Ordinary admissions (FFCEs)



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	14/15 Plan	15/16 Plan
Halton Inpatient Per Month	283	316	317	335	260	295	312	316	307	310
Halton 2013/14 Ave	304	304	304	304	304	304	304	304	304	304

A small increase in activity is expected due to changes in the population of Halton

Growth has been calculated as follows

From ONS report on Hospital admissions by age & sex 2007/08: NHS Information Centre for Health & Social care Halton UA hospital admissions were split 70 / 30 between 0-64's and 65+
Between mid-2013 and mid 2015 Halton 0-64 population is not expected to change
Between mid-2013 and mid 2014 the 65+ population is expected to increase by 2.46%
Between mid-2014 and mid 2015 the 65+ population is expected to increase by 3.85%
(Population figures sourced from ONS.gov.uk sub national population projections

30% of 2.46% is 0.74% (activity increase for 2014/15)
30% of 3.85% is 1.16% (activity increase for 2015/16)

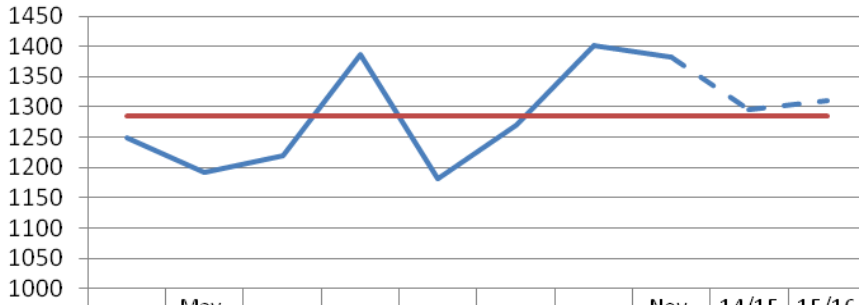
[10] http://www.england.nhs.uk/statistics/statistical-work-areas/hospital-activity/monthly-hospital-activity/mar-data/

The average number of G&A ordinary admissions per month in 2013/14 is estimated to be 304; by 14/15 this is expected to have increased to 307 and by 2015/16 to 310 per month.

The 14/15 plan and 15/16 plan figures are the monthly average for those years.

10.1.2 Elective G&A Day case Admissions (FF CEs)

10.1.2 Monthly activity data - Elective G&A Daycase admissions (FFCEs)



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	14/15 Plan	15/16 Plan
Halton Daycase Per Month	1249	1193	1219	1386	1182	1271	1402	1382	1295	1310
Halton 2013/14 Ave	1286	1286	1286	1286	1286	1286	1286	1286	1286	1286

A small amount of increased activity is expected due to the changes in the population of Halton, the calculations behind how this has been done are described in 10.1.1.

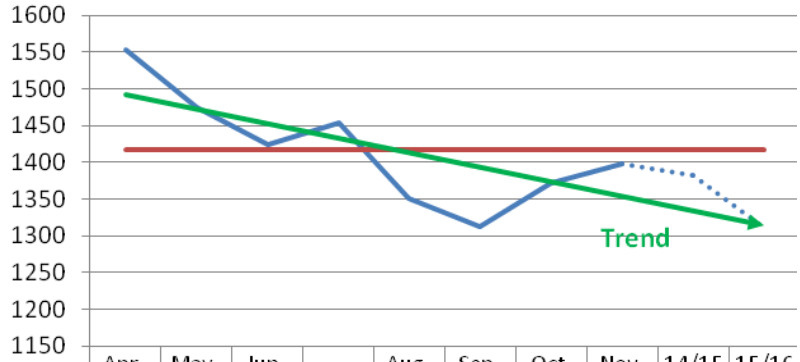
For the number of elective G&A day case admissions the average number of admissions per month in 2013/14 is expected to be 1286, for 14/15 this is expected to have increased to 1295 and for 2015/16 an increase to 1310 per month.

The 14/15 plan and 15/16 plan figures are the monthly average for those years.

10.2 Non Elective admissions FFCE's

10.2.1 Total Non-elective G&A Admissions (FFCEs)

10.2.1 Monthly activity data - Total Non-elective G&A admissions (FFCEs)



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	14/15 Plan	15/16 Plan
Halton Non electives per month	1553	1475	1424	1454	1351	1312	1372	1397	1382	1311
Average per month	1417	1417	1417	1417	1417	1417	1417	1417	1417	1417

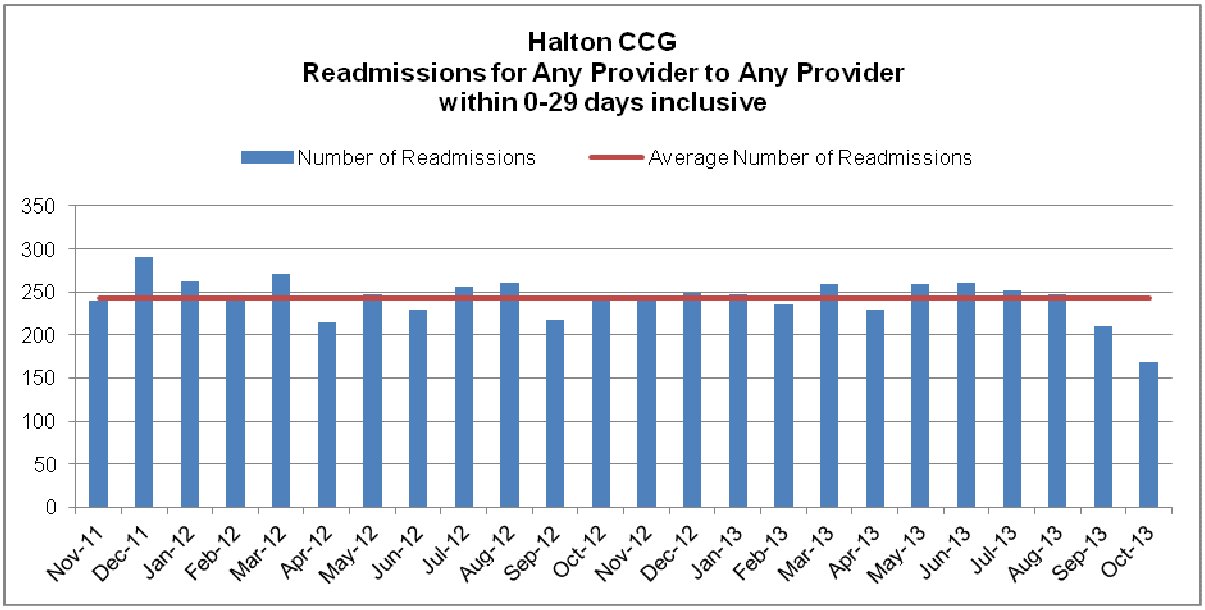
The actions being put into place as part of the five year strategy and 2-year operational plan are forecast to have the impact of reducing the number of non-elective admissions by 2.5% (based on 13/14 estimate) for 2014/15 then a further 5% in 2015/16 and 2016/17.

For 2013/14 the estimate has been calculated as the April to November average of 1417. A 2.5% reduction equates to 35 cases per month. The 14/15 plan is 1382 per month and 15/16 plan of 1311 per month.

The 14/15 and 15/16 plans shown in the chart above are the monthly averages.

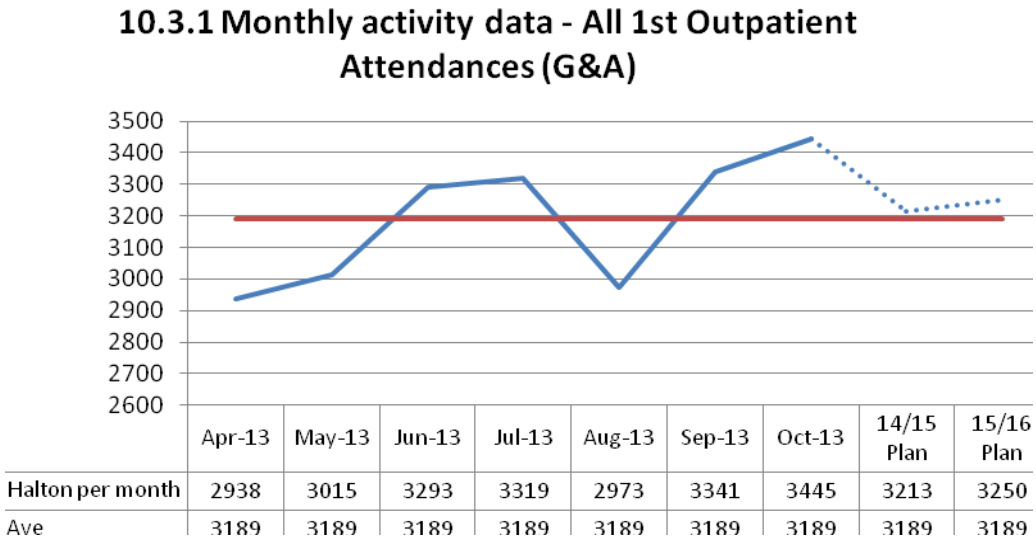
10.2.2 Readmissions 0-28 days

As represented in the chart below, readmissions across all trusts for Halton residents are improving. The schemes and attention paid to ensuring quality care outside of hospital is paying dividend. We aim to continue to drive this direction of travel and maintain at a safe and affordable level. At this trajectory at the end of 2015/16 Halton will have moved into all areas of green activity based on the ADASS National Scorecard



10.3 Outpatient attendances

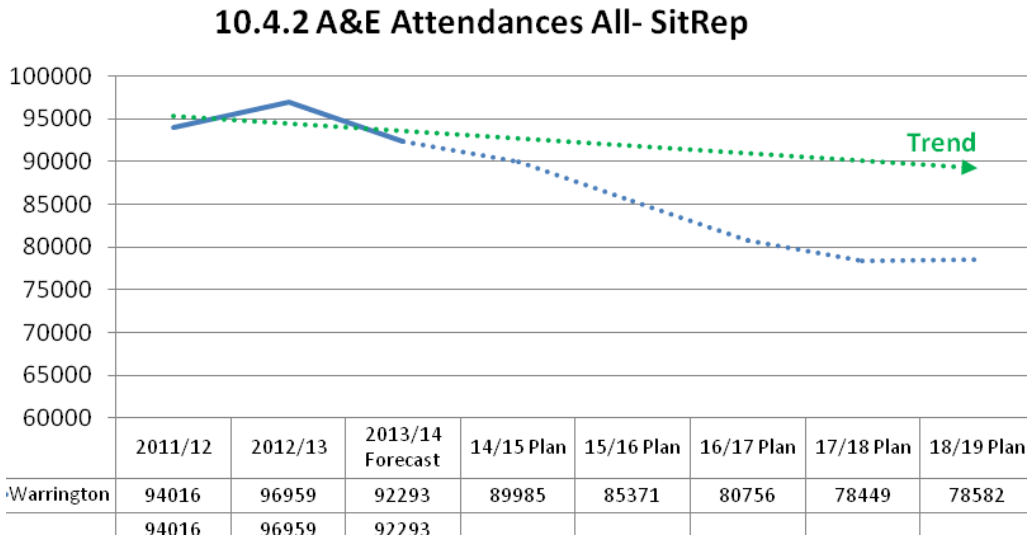
10.3.1 All first outpatient attendances in general & acute specialties



Increases in the number of outpatient attendances recorded at the general and acute trusts are expected in both 2014/15 and 15/16. These increases have been calculated in line with the different rates of demographic change differing age groups and the proportion of activity that is made up from those age groups. This equates to a small increase of 0.74% in the overall total number of outpatient admissions for 14/15 and a slightly larger increase of 1.15% for 2015/16

10.4 A&E Attendances[11]

All A&E Attendance



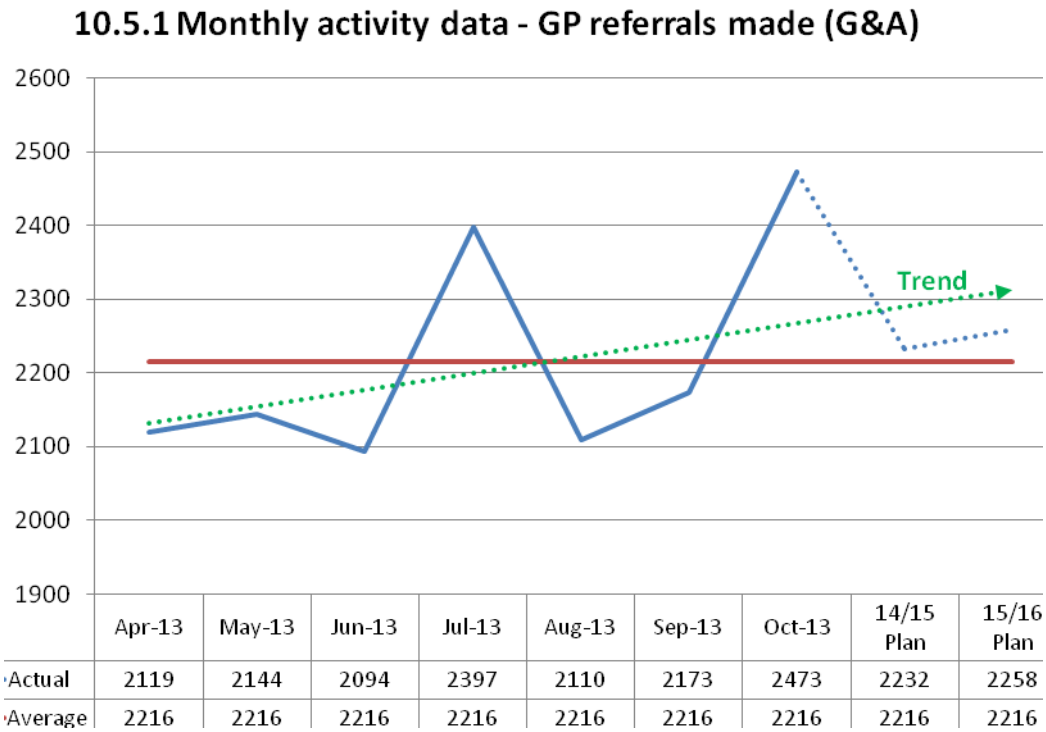
The plan is to reduce A&E attendances by 2.5% in 14/15, 5% in both 15/16 and 16/17 and 2.5% in 17/18. This is significantly lower than would be expected by looking at the trend over the last three years (shown as the green dotted line in the chart above, it is also a planned reduction when demographic changes are forecasting an increase over the next five years.

This reduction will be achieved by the schemes being put into place by the CCG and the LA to provide care closer to home and the development of the Urgent Care Centres.

[11] http://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/weekly-ae-sitreps-2012-13/

10.5 Referrals

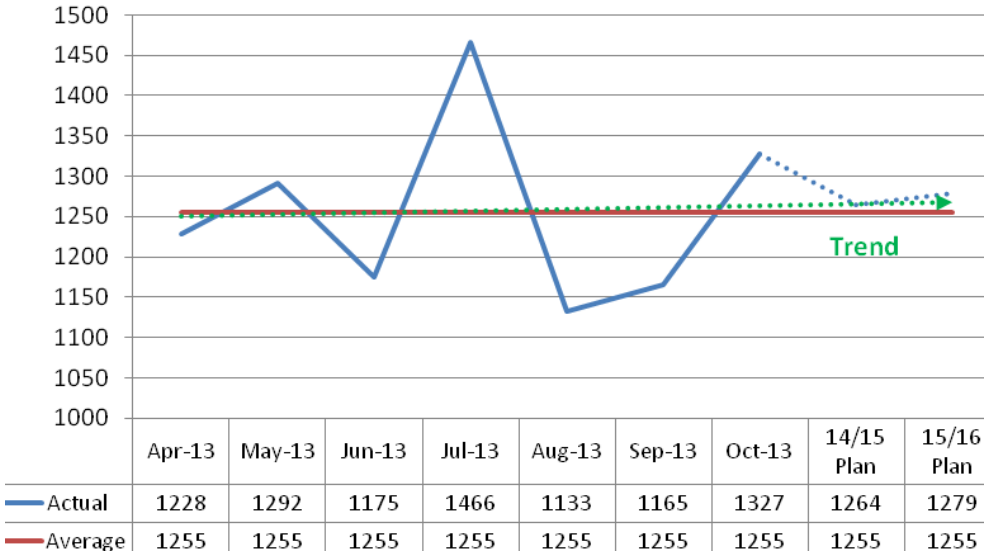
10.5.1 GP Referrals made (G&A)



Small increases in activity have been planned for 14/15 and 15/16, these have been calculated based on demographic changes and the age breakdown in service use. This has been calculated as a 0.74% increase in 2014/15 and a further 1.15% increase in 15/16. This increase in activity is below the trend since April 2013 but follows the same trajectory.

10.5.2 Other referrals made (G&A)

10.5.2 Monthly activity data - Other referrals made (G&A)



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	14/15 Plan	15/16 Plan
Actual	1228	1292	1175	1466	1133	1165	1327	1264	1279
Average	1255	1255	1255	1255	1255	1255	1255	1255	1255

There have been large variations in the monthly figures available for Halton from April 2013. Over the last seven moths the average is 1255 per month and the trend is flat.

Small increases are planned for 2014/15 and 2015/16 based on anticipated increase in demand from demographic changes and the age profile of service users. This has been calculated as 0.74% for 2014/15 and 1.15% for 2015/16. The figures reported in the chart for these two years are the average number of 'other referrals' per month in that year.

11 Better Care Fund Plan

The 5 year strategic plan and 2 year operational plans have been developed alongside the Better Care Fund plan. The work that both NHS Halton CCG and Halton Borough Council are doing to integrate commissioning and service provision has identified 6 measures which provide good indications of the success of this integrated working. These are identified below.

11.1 Permanent admissions of older people (aged 65 and over) to residential and nursing care homes per 100,000 population.

Metrics		Current Baseline (as at….)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	821.3		816.2 (target)
	Numerator	161		N/A
	Denominator	19,603		N/A
		(April 2013 - March 2014)		(April 2014 - March 2015)

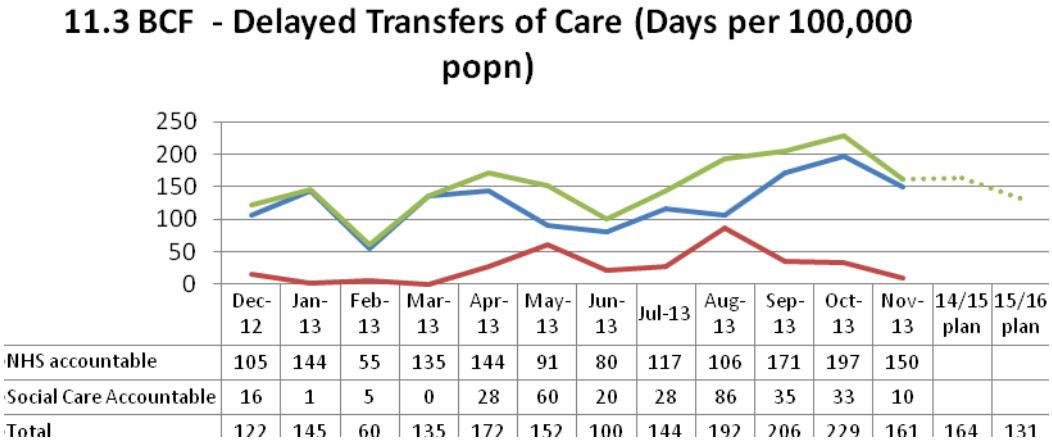
As a part of this scheme, there is a strong focus on assessing and intervening with people with complex needs, and their carers, at an earlier stage, providing care and support in the community for as long as possible. Expected outcomes and benefits include a reduction in the proportion of people requiring residential or nursing care, more people being supported to live at home, a reduction in the numbers of people requiring inpatient services, and improved reported quality of life.

11.2 Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services.

Metrics		Current Baseline (as at….)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	68%	N/A	68% (target)
	Numerator	63		N/A
	Denominator	93		N/A
		(April 2012 - March 2013)		(April 2014 - March 2015)

Continued developments of the intermediate care and reablement services will deliver a greater proportion of people who remain at home beyond 91 days of discharge from hospital. Additional benefits will include improved health outcomes, greater levels of personal independence and improved quality of life. These will be measured by the recorded national data sets on intermediate care and rehabilitation services, and by surveys which measure quality of life and satisfaction with services.

11.3 Delayed transfers of care from hospital per 100,000 population (average per month)



This measure has been calculated as the number of delayed transfers of care days per 100,000 18+ LA population. The number of patients per month is not available other than as a snapshot on the last Thursday of the month and this method of calculation has been specifically excluded in the technical guidance.

The baseline has been calculated as 172 days per 100,000 per month based on the most recent six month average (Jun 13 to Nov 13) and a mid 2012 18+ pop estimate of 97,677

The Plan for 14/15 is for a 5% reduction from 172 to 164.

The plan for 15/16 is for a return to the average seen between Dec 12 and May 2013. Calculated as 131 days per 100,000 per month.

11.4 Avoidable emergency admissions (composite measure)

Metrics		Current Baseline (as at….)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Avoidable emergency admissions (composite measure)	*Metric Value*	1561	1522	1483
	Numerator	1962	1913	1864
	Denominator	125,692	125,692	125,692
		(March 2013 - Aug 2013)	(April - September 2014)	(October 2014 - March 2015)

This measure is a composite of 4 emergency admission measures. The data has been taken from the Operational Planning Atlas tool[12]

NHS England will provide the baseline in January 2014, however there is little difference in looking at the performance over the last 6 month or 12 month period so a baseline of 260 per 100,000 has been used.

The plan for 14/15 is for a 2.5% reduction in admissions on the baseline.

The plan for 15/16 is for a 5% reduction on the baseline.

The redesign of the Urgent Care pathway (and in particular the development of the Urgent Care Centres), developments in preventive and early intervention services including Community Multidisciplinary Teams, and further developments with partners in diverting people with mental health needs from emergency care, will all result in a reduction in emergency admissions to hospital. This will be measured through the development of integrated performance measures with health service partners.

[12] http://ccgtools.england.nhs.uk/opa/flash/atlas.html

11.5 Patient / service user experience

The national metric will be used, this has yet to be developed but will be in place for 2015

11.6 Local Measure

Hospital readmissions where original admission was due to a fall (65+)

Metrics		Current Baseline (as at….)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Hospital readmissions where original admission was due to a fall (65+)	*Metric Value*	809.8	769.8	734.8
	Numerator	162	154	147
	Denominator	20,005	20,005	20,005
		(April 2012 - March 2013)	(April 2013 - March 2014)	(April 2014 - March 2015)

One of the areas of focus in the Health and Wellbeing Plan is the reduction in the number of falls. This has been selected as one of the local measures in the better care fund plan, it has also been selected as a CCG quality premium indicator.

Appendix A - Operational Plan Schemes

A1 Planned Care

Project Description		Develop a respiratory strategy for Halton and implement actions from the strategy. To include: 1) reviewing the pathway for people with sleep apnoea. This will include the possibility of using technology to manage sleep apnoea in the community, and considering whether weight management is part of the pathway 2) Reviewing the provision of spirometry services in Halton			
Ref	PC141501	Commissioning Area	Planned Care	Programme / Project	Respiratory
				Oversight Group	Respiratory Group
Desired Outcome		Completion of respiratory strategy (which will support the CCG in its work to reduce the likelihood of people developing a respiratory condition and improve outcomes for people who have a respiratory condition). This will be supported by an action plan, the actions from this will form a part of the 2014/15 commissioning plan once agreed.		Commissioning Lead	Steve Eastwood
				Clinical Lead	Dr Chris Woodforde
				Integrated Commissioning Partners	LA, PH, NHSE
				Better Care Fund Plan	No
Financial Impact		Informed by the Action plan, will expect to see an increase in prescribing but a reduction in the length of stay and a reduction in admissions. Overall expect to be cost neutral in the medium term with the potential for savings in the long term. Likely to be additional cost in relation to the provision of spirometry services		Strategic Objectives supported	CCGICS1, CCGICS3, NHSOF1, NHSOF2, NHSOF3

Milestones		
2014/15		2015/16
Q1	Strategy and action plan in place	Commissioning intentions implemented
Q2	Commissioning intentions developed from action plan	
Q3	Commissioning intentions implemented	
Q4	Commissioning intentions implemented	
Supporting measures	Prescribing spend, reduction in admissions, reduction in length of stay	

Project Description		Review pathway around cancer presentations. This will look at the evidence across all pathways, and will include examining the evidence to introduce a targeted screening programme to increase early detection rates of lung cancer			
Ref	PC141505	Commissioning Area	Planned Care	Programme / Project	Cancer & EOL
				Oversight Group	none
Desired Outcome		Increased early detection of cancer, reduced mortality from cancer		Commissioning Lead	Emma Alcock
				Clinical Lead	Dr Mel Forrest
				Integrated Commissioning Partners	PH
				Better Care Fund Plan	No
Financial Impact		External funding is available to support audit. Possibly increased costs following increased levels of diagnosis for increased scanning, increased treatment costs as more lung cancer detected.		Strategic Objectives supported	HHAWS1, NHSOF1, CCGICS1

Milestones		
2014/15		2015/16
Q1	Complete Primary Cancer Audit	Full roll out (if appropriate)
Q2	Completion of action plan / strategy & Business plan	
Q3	Potential pilot projects (if appropriate) begin	
Q4	Evaluation of pilot projects (if appropriate)	
Supporting measures	Long term- reduced mortality, short term - increased lung cancer staging data. (Primary lung cancers)	

Project Description		Implement tools to improve the sharing of information at the end of life: - Work towards implementing the EPACCs IT system - Improve the use of special patient notes in end of life care			
Ref	PC141506	Commissioning Area	Planned Care	Programme / Project	Cancer & EOL
				Oversight Group	None
Desired Outcome		Increased sharing of information at the end of life.		Commissioning Lead	Emma Alcock
				Clinical Lead	Dr Mel Forrest
				Integrated Commissioning Partners	NHSE
				Better Care Fund Plan	No
Financial Impact		Potential savings with regard to unplanned admissions		Strategic Objectives supported	NHSOF4, CCGOIS1, CCGICS4

Milestones		
	2014/15	2015/16
Q1	Options paper available Jan 14. Possible development of interim viewer.	Should be available nationally by December 15.
Q2		
Q3		
Q4		
Supporting measures	Improvement seen in preferred place of care, reduced unplanned admissions in last 12 months of life	

Project Description		Implement the replacement for the Liverpool Care Pathway			
Ref	PC141507	Commissioning Area	Planned Care	Programme / Project	Cancer & EOL
				Oversight Group	None
Desired Outcome		Increased quality of care at the end of life		Commissioning Lead	Emma Alcock
				Clinical Lead	Dr Mel Forrest
				Integrated Commissioning Partners	LA, NHSE
				Better Care Fund Plan	No
Financial Impact		Possible small amount of additional costs relating to additional training,		Strategic Objectives supported	NHSOF4, CCGICS1

Milestones		
2014/15		2015/16
Q1	National guidance issued February. Task and finish group set up	
Q2	Actions dependent on requirements of national guidance	
Q3		
Q4		
Supporting measures		

Project Description		To review access to lifestyles services for patients with cancer, for example breast cancer weight loss and exercise programme			
Ref	PC141508	Commissioning Area	Planned Care	Programme / Project	Cancer & EOL
				Oversight Group	None
Desired Outcome		Improved quality of life, increased life expectancy		Commissioning Lead	Emma Alcock
				Clinical Lead	Dr Mel Forrest
				Integrated Commissioning Partners	PH
				Better Care Fund Plan	No
Financial Impact		Potential increase in costs in the short term, dependent on increased uptake. Should enable longer term cost savings		Strategic Objectives supported	NHSOF1, NHSOF2, CCGICS1

Milestones		
2014/15		2015/16
Q1	Plan in place	Roll out of services
Q2	Pilot begins	
Q3	Pilot evaluated	
Q4	Roll out of services	
Supporting measures		

Project Description		Review pathways for patients with cancer attending hospital to explore alternative models of follow up e.g. telephone follow up or GP Led			
Ref	PC141509	Commissioning Area	Planned Care	Programme / Project	Cancer & EOL
				Oversight Group	None
Desired Outcome		Reduced hospital based follow up for people with cancer		Commissioning Lead	Emma Alcock
				Clinical Lead	Dr Mel Forrest
				Integrated Commissioning Partners	None
				Better Care Fund Plan	No
Financial Impact		Should result in financial savings for hospital follow ups for prostates		Strategic Objectives supported	NHSOF2, CCGICS1

Milestones		
2014/15		2015/16
Q1	Initially looking at prostate. Pathway review & plan in place	Full rollout
Q2	Pilot begins	
Q3	Pilot	
Q4	Evaluation of pilot	
Supporting measures	Reduction in hospital follow ups – initially for prostate cases	

Project Description		Develop a Cardiovascular strategy for Halton and implement actions arising from the strategy. To include 1) Securing 1 day service provision for people who have had a TIA			
Ref	PC141510	Commissioning Area	Planned care	Programme / Project	CVD
				Oversight Group	CVD Board
Desired Outcome		Cardiovascular strategy which will support the CCG in its work to reduce the likelihood of people developing cardiovascular disease and improve outcomes for people who have cardiovascular disease. This will be supported by an action plan, the actions from this will form a part of the 2014/15 commissioning plan once agreed.		Commissioning Lead	Mark Holt
				Clinical Lead	Dr Mick O'Connor / Dr Damian McDermott
				Integrated Commissioning Partners	PH, LA, NHSE
				Better Care Fund Plan	No
Financial Impact		Expect to be cost neutral, but exact costing will be informed by the action plan.		Strategic Objectives supported	CCGICS1, NHSOF1, NHSOF2, NHSOF3

Milestones		
2014/15		2015/16
Q1	Strategy and action plan in place. Recommendations for TIA service in place for end of June 2014	To be informed by action plan
Q2	Commissioning intentions from action plan. TIA service in place	
Q3	To be informed by action plan	
Q4	To be informed by action plan	
Supporting measures	Reduction seen in under 75 mortality rate from CVD. Others informed by strategy. % of people seen by TIA service within 24 hours of stroke.	

Project Description		Review the cardiology direct access service			
Ref	PC141512	Commissioning Area	Planned Care	Programme / Project	CVD
				Oversight Group	CVD Board
Desired Outcome		Improved interpretation of echocardiogram results		Commissioning Lead	TBC
				Clinical Lead	TBC
				Integrated Commissioning Partners	None
				Better Care Fund Plan	No
Financial Impact		None		Strategic Objectives supported	CCGICS1, NHSOF1

Milestones		
2014/15		2015/16
Q1	Planning – need to baseline current level of dissatisfaction	
Q2	Improved reporting in place	
Q3	Review of new service. Has satisfaction increased?	
Q4		
Supporting measures	Increased GP satisfaction of echo results (from Hospital) from Baseline.	

Project Description		Review provision of services for people with diabetes who have developed foot problems			
Ref	PC141513	Commissioning Area	Planned Care	Programme / Project	CVD
				Oversight Group	CVD Board
Desired Outcome		Reduction in complications associated with foot problems in people with diabetes		Commissioning Lead	Emma Alcock
				Clinical Lead	Dr Damian McDermott
				Integrated Commissioning Partners	None
				Better Care Fund Plan	No
Financial Impact				Strategic Objectives supported	CCGICS1, NHSOF2

Milestones		
2014/15		2015/16
Q1	Review current pathways, services & outcomes (baseline foot checks at GP)	Review & monitor service
Q2	Develop foot care pathway	
Q3	Launch	
Q4		
Supporting measures	Improved performance in foot checks at GP. Reduction in amputations	

Project Description		Review the scope of the community diabetes provision			
Ref	PC141514	Commissioning Area	Planned Care	Programme / Project	CVD
				Oversight Group	CVD Board
Desired Outcome		Reduction in secondary care activity, improved outcomes for people with diabetes.		Commissioning Lead	Emma Alcock
				Clinical Lead	Dr Damian McDermott
				Integrated Commissioning Partners	Leslie Mills, Community Diabetes Nurse.
				Better Care Fund Plan	No
Financial Impact		Cost neutral or possible reduction in secondary spend		Strategic Objectives supported	CCGICS1, NHSOF1, NHSOF2, NHSOF3

Milestones		
2014/15		2015/16
Q1		Implement recommendations
Q2	Review the scope of the current service & develop recommendations	
Q3	Review the scope of the current service & develop recommendations	
Q4		
Supporting measures	Reduction in outpatient appointments at hospital. Fewer Hypo'. Improved measures QOF around blood & Cholesterol	

Project Description		Continue work on increasing integration in the Musculoskeletal (MSK) pathway			
Ref	PC141515	Commissioning Area	Planned Care	Programme / Project	Planned care general
				Oversight Group	None
Desired Outcome		Improved access to services, increased integration of services. Maintain/improve position on SPOT tool (lower spend, better outcomes) – Source NHS PH England		Commissioning Lead	Lyndsey Abercromby
				Clinical Lead	Dr Cliff Richards
				Integrated Commissioning Partners	None
				Better Care Fund Plan	No
Financial Impact		Intention that this will be within current financial envelope but some is AQP therefore increase demand – increase £		Strategic Objectives supported	CCGICS1, NHSOF3

Milestones		
2014/15		2015/16
Q1	Design new model	Implement new model
Q2	As above	
Q3	Secure new model	
Q4	As above	
Supporting measures		

Project Description		Review the gynae physiotherapy pathway			
Ref	PC141516	Commissioning Area	Planned care	Programme / Project	Planned care general
				Oversight Group	None
Desired Outcome		Clarity of gynae physiotherapy pathway, improved outcomes for people requiring gynae physiotherapy.		Commissioning Lead	Kate Wilding
				Clinical Lead	Dr Fenella Cottier
				Integrated Commissioning Partners	None
				Better Care Fund Plan	No
Financial Impact		Tbc as part of work. Appears no service funded at the moment so may require further financial investment		Strategic Objectives supported	CCGICS1

Milestones		
2014/15		2015/16
Q1	Define current provision	Monitor service
Q2	Define options and agree future state	
Q3	Implement future state	
Q4	As above	
Supporting measures		

Project Description		Increase access to and equity of provision of community gynae services			
Ref	PC141517	Commissioning Area	Planned Care	Programme / Project	Planned care general
				Oversight Group	none
Desired Outcome		Reduction in unnecessary referrals to secondary care		Commissioning Lead	Kate Wilding
				Clinical Lead	Dr Fenella Cottier
				Integrated Commissioning Partners	None
				Better Care Fund Plan	No
Financial Impact		Intention that this will be within existing £ / release £		Strategic Objectives supported	CCGICS1

Milestones		
2014/15		2015/16
Q1	Design new model	Implement
Q2	As above	
Q3	Secure new model	
Q4	As above	
Supporting measures	No of gynae 1st and f/u appointments	

Project Description		Review the provision of urology services			
Ref	PC141518	Commissioning Area	Planned Care	Programme / Project	Planned care general
				Oversight Group	none
Desired Outcome		Reduction in secondary care activity		Commissioning Lead	Emma Alcock
				Clinical Lead	? Dr Fenella Cottier
				Integrated Commissioning Partners	None
				Better Care Fund Plan	No
Financial Impact		Will be within existing resource / or will release £		Strategic Objectives supported	CCGICS1

Milestones		
2014/15		2015/16
Q1	Define current provision and activity	Implement alternatives
Q2	As above	
Q3	Scope and agree alternatives	
Q4	As above	
Supporting measures	No of urology first and follow up appointments in secondary care	

Project Description		Review the provision of the lymphoedema services			
Ref	PC141519	Commissioning Area	Planned care	Programme / Project	Planned care general
				Oversight Group	none
Desired Outcome		Improved access to service		Commissioning Lead	Emma Alcock
				Clinical Lead	? Dr Mel Forrest
				Integrated Commissioning Partners	None
				Better Care Fund Plan	No
Financial Impact		Not clear, may require £		Strategic Objectives supported	CCGICS1

Milestones		
2014/15		2015/16
Q1	Business case	Implement service
Q2	As above	
Q3	Secure service	
Q4	As above	
Supporting measures	No of patients accessing service, others to be determined as part of work	

Project Description		(TBC may be resolved in 2013/14) Review phlebotomy & pathology provision			
Ref	PC141520	Commissioning Area	Planned care	Programme / Project	Planned care general
				Oversight Group	None
Desired Outcome		increased quality of provision, increased equity of provision, increased access to information (if agreed as CQUIN)		Commissioning Lead	Lyndsey Abercromby
				Clinical Lead	Dr Cliff Richards, Dr Mick O'Connor
				Integrated Commissioning Partners	None
				Better Care Fund Plan	No
Financial Impact		Expected to be within current £ envelope, may still require small £ investment if need for domiciliary service established		Strategic Objectives supported	CCGICS1

Milestones		
2014/15		2015/16
Q1	Joint meeting with both main providers	
Q2	Other timescales to be agreed in CQUIN	
Q3		
Q4		
Supporting measures		

Project Description		(TBC may be resolved in 2013/14) Review access to termination of pregnancy services			
Ref	PC141521	Commissioning Area	Planned care	Programme / Project	Planned care general
				Oversight Group	none
Desired Outcome		Improved access to termination of pregnancy services. Clear contractual arrangements. Decision re need for number of providers		Commissioning Lead	Kate Wilding
				Clinical Lead	Dr Fenella Cottier
				Integrated Commissioning Partners	None
				Better Care Fund Plan	No
Financial Impact		Expected to be within current £ envelope		Strategic Objectives supported	CCGICS1, CCGICS5

Milestones		
2014/15		2015/16
Q1	Current contractual arrangement clarified and decision whether will be done on local footprint or wider	
Q2	Business case re need for other provider	
Q3	As above	
Q4	Secure provision (if needed)	
Supporting measures		

A2 Women Children & Families

Project Description		Contribute to on-going work of service reviews for children's community services including 1) To continue to review community services and investigate procurement of Community Paediatric Consultant service (following review of service this year)			
Ref	WCF141502	Commissioning Area	Children & Family	Programme / Project	Community Services
				Oversight Group	None
Desired Outcome		Improve the pathway for diagnosis and treatment of children with ADHD		Commissioning Lead	Sheila McHale
				Clinical Lead	Gill Frame
				Integrated Commissioning Partners	LA
				Better Care Fund Plan	No
Financial Impact		Potential financial savings – possible reduction in contract value. Will be a proportion of £650K		Strategic Objectives supported	CCGICS1, HHAWS2

Milestones		
2014/15		2015/16
Q1	Roll over existing contract – serve notice (due to changes in the service specification)	Potential savings will be made in 2015/16
Q2	Out to procurement	
Q3		
Q4	New service live before April 15/16	
Supporting measures	Increase in number of children transferred to Primary care under shared care protocol. (Baseline nil) Change in Ritalin prescribing from secondary care to Primary care.	

Project Description		Move to local community tariff basis for special schools orthoptic service and expand community provision on a tariff basis.			
Ref	WCF141503	Commissioning Area	Children & Family	Programme / Project	Community Services
				Oversight Group	None
Desired Outcome		Improved access to community based provision within time frames associated with tariff based service (18 weeks)		Commissioning Lead	Sheila McHale
				Clinical Lead	Gill Frame
				Integrated Commissioning Partners	LA
				Better Care Fund Plan	No
Financial Impact		There will a cost attached to expanding community provision £66K special schools		Strategic Objectives supported	CCGICS1, HHAWS2, NHSOF2, NHSOF4, NHSOF5

Milestones		
2014/15		2015/16
Q1	Contract variation	review
Q2	Move to tariff basis (from block)	
Q3		
Q4		
Supporting measures	Need to identify activity – expect to see reduction of waiting list and reduction in number waiting more than 18 weeks	

Project Description		Continue to review with possible procurement community midwifery service			
Ref	WCF141504	Commissioning Area	Children & Family	Programme / Project	Community services
				Oversight Group	None
Desired Outcome		Sustainable service in light of new national tariff, improved outcome for mothers and babies		Commissioning Lead	Sheila McHale
				Clinical Lead	Gill Frame
				Integrated Commissioning Partners	None
				Better Care Fund Plan	Yes
Financial Impact		Likely increase in cost due to tariff impact		Strategic Objectives supported	CCGICS1, NHSOF4, NHSOF5

Milestones		
	2014/15	2015/16
Q1	Needs SDC review, wait for outcome of appraisal, Block / tariff	
Q2		
Q3		
Q4		
Supporting measures		

Project Description		Undertake joint review of Children's Speech & Language services with LA to deliver single specification and single budget through 'pooled' arrangements with subsequent procurement during 2014/15			
Ref	WCF141505	Commissioning Area	Children & Family	Programme / Project	Community Services
				Oversight Group	Children's Trust
Desired Outcome		Improved access to community based provision within specified time frames with improved quality based outcome metrics		Commissioning Lead	Sheila McHale
				Clinical Lead	Gill Frame
				Integrated Commissioning Partners	LA
				Better Care Fund Plan	Yes
Financial Impact		Probable financial savings identified		Strategic Objectives supported	CCGICS1, HHAWS2

Milestones		
2014/15		2015/16
Q1	Roll forward contract and give notice	New service running
Q2	Out to procurement	
Q3		
Q4	Possible new provider identified	
Supporting measures	Improved quality based outcome through Swemweb survey developed, reduction in waiting times, increased numbers going through service.	

Project Description		To support delivery of the Halton's mental Health Strategy in relation to young people including; 1) Continue review of emotional wellbeing and psychological pathway for young people with a view to delivering revised Integrated Tier 2 CAMHS specification as a joint project with the LA and procurement during 2014/15			
Ref	WCF141508	Commissioning Area	Children & Family	Programme / Project	CAMHS
				Oversight Group	CAMHS partnership board
Desired Outcome		Improved integration of CAMHS as part of the wider health and social care offer. Ensure appropriate capacity and earlier transfer up to tier 3 where appropriate (e.g. self-harm).		Commissioning Lead	Sheila McHale / Simon Bell / Gareth Jones
				Clinical Lead	Gill Frame
				Integrated Commissioning Partners	LA
				Better Care Fund Plan	Yes
Financial Impact		Possible financial savings identified from 2015/16		Strategic Objectives supported	CCGICS1, HHAWS2, PHOF1, PHOF2

Milestones		
2014/15		2015/16
Q1	Revised specification end Q1	New service in place
Q2	Consultation	
Q3	Out to procurement	
Q4		
Supporting measures	Need to develop waiting time measures	

Project Description		(TBC may be resolved in 2013/14) Evaluate the Mersey QIPP pilot for children's community nursing service. Including evaluation and on-going funding for end of life care for children			
Ref	WCF141510	Commissioning Area	Children & Family	Programme / Project	Other
				Oversight Group	None
Desired Outcome		This may have to happen this year not next – Whiston hospital at home, pilot completed, service continuing. Could lead to possible inequity (Runcorn / Widnes) as service not currently funded for Warrington. This could be a minimum extra cost of £60k plus end of life care for children currently purchased as a pilot from Clare House Hospice at an extra cost of £25k		Commissioning Lead	Sheila McHale
				Clinical Lead	Gill Frame
				Integrated Commissioning Partners	LA
				Better Care Fund Plan	No
Financial Impact		Possible minimum extra cost of £85k p.a.		Strategic Objectives supported	CCGICS1, HHAWS2

Milestones		
	2014/15	2015/16
Q1	Await outcome of SDC, minimum cost of £85k p.a.	
Q2		
Q3		
Q4		
Supporting measures	Maintain current position with regard to early discharge.	

Project Description		Review of the Halton Women's centre			
Ref	WCF141511	Commissioning Area	Children & Family	Programme / Project	Other
				Oversight Group	Children's Trust
Desired Outcome		Improve outcomes for people experiencing domestic violence		Commissioning Lead	Sheila McHale
				Clinical Lead	Gill Frame
				Integrated Commissioning Partners	LA
				Better Care Fund Plan	Yes
Financial Impact		none		Strategic Objectives supported	CCGICS1, NHSOF4

Milestones		
2014/15		2015/16
Q1	Review service Q1 & Q2	
Q2		
Q3	Work with LA to produce new spec	
Q4		
Supporting measures	Number of women experiencing domestic violence AND attending service. Swemweb survey developed.	

Project Description		Amend existing asthma care provision for children to build on work done currently to divert emergency admissions and A&E presentations to the new Urgent care centre			
Ref	WCF141512	Commissioning Area	Planned Care	Programme / Project	Respiratory
				Oversight Group	Respiratory Group
Desired Outcome		Reduction in emergency admissions and A&E presentations related to common paediatric conditions in Children.		Commissioning Lead	Kate Wilding / Sheila McHale
				Clinical Lead	Dr Chris Woodforde /Gill Frame
				Integrated Commissioning Partners	LA
				Better Care Fund Plan	No
Financial Impact		Reduce PBR A&E attendance by 5% in year one and 15% by end of year two. Proportionate savings will be made on the current £1.05M spend at Warrington and Whiston. It is anticipated that there will also be a reduction in Urgent Admissions at Whiston of between 3 and 5% due to the reduction in the number of A&E attendances. (between £38,000 and £64,000) at current tariff		Strategic Objectives supported	CCGICS1, NHSOF1, NHSOF2, NHSOF3

Milestones		
2014/15		2015/16
Q1	Data review	
Q2	Take part in Urgent Care project plan preparation work with GP's	
Q3	First diversions / data gather	
Q4	Assess outcome & take remedial action if required	
Supporting measures	Reduction in A&E attendance / admissions at WHH and StHK	

A3 Primary & Community care

Project Description		Strengthen the GPs role at the heart of out of hospital care and supporting people to stay healthy by identifying people at risk of hospital admission including the introduction of a named accountable clinician			
Ref	PCI141501	Commissioning Area	Primary & Community	Programme / Project	Community
				Oversight Group	None
Desired Outcome		Reduction in the number of emergency admissions/readmissions, individual patient care plans, integrated working and self-care		Commissioning Lead	Jo O'Brien
				Clinical Lead	Dr David Lyon
				Integrated Commissioning Partners	LA
				Better Care Fund Plan	Yes
Financial Impact		Tbc, possible reduction in secondary care spend		Strategic Objectives supported	CCGICS1, NHSOF2

Milestones		
2014/15		2015/16
Q1	National guidance issued April/May, strategic group established	
Q2	Actions dependent on requirements of guidance	
Q3		
Q4		
Supporting measures	Reduced emergency admissions, increase patient care plans, increased use of self-care. Further measures to be developed using Swemweb and EQ5D	

Project Description		Review the design of community services to focus on outcome based services			
Ref	PCI141503	Commissioning Area	Primary & Community	Programme / Project	Community
				Oversight Group	None
Desired Outcome		Increased integration, improved outcomes for patients, reduction in inappropriate hospital admissions for conditions normally managed within community		Commissioning Lead	Jo O'Brien
				Clinical Lead	Dr David Lyon
				Integrated Commissioning Partners	LA, PH
				Better Care Fund Plan	Yes
Financial Impact		Expect to be cost neutral		Strategic Objectives supported	CCGICS1, CCGICS3

Milestones		
2014/15		2015/16
Q1	Review current services, service specifications & outcomes in line with CCG priorities and integrated care model	
Q2	As above	
Q3	Develop recommendations and revised specifications following reviews	
Q4	Develop recommendations and revised specifications following reviews	
Supporting measures	Increased integration of services, KPI and outcome measures	

Project Description		To support GP practices and other providers where appropriate to deliver services over and above their core contractual responsibilities (Local Commissioning Schemes – previously known as Enhanced Services)			
Ref	PCI141505	Commissioning Area	Primary & Community	Programme / Project	Primary
				Oversight Group	None
Desired Outcome		Improved patient experience, continuity of care, care closer to home, more integrated care, reduction in inappropriate admissions / A&E attendances		Commissioning Lead	Julie Holmes
				Clinical Lead	Dr Gary O'Hare, Dr Salil Veedu
				Integrated Commissioning Partners	NHSE
				Better Care Fund Plan	No
Financial Impact		Tbc however will require initial investment. Longer term objective is the shift from secondary care into primary/community care as services are developed within the community to reduce activity within secondary care		Strategic Objectives supported	CCGICS1, NHSOF2, NHSOF4,

Milestones		
2014/15		2015/16
Q1	Identify gaps/opportunities in service provision in line with commissioning priorities. Prioritise above and develop a timetable for implementation. Service specifications developed and relevant procurement route to be confirmed, contracts awarded. This work is on-going throughout the year and can commence at any point therefore the process will remain the same.	
Q2	As above	
Q3	As above	
Q4	As above	
Supporting measures	KPI and outcome measures monitored, impact on secondary care activity	

Project Description		A strategy for sustainable general practice services in Halton			
Ref	PCI141506	Commissioning Area	Primary & Community	Programme / Project	Primary
				Oversight Group	To be agreed
Desired Outcome		The problem is that general practice services in Halton are not sustainable and there is no agreed strategy to address this. NHS Halton CCG, with NHS England, will support member practices to develop and agree a strategy to deliver sustainable general practice services in Halton. Sustainable general practice services are required to: • Reduction in variation • Increase capacity in general practice and the reconfiguration of urgent in hours primary care to reduce unnecessary admissions • Enable 7/7 working • Improve long term condition management, particularly for frail and/or elderly people • Reduce health inequalities • Increase patient choice and access • Develop specialist skills, knowledge and service delivery amongst the local workforce providing general practice services • Provide local service alternatives in straight forward planned care • Develop a plan for managing the changing age and skill profiles of the local general practice workforce		Commissioning Lead	Jo O'Brien
				Clinical Lead	Dr Gary O'Hare, Dr Salil Veedu, Dr Cliff Richards
				Integrated Commissioning Partners	NHSE as the commissioner and principal contractor for general practice services in Halton. 17 general practices in Halton as small/medium businesses and independent contractors within the NHS
				Better Care Fund Plan	No
Financial Impact		Tbc, however whilst contractual responsibility sits with NHSE may require considerable CCG staff input which may put pressures on existing core work		Strategic Objectives supported	CCGICS3

Milestones		
2014/15		2015/16
Q1	Agreement on problem statement across key stakeholders	Implementation of final strategy continues
Q2	Development and comparison of alternative strategies	
Q3	Agreement on final strategy.	
Q4	Implementation and evaluation plan agreed and final strategy delivery begins	
Supporting measures	The Key process measure will be the delivery of an agreed strategy for general practice services across Halton. Other process and outcome measures will be developed	

Project Description		Support NHS England in ensuring quality in primary care			
Ref	PCI141508	Commissioning Area	Primary & Community	Programme / Project	Primary
				Oversight Group	None
Desired Outcome		Reduction in variation across membership practices, increased prevalence and screening in line with national averages. Protected time for peer review and learning & development		Commissioning Lead	Jo O'Brien
				Clinical Lead	Dr Gary O'Hare, Dr Salil Veedu
				Integrated Commissioning Partners	NHSE
				Better Care Fund Plan	No
Financial Impact		Cost neutral		Strategic Objectives supported	NHSOF4

Milestones		
	2014/15	2015/16
Q1	Identify areas of variance and agree work programme for 14/5. Work with NHS E and neighbouring CCGs to agree common dashboard for Primary Care Quality	
Q2	Launch above with members and continue to monitor through Primary Care Quality & Development Group. Develop programme of practice support though PLT and Peer review.	
Q3	As above	
Q4	As above	
Supporting measures	Reduction in variation in key areas including prevalence, screening and prescribing.	

Project Description		Develop an Integration Health & Social Care IM&T Strategy & work plan to include; 1) exploring ways for clinicians and carers to have access to the same information regardless of setting, 2) explore opportunities for OOH providers to have access to primary care record OOH, 3) use of Telehealth and telemedicine to improve patient care, 4) identify the benefits and possibly introduction of Map of Medicine and 5) extending the uptake and use of Choose & Book to improve pathways to hospital and patient choice			
Ref	PCI141510	Commissioning Area	Primary & Community	Programme / Project	Primary
				Oversight Group	None
Desired Outcome		Joint Strategy developed and work plan implemented, increased interoperability between providers, increased use of summary care records for continuity of care, increased patient choice, care closer to home		Commissioning Lead	Jo O'Brien
				Clinical Lead	Dr David Wilson
				Integrated Commissioning Partners	LA
				Better Care Fund Plan	Yes
Financial Impact		Actual cost tbc, however likely to be significant overall but some funding for informatics provided centrally		Strategic Objectives supported	CCGICS3

Milestones		
	2014/15	2015/16
Q1		
Q2		
Q3		
Q4		
Supporting measures		

Project Description		Explore the potential for introduction of a programme of care for Familial hypercholesterolemia			
Ref	PCI141512	Commissioning Area	Primary & Community	Programme / Project	Primary
				Oversight Group	None
Desired Outcome		Reduction in people dying prematurely, enhanced quality of life and experience of care for people with long-term conditions		Commissioning Lead	Julie Holmes
				Clinical Lead	TBC
				Integrated Commissioning Partners	PH
				Better Care Fund Plan	No
Financial Impact				Strategic Objectives supported	CCGICS3, NHSOF1, NHSOF2

Milestones		
2014/15		2015/16
Q1	Review the scope of the current service & develop recommendations	
Q2	As above	
Q3	Implement findings from recommendations	
Q4	As above	
Supporting measures	Reduction in strokes, improved measures QOF around Cholesterol	

Project Description		Secure provision of community services from 2015 - new			
Ref	PCI141514	Commissioning Area	Primary & Community	Programme / Project	Community
				Oversight Group	None
Desired Outcome		VfM contract that reflects the needs of the population of Halton supporting more integrated care in the community with a focus on improved outcome measures and a reduction in unnecessary admission to hospital.		Commissioning Lead	Jo O'Brien
				Clinical Lead	Dr David Lyon
				Integrated Commissioning Partners	LA, PH
				Better Care Fund Plan	Yes
Financial Impact		Reduction in current community contract value however will only be informed by the new service specifications		Strategic Objectives supported	CCGICS1, CCGICS3

Milestones		
2014/15		2015/16
Q1	Establish process for procurement and agree services to be considered for procurement	
Q2	As per procurement guide timetable	
Q3	As per procurement guide timetable	
Q4	As per procurement guide timetable	
Supporting measures	Services agreed signed off in quarter 2, procurement timetable adhered to	

A4 Mental Health & Unplanned care

Project Description		Develop local services to reduce suicide attempts			
Ref	MHUC141 501	Commissioning Area	Mental Health & Unplanned Care	Programme / Project	Mental Health
				Oversight Group	5BP Contract Board Mental Health strategic commissioning board
Desired Outcome		Reduce excess mortality in people with mental health problems known to services and from suicide		Commissioning Lead	Jennifer Owen/ Simon Bell
				Clinical Lead	Dr Anne Burke, Dr Elspeth Anwar
				Integrated Commissioning Partners	PH, LA
				Better Care Fund Plan	Yes
Financial Impact		Cost of CPN would be at least £50k. there would be potential savings across the whole health economy but not all of these would be aligned to CCG budgets		Strategic Objectives supported	NHSOF1, NHSOF2, CCGICS1

Milestones		
	2014/15	2015/16
Q1	Suicide prevention strategy development, Pilot around A&E Liaison	
Q2	Implement actions from suicide prevention strategy. Pilot CPN with police across Warrington & Halton	
Q3	As above	
Q4		
Supporting measures	Reduction in suicide attempts	

Project Description		Review the AED liaison psychiatry model across Mid Mersey CCGs			
Ref	MHUC141 502	Commissioning Area	Mental Health & Unplanned Care	Programme / Project	Mental Health
				Oversight Group	5BP contract Board Bridgewater Oohs contract Board-WCCG WHHFT contract board STH&K contract Board Mental Health strategic commissioning board
Desired Outcome		Acute and emergency care for people in mental health crisis is as accessible and high-quality as for physical health emergencies. Ensure equitable liaison psychiatry services to support effective crisis care – Linked to MHUC141501		Commissioning Lead	Jennifer Owen
				Clinical Lead	Dr Anne Burke
				Integrated Commissioning Partners	Other CCGs
				Better Care Fund Plan	No
Financial Impact				Strategic Objectives supported	NHSOF2, NHSOF3, NHSOF4, NHSOF5, HHWS 5, CCGOIS1

Milestones		
	2014/15	2015/16
Q1		
Q2		
Q3		
Q4		
Supporting measures	No variation in 4-hour A&E waits between providers for people in mental health crisis	

Project Description		Develop and launch safe in town initiative across the Borough of Halton			
Ref	MHUC141 503	Commissioning Area	Mental Health & Unplanned Care	Programme / Project	Mental Health
				Oversight Group	Mental Health strategic commissioning board
Desired Outcome		Increase in vulnerable groups feeling safe in their communities		Commissioning Lead	Mark Holt and Lynne Edmondson
				Clinical Lead	Dr David Lyon, Lisa Birtles Smith
				Integrated Commissioning Partners	LA
				Better Care Fund Plan	Yes
Financial Impact				Strategic Objectives supported	NHSOF2, CCGICS1

Milestones		
	2014/15	2015/16
Q1		
Q2		
Q3		
Q4		
Supporting measures		

Project Description		Work with other North West CCGs to secure provision of an IAPT service for military veterans			
Ref	MHUC141 504	Commissioning Area	Mental Health & Unplanned Care	Programme / Project	Mental Health
				Oversight Group	5BP contract board IAPT mobilisation group Mental Health strategic commissioning board
Desired Outcome		Improved outcomes for patients		Commissioning Lead	Lynne Edmondson
				Clinical Lead	Dr Anne Burke
				Integrated Commissioning Partners	Other CCGs
				Better Care Fund Plan	No
Financial Impact				Strategic Objectives supported	HHWS5. NHSOF3, NHSOF4, NHSOF5, CCGOIS1

Milestones		
2014/15		2015/16
Q1		
Q2		
Q3		
Q4		
Supporting measures		

Project Description		Review and redesign current eating disorder service			
Ref	MHUC141 506	Commissioning Area	Mental Health & Unplanned Care	Programme / Project	Mental Health
				Oversight Group	CWP contract board 5BP contract board Mental Health strategic commissioning board
Desired Outcome		Improved outcomes for patients		Commissioning Lead	Sheila McHale, Lynne Edmondson, Kate Wilding
				Clinical Lead	Dr Anne Burke
				Integrated Commissioning Partners	Other CCGs
				Better Care Fund Plan	No
Financial Impact				Strategic Objectives supported	HHWS5. NHSOF3, NHSOF4, NHSOF5

Milestones		
2014/15		2015/16
Q1		
Q2		
Q3		
Q4		
Supporting measures		

Project Description		Implement the action plan from the Health Needs Assessment for Learning Disabilities			
Ref	MHUC141 507	Commissioning Area	Mental Health & Unplanned Care	Programme / Project	Learning Disabilities
				Oversight Group	LD Partnership Board
Desired Outcome		Improve outcomes for people with learning disabilities		Commissioning Lead	Lynne Edmondson
				Clinical Lead	Lisa Birtles Smith
				Integrated Commissioning Partners	LA
				Better Care Fund Plan	Yes
Financial Impact				Strategic Objectives supported	NHSOF1, NHSOF2, NHSOF4, CCGICS1, PHOF01, PHOF02.

Milestones		
2014/15		2015/16
Q1		
Q2		
Q3		
Q4		
Supporting measures		

Project Description		Develop alternative employment opportunities for vulnerable groups			
Ref	MHUC141 508	Commissioning Area	Mental Health & Unplanned Care	Programme / Project	Learning Disabilities
				Oversight Group	LD Partnership board
Desired Outcome		Improve emotional wellbeing and support individual personal development		Commissioning Lead	Lynne Edmondson
				Clinical Lead	Lisa Birtles Smith
				Integrated Commissioning Partners	LA
				Better Care Fund Plan	Yes
Financial Impact		£50k provision for working farm		Strategic Objectives supported	NHSOF2, CCGOIS1

Milestones		
2014/15		2015/16
Q1		
Q2		
Q3		
Q4		
Supporting measures		

Project Description		Roll out of learning disabilities health checks to under 16s			
Ref	MHUC141 510	Commissioning Area	Mental Health & Unplanned Care	Programme / Project	
				Oversight Group	
Desired Outcome		Improve outcomes for people with learning disabilities		Commissioning Lead	Lynne Edmondson
				Clinical Lead	Lisa Birtles Smith
				Integrated Commissioning Partners	LA
				Better Care Fund Plan	Yes
Financial Impact		Public Health – no funding implications		Strategic Objectives supported	NHSOF1, NHSOF2, NHSOF4. CCGICS1, PHOF1, PHOF2.

Milestones		
2014/15		2015/16
Q1		
Q2		
Q3		
Q4		
Supporting measures		

Project Description		Delivery of Direct Enhanced Service for Dementia within general practice, to increase awareness and screening for dementia.			
Ref	MHUC141 511	Commissioning Area	Mental Health & Unplanned Care	Programme / Project	Dementia
				Oversight Group	Dementia partnership board
Desired Outcome		67% target for diagnosis by March 2015		Commissioning Lead	Mark Holt
				Clinical Lead	Dr David Lyon
				Integrated Commissioning Partners	LA
				Better Care Fund Plan	Yes
Financial Impact				Strategic Objectives supported	NHSOF2, HHAWS5, CCGOIS1

Milestones		
	2014/15	2015/16
Q1		
Q2		
Q3		
Q4		
Supporting measures	C2.13 Estimated diagnosis rate for people with dementia	

Project Description		Support the regional procurement of NHS 111 through identified clinical and managerial leads			
Ref	MHUC141 513	Commissioning Area	Mental Health & Unplanned Care	Programme / Project	Urgent care
				Oversight Group	Urgent care working group
Desired Outcome		A tender for another provider of 111 services will be undertaken across Merseyside, with the outcome to improve access to health advice and reduce need to access GP		Commissioning Lead	Jane Hulme / Lynne Edmondson
				Clinical Lead	Dr Neil Martin
				Integrated Commissioning Partners	Other CCGs
				Better Care Fund Plan	Yes
Financial Impact				Strategic Objectives supported	NHSOF1

Milestones		
2014/15		2015/16
Q1		
Q2		
Q3		
Q4		
Supporting measures		

Project Description		Implement the Urgent Care redesign preferred model			
Ref	MHUC141 514	Commissioning Area	Mental Health & Unplanned Care	Programme / Project	Urgent Care
				Oversight Group	Urgent care working group
Desired Outcome		Reduction in inappropriate A&E attendances and subsequent admissions		Commissioning Lead	Damian Nolan
				Clinical Lead	Dr Neil Martin
				Integrated Commissioning Partners	None
				Better Care Fund Plan	No
Financial Impact		£600k recurrence spend, will result in 5% savings 14/15 and 10% 15/16		Strategic Objectives supported	NHSOF2, NHSOF3, CCGOIS1

Milestones		
2014/15		2015/16
Q1		
Q2		
Q3		
Q4		
Supporting measures		

Project Description		Care Home Liaison Service – To establish a single supplementary specialist service for dementia patients that's able to effectively respond and meet the multiple and complex needs of a care home population through the provision of enhanced support			
Ref	MHUC141 515	Commissioning Area	Mental Health & Unplanned Care	Programme / Project	None Identified
				Oversight Group	Dementia Board
Desired Outcome		The primary objective of the service is to manage the care pathways into and out of care homes, to improve patient care, reduce current levels of illness and prevent unscheduled admissions / readmissions from care homes into secondary care. This service takes active steps to reduce referrals to primary care, ultimately enabling people to remain in their own care home as long as it remains appropriate.		Commissioning Lead	Jenny Owen
				Clinical Lead	David Lyon
				Integrated Commissioning Partners	None
				Better Care Fund Plan	No
Financial Impact		Cost of £150k for 14/15		Strategic Objectives supported	

Milestones		
	2014/15	2015/16
Q1		
Q2		
Q3		
Q4		
Supporting measures		

A5.1 Communication

Project Description		Investigate the reasons behind the number of people who do not attend appointments (DNA's). Review practices and develop methods for reduction			
Ref	ADD141501	Commissioning Area	Other	Programme / Project	Communication
				Oversight Group	None
Desired Outcome		Reduction in DNA's across all service areas		Commissioning Lead	Des Chow, Lyndsey Abercromby
				Clinical Lead	TBC
				Integrated Commissioning Partners	None
				Better Care Fund Plan	No
Financial Impact		none		Strategic Objectives supported	NHSOF4, CCGICS1

Milestones		
2014/15		2015/16
Q1	Data & evidence gathering including literature review	Actions developed & quick wins started
Q2	Develop & distribute survey	
Q3	Collection and analysis of data	
Q4	Final report	
Supporting measures	From 2015/16 Q2 onwards look to see a reduction in DNA's	

Project Description		Continue to develop mechanisms to ensure we listen to the whole population, including young people and BME communities			
Ref	ADD141502	Commissioning Area	Other	Programme / Project	Communication
				Oversight Group	None
Desired Outcome		Proportionate representation evidenced from public engagement events and consultation exercises. Look especially at the 'protected characteristics' group		Commissioning Lead	Des Chow
				Clinical Lead	N/a
				Integrated Commissioning Partners	LA
				Better Care Fund Plan	Yes
Financial Impact		none		Strategic Objectives supported	CCGICS1, CCGICS2

Milestones		
	2014/15	2015/16
Q1	Identify protected characteristics groups for Halton	
Q2	Ensure all surveys are proportionately targeted to protected characteristics groups.	
Q3		
Q4		
Supporting measures	Evidence of proportionate representation from BME & protected characteristics groups.	

A5.2 Quality

Project Description		Work towards reporting on the quality of services at GP practice level and also at the level of consultant-led teams for a number of specific specialties			
Ref	ADD141503	Commissioning Area	Other	Programme / Project	Quality
				Oversight Group	Quality Committee
Desired Outcome		Production of relevant dashboard & reporting mechanisms Improved quality of services. Reporting as near to real time as possible.		Commissioning Lead	N/a
				Clinical Lead	Jan Snoddon
				Integrated Commissioning Partners	None
				Better Care Fund Plan	No
Financial Impact				Strategic Objectives supported	NHSOF4, NHSOF2, CCGOIS1, CCGOIS4

Milestones		
2014/15		2015/16
Q1	Review current provision – define what's needed – need to get as close to real time as possible.	
Q2		
Q3		
Q4	Need to report by domains by end of year.	
Supporting measures		

Project Description		Extend the friends and family test in line with national timescales, including Mental Health and Community based services from April			
Ref	ADD141504	Commissioning Area	Other	Programme / Project	Quality
				Oversight Group	Quality Committee
Desired Outcome		Improved quality of services		Commissioning Lead	N/a
				Clinical Lead	Jan Snoddon
				Integrated Commissioning Partners	None
				Better Care Fund Plan	No
Financial Impact		CQUIN with Bridgwater.		Strategic Objectives supported	NHSOF4

Milestones		
2014/15		2015/16
Q1	Pilot 2 GP practices with F&FT, 5BP to collect data in Q1	Full implementation
Q2	First reports generated from 5BP and GP pilots	
Q3	Review success / otherwise of pilot with view to wider roll out	
Q4	Preparation for full implementation with community svs /MH	
Supporting measures		

Project Description		Implement the commissioning outcomes of both the Francis report and the government response			
Ref	ADD141505	Commissioning Area	Other	Programme / Project	Quality
				Oversight Group	Quality Committee
Desired Outcome		Improved quality of services. - Duty of candour - Clinical leadership - Competency		Commissioning Lead	N/a
				Clinical Lead	Jan Snoddon
				Integrated Commissioning Partners	None
				Better Care Fund Plan	No
Financial Impact		Cquin with 5BP/BW/ & acute trusts. To show evidence of duty of candour, quality strategy, visibility of clinical leads		Strategic Objectives supported	NHSOF2, NHSOF4, NHSOF5, HICS1,

Milestones		
2014/15		2015/16
Q1	Review of performance against last year and against Cavendish review, 'patients first' government response and Berwick re patient safety collaborative.	
Q2	Presentation and report against updates	
Q3		
Q4		
Supporting measures	Evidence of training programmes, mandatory training. i.e. Infection control, safeguarding	

Project Description		Develop process to monitor and improve quality standards in secondary care including appropriate use of SHMI and HSMR mortality figures			
Ref	ADD141506	Commissioning Area	Other	Programme / Project	Quality
				Oversight Group	Quality committee
Desired Outcome		Evidence of work undertaken by the acute trusts to investigate mortality figures and report findings and areas for improvement are actioned.		Commissioning Lead	N/a
				Clinical Lead	Jan Snoddon
				Integrated Commissioning Partners	None
				Better Care Fund Plan	No
Financial Impact				Strategic Objectives supported	NHSOF1, NHSOF5, PHOF1

Milestones		
2014/15		2015/16
Q1		
Q2		
Q3		
Q4		
Supporting measures		

A5.3 Process & Policy

Project Description		Review the process for applying for grants from the CCG			
Ref	ADD141507	Commissioning Area	Other	Programme / Project	Process & Policy
				Oversight Group	None
Desired Outcome		Clear and transparent process developed, available and implemented		Commissioning Lead	TBC
				Clinical Lead	None
				Integrated Commissioning Partners	None
				Better Care Fund Plan	No
Financial Impact				Strategic Objectives supported	CCGICS4

Milestones		
2014/15		2015/16
Q1		
Q2		
Q3		
Q4		
Supporting measures		

Project Description		Further develop integrated services between the NHS and Local Authorities for people with complex needs			
Ref	ADD141508	Commissioning Area	Other	Programme / Project	Process & Policy
				Oversight Group	None
Desired Outcome		Develop integration further between the LA and CCG, ensure included in better care fund plan and integrated commissioning framework		Commissioning Lead	Sue Wallace Bonner
				Clinical Lead	None
				Integrated Commissioning Partners	LA, CCG
				Better Care Fund Plan	Yes
Financial Impact				Strategic Objectives supported	NHSOF2

Milestones		
2014/15		2015/16
Q1		
Q2		
Q3		
Q4		
Supporting measures		

Project Description		Develop plans in relation to the Better Care Fund			
Ref	ADD141509	Commissioning Area	Other	Programme / Project	Process & Policy
				Oversight Group	None
Desired Outcome		Production of plan, which will lead to increased delivery of integrated care		Commissioning Lead	Emma Sutton Thompson / Mike Shaw
				Clinical Lead	TBC
				Integrated Commissioning Partners	LA/CCG
				Better Care Fund Plan	Yes
Financial Impact				Strategic Objectives supported	CCGICS1, CCGICS2, CCGICS2

Milestones		
2014/15		2015/16
Q1		
Q2		
Q3		
Q4		
Supporting measures		

A5.4 Medicines Optimisation

Project Description		Ensure appropriate prescribing of antibacterials			
Ref	ADD141510	Commissioning Area	Other	Programme / Project	Medicines Optimisation
				Oversight Group	None
Desired Outcome		Reduction in Antibiotic prescribing seen		Commissioning Lead	Lucy Reid
				Clinical Lead	Dr Claire Forde. Dr Jan Breeden
				Integrated Commissioning Partners	None
				Better Care Fund Plan	No
Financial Impact		Small amount of savings possible in meds spend and possible quality payment on reduction in HCAI's		Strategic Objectives supported	CCGICS1, NHSOF3, NHSOF2

Milestones		
2014/15		2015/16
Q1	Quality Prescribing Initiative in place (Q1 to Q3)	
Q2		
Q3	Communication strategy re patients, public and GP's, piece of work needs to be regarding triangulating A&E admissions & attendances for infections & antibiotic prescribing rates)	
Q4		
Supporting measures	Reduction of 10% in prescribing of antibiotics, reduction In antibiotic prescribing for those antibiotics associated with HCAI's (C.diff & MRSA)	

Project Description		Reduce variation in prescribing between Practices			
Ref	ADD141511	Commissioning Area	Other	Programme / Project	Medicines Optimisation
				Oversight Group	None
Desired Outcome		Variation reduced between highest and lowest volume practices		Commissioning Lead	Lucy Reid
				Clinical Lead	Dr Claire Forde. Dr Jan Breeden
				Integrated Commissioning Partners	None
				Better Care Fund Plan	No
Financial Impact		Achieve Quip target.		Strategic Objectives supported	NHSOF3, CCGICS1

Milestones		
2014/15		2015/16
Q1	Initially targeting practices which have the biggest financial impact	
Q2	All practices targeted	
Q3		
Q4		
Supporting measures	Identify key areas of variation by Q1, be able to tell if gap is shrinking. Can use EPACT data from September onwards.	

Project Description		Develop an Integrated approach with Local Authority with community pharmacies			
Ref	ADD141512	Commissioning Area	Other	Programme / Project	Medicines Optimisation
				Oversight Group	None
Desired Outcome		In community pharmacy services in place commissioned jointly by LA and CCG		Commissioning Lead	Lucy Reid
				Clinical Lead	Dr Claire Forde. Dr Jan Breeden
				Integrated Commissioning Partners	LA/CCG
				Better Care Fund Plan	Yes
Financial Impact		Not known yet		Strategic Objectives supported	CCGICS1, NHSOF3

Milestones		
2014/15		2015/16
Q1	Investigating proposals for community pharmacy services	
Q2	To be decided depending on investigations.	
Q3		
Q4		
Supporting measures		

Agenda Item 7

REPORT TO: Health and Wellbeing Board

DATE: 12th March 2014

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Wellbeing

SUBJECT: Public Health Annual Report

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 The purpose of this report is to provide the Health and Wellbeing Board with an update on the development of the Halton Public Health Annual Report (PHAR).

2.0 RECOMMENDATION: That the Board note the theme and development of the Public Health Annual Report.

3.0 SUPPORTING INFORMATION

3.1 Since 1988 Directors of Public Health have been tasked with preparing annual reports - an independent assessment of the health of local populations. The annual report is the DPH's professional statement about the health of local communities, based on sound epidemiological evidence, and interpreted objectively.

3.2 The annual report is an important vehicle by which a DPH can identify key issues, flag problems, report progress and, thereby, serve their local populations. It will also be a key resource to inform local inter-agency action. The annual report remains a key means by which the DPH is accountable to the population they serve.

3.3 The Faculty of Public Health guidelines on DPH Annual Reports list the report aims as the following.

- Contribute to improving the health and well-being of local populations.
- Reduce health inequalities.
- Promote action for better health through measuring progress towards health targets.
- Assist with the planning and monitoring of local programmes and services that impact on health over time.

3.3 The PHAR is the Director of Public Health's independent, expert assessment of the health of the local population. Whilst the views and contributions of local partners have been taken into account, the assessment and recommendations made in the report are those held by the DPH and do not necessarily reflect the position of the employing and partner organisations.

3.4 Each year a theme is chosen for the PHAR. Therefore it does not encompass every issue of relevance but rather focuses on a particular issue or set of linked issues. These may cover one of the three work streams of public health practice (health improvement, health protection or healthcare public health), an over-arching theme, such as health inequalities, or a particular topic such as mental health or cancer.

3.5 For the 2013-14 the Public Health Annual Report will cover the topic of reducing alcohol related harm in Halton. This topic has been chosen as alcohol harm reduction is a key priority within the Health and Wellbeing Strategy.

3.6 How best we can reduce alcohol related harm in Halton will be outlined using a life-course approach from pre-conception and early years through to older adults. There will also be a "Communities" chapter which will look at the issue from a Safer Halton perspective by focussing on promoting community safety, the night-time economy and licensing and enforcement.

3.7 Each chapter has a lead author who has been tasked with producing the relevant section. Chapter content will cover the following areas:

- Key issues
- Background- overview of alcohol related harm
- What makes a difference- what works (national evidence base e.g. NICE), examples of good practice provided through local case studies
- Where are the gaps?
- Recommendations

3.8 Summary of Outline and Example Content

Chapter	Section and Example Content
1.	**Pre-conception and early years:** • Overview of alcohol related harm during pregnancy and the early years • Reducing alcohol related harm during pregnancy – evidence base and local actions related to prevention, early identification and treatment (including local case studies) • Alcohol and the early years - evidence base and local actions related to prevention, early identification and treatment (including local case studies) • Recommendations
2.	**School age children and young adults:** • Overview of alcohol related harm in school age children and young adults • Reducing alcohol related harm in school age children – evidence base and local actions related to prevention, early identification and treatment (including local case studies) • Reducing alcohol related harm in young adults – evidence base and local actions related to prevention, early identification and treatment (including local case studies) • Recommendations
3.	**Working Age Adults:** • Overview of alcohol related harm in adults • Reducing alcohol related harm in adults – evidence base and local actions related to prevention, early identification and treatment (including local case studies) • Recommendations
4.	**Older Adults:** • Overview of alcohol related harm in older adults • Reducing alcohol related harm in adults – evidence base and local actions related to prevention, early identification and treatment (including local case studies) • Recommendations
5.	**Communities:** • Overview of alcohol related harm in local communities (crime and disorder, anti-social behaviour, domestic violence, economic cost) • Reducing alcohol related harm in our local communities – evidence base and local actions related to promoting community safety, promoting a safe night time economy and licensing and enforcement (including local case studies) • Recommendations
6.	**Update on recommendations from 2012 PHAR**

3.10 The final draft of the report will be presented to the Health and Wellbeing Board in July. Following any further amendments the final version will be made available in hard copy and online.

4.0 POLICY IMPLICATIONS

4.1 The Public Health Annual Report should be used to inform commissioning plans and collaborative action for the NHS, Social Care, Public Health and other key partners as appropriate.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 None identified at this time.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

Improving the Health and Wellbeing of Children and Young People is a key priority in Halton. Alcohol consumption during any stage of childhood can have a harmful effect on a child's development. Children and young people in Halton are also impacted by excessive alcohol consumption among parents and carers which may lead to neglect, violence, isolation and fear. The PHAR will outline how harm related to alcohol can be minimised for children and young people in Halton.

6.2 Employment, Learning & Skills in Halton

Employment, Learning and Skills is a key determinant of health and wellbeing and is therefore a key consideration when developing strategies to address health inequalities. Excessive alcohol consumption can have negative impacts upon employment, learning and skills in Halton – the PHAR will outline how harm related to alcohol can be minimised.

6.3 A Healthy Halton

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

6.4 A Safer Halton

Excessive alcohol consumption is associated with higher levels of crime and disorder, anti-social behaviour and domestic violence. The PHAR will outline how alcohol related harm to our communities can be minimised in order to promote a safer Halton.

6.5 **Halton's Urban Renewal**

The environment in which we live and the physical infrastructure of our communities has a direct impact on our health and wellbeing. The PHAR will consider how urban renewal can be implemented in a way that reduces alcohol related harm e.g. through the promotion of a safe night time economy.

7.0 RISK ANALYSIS

7.1 Developing the PHAR does not present any obvious risk however, there may be risks associated with the resultant recommendations. These will be assessed as appropriate.

8.0 EQUALITY AND DIVERSITY ISSUES

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

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

There are none within the meaning of the Act.

REPORT TO: Health & Wellbeing Board

DATE: 12th March 2014

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Physical Environment

SUBJECT: Halton Homelessness Strategy 2013 - 2018

WARD(S): Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 The purpose of the report is to present Halton's Homelessness Strategy 2013-2018 to members of the Health & Wellbeing Board.

2.0 **RECOMMENDATION: That Members of the Board note and comment on the Strategy.**

3.0 **SUPPORTING INFORMATION**

3.1 In accordance with Homelessness Act 2002 the local authority has conducted a full Strategic Review of Homelessness within the area and formulated a Homelessness Strategy for the next five year period.

3.1.1 The Homelessness Strategy 2013-2018 is based upon the findings and recommendations of two other documents, one being a comprehensive review of the current homelessness services which was conducted over a nine month period during 2012 -2013. The other being the previous Homelessness Strategy 2009-2013, which involved active engagement with service users, providers and members**.**

3.1.2 The Strategic Review of Homelessness involved active engagement with service users, service providers and all partner agencies and Elected Members. The draft findings were discussed and agreed with all key stakeholders prior to the report being finalised.

3.1.3 The Review provided clear direction for preventing and addressing homelessness in Halton and reflects the factors known to affect future homelessness. It also forms the basis of this new Homelessness Strategy for Halton over the next five years.

3.1.4 During 2012/13 a Homelessness Scrutiny Review was conducted by Members to review supported accommodation services within the district. A number of recommendations were made and were

incorporated within the Strategic Review of Homelessness in 2012 and form part of the Homelessness Strategy 2013-2018

3.2 Issues

3.2.1 Halton is experiencing a gradual increase in homelessness presentations and statutory homelessness acceptances. The main causes of homelessness are due to family exclusions, relationship breakdown and the loss of private rented accommodation.

3.2.2 There are a number of client groups that do not meet the statutory homelessness criteria, but have a pressing housing need. Concerted efforts are being made by the Housing Solutions Team to assist these client groups, offering temporary accommodation for a limited period and facilitating a more efficient and accessible move on process.

3.2.3 The Scrutiny Review highlighted the high vacancy levels across all the supported hostel accommodation schemes. Due consideration was given towards reducing capacity and a number of recommendations were proposed to address the changing homelessness culture and reliance upon supported housing provision.

3.2.4 The Housing Solutions Team is more accessible and community focused, with emphasis placed upon Prevention. The team strive to reduce the levels of homelessness within the district and fully utilise the prevention options and services available to vulnerable clients.

3.3 Legislation

3.3.1 The Localism Act 2011 introduced many changes to homelessness and allocations legislation. In November 2012, the Localism Act 2011 brought into force provisions that allow local authorities to end the main housing duty to a homeless applicant by means of a private rented sector offer, i.e. a fixed term assured shorthold tenancy for a minimum of 12 months. The authority should consider the new allocated powers, which will impact upon future homelessness and service delivery.

3.3.2 Furthermore, it was determined that the council would be able to reduce the length of stay for households in temporary accommodation and the associated costs. Additionally, it will help the council to avoid future use of B&B accommodation

3.3.3 Welfare reforms affecting single people and couples aged 18-35 have put significant pressures on local housing providers, as suitable accommodation is in short supply. It is therefore anticipated that welfare reform and recent legislative changes will result in a further increase in levels of homelessness across the district.

3.3.4 The Homelessness Strategy identifies the gaps in provision and the need to improve communication between partner agencies. An integrated approach will enable the authority to address both the social and health care issues, reduce homelessness and encourage lifestyle change.

3.3.5 Halton is fully committed and focused upon health care and service provision for homeless people. The integration of CCG, Public Health and Homelessness will enable the authority to develop a new holistic approach. The aim would be to improve health care for vulnerable people, offering a more flexible and accessible service to achieve positive and sustainable outcomes for service users.

4.0 POLICY IMPLICATIONS

4.1 The Localism Act 2011 will have future policy implications and will impact upon future housing provision and allocation of accommodation within the private rented sector.

The Homelessness Strategic Action Plan identifies a task to develop a Private Rented Sector Offer policy to ensure the Authority is fully compliant with its statutory housing duty, in accordance with Part 7, Housing Act 1996. It is recommended that future consideration be given to develop a PRSO policy and implement the option to adopt the power to end the homelessness duty within the private rented sector.

4.2 The following sections within the primary legislation represent the recent history of the new powers arising from the Localism Act 2011. The policy will fully comply with the following legal requirements:

- Housing Act 1996
- Homelessness Act 2002
- Localism Act 2011
- Equality Act 2010
- Suitability of Accommodation Order 2012
- Homelessness Code of Guidance 2006
- Localism Act 2011

The policy will reflect the priorities and rules shown within the authority's local documents and would be implemented and administered by the Housing Solutions Team.

4.3 Upon considering the policy option, weight was given to the fact that the local Homelessness Strategy already promotes the use of private rented accommodation to prevent homelessness.

The Housing Solutions Team have successfully helped numerous households who may be threatened with homelessness to obtain

accommodation from a private landlord, fully utilising various incentives, such as rent deposit, Bond Guarantee and Discretionary Housing Payments.

5.0 FINANCIAL IMPLICATIONS

5.1 The financial implications of delivering the Homelessness Strategy are outlined in the Action Plan.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

Homelessness can have an adverse impact on the wellbeing of children and young people with educational attainment being affected by adverse residential mobility. The prevention focus of the Strategy will ensure that families with children are assisted swiftly to ensure minimal disruption. In addition, the Strategy recognises that homelessness amongst young people in Halton is challenging and therefore includes priorities to strengthen joint working to ensure this group is provided with the most appropriate support by the relevant agencies.

6.2 Employment, Learning & Skills in Halton

The lack of a settled home can adversely impact an individual's ability to find and sustain employment – the Strategy's focus on homelessness prevention allows people to remain in their homes wherever possible.

6.3 A Healthy Halton

The Homelessness Strategy places emphasis on the links between health and homelessness and one of the strategy objectives is specifically focussed on this issue. Therefore, implementation of actions contained within the strategy will have positive implications for the health and wellbeing of those experiencing homelessness.

6.4 A Safer Halton

Criminal activity can be both a cause and consequence of homelessness and homeless prisoners are more likely to re-offend following release than those who have settled accommodation. Therefore, the Strategy includes a priority to improve joint working with the police and probation service to address the growing housing need for offenders.

6.5 Halton's Urban Renewal

The presence of rough sleeping can have a negative impact on the environment and the Strategy seeks to continue to ensure that this does not pose an issue for Halton through the 'No Second Night

Out' initiative.

7.0 RISK ANALYSIS

7.1 The Communities and Local Government Homelessness Grant funding makes an important contribution to the delivery of a range of homelessness services in Halton. This fund is currently frozen and arrangements for distribution of the grant for the financial years 2014/15 are unclear. If the homelessness grant funding were to be reduced or ceased completely, it would adversely affect the ability of the Housing Solutions Team to offer a range of housing options and would impact upon performance and service delivery.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 The Strategy includes priorities targeted at providing support for those who are vulnerable or have complex needs and other marginalised groups such as young people and offenders.

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

There are none within the meaning of the Act.

HALTON
BOROUGH COUNCIL

Halton Homelessness Strategy

2013-2018

Contents

1. Foreword

Halton Borough Council is pleased to present its Homelessness Strategy 2013 - 2018 which sets out the key challenges, objectives and priorities for tackling homelessness in Halton over the coming years.

The Strategy highlights and reinforces our commitment to reducing and preventing homelessness. It identifies and examines the current homelessness issues faced by Halton and sets out how we plan to address the housing needs and aspirations of those who are homeless or threatened with homelessness.

Although there have been many achievements in delivering effective homelessness services in Halton, the council recognises that some significant challenges lie ahead. The Localism Act has introduced the greatest changes to homelessness and allocation legislation since 1977 and we believe that many households, both new and existing ones, will be adversely affected by not only the housing and welfare reforms, but other new legislation. To respond to this and its impact on homelessness, joint working between the council and its key partners will be central in ensuring local housing need is met.

Demand for private rented accommodation greatly outstrips supply and rents are rising. Levels of homelessness fell during 2006–2011, but there are worrying signs now as the effects of the recession and overall economic environment begin to become apparent, that it is once again on the rise. In addition, vulnerable households will have specific needs. Among these is specialist housing with appropriate support. This can enable the person to remain at home for longer.

The Homelessness Strategy is based upon the findings and recommendations of two other documents – a comprehensive review of current homelessness services over a nine month period during 2012-2013 and the Homelessness Strategy 2008–2012 which involved active engagement with service users, service providers and members. This Strategy continues to build on current good practice and strives to meet the gaps in existing service provision to ensure the needs of those individuals who are at risk of homelessness are met.

Halton is fully committed and focused on the health care and service provision for homeless people. The integration of the Clinical Commissioning Group, Public Health and Homelessness will enable the council to develop a new holistic approach. The aim would be to improve health care for extremely vulnerable people whenever they need help, within primary and community care and hospitals.

Halton aims to put the person/patient back at the heart of healthcare with the focus on what the individual wants and needs. With cross professional and organisation boundaries to shape care around the person and ensure services are more flexible and accessible. Experienced health and homeless professionals will be included at every level of the future shaping of services.

The Strategy is supported by a five year Action Plan which clearly sets out the short, medium and long term solutions along with specific actions to deliver long lasting change to those at risk.

To ensure the Strategy remains relevant it will be monitored by the Halton Homelessness Forum and reviewed annually in order that it can be responsive to emerging change.

Yours sincerely,

Councillor Ron Hignett
Executive Board Member – Physical Environment

2. Introduction

The Homelessness Act 2002 places a duty on local authorities to carry out a Strategic Review of Homelessness in their area and then formulate and publish a Homelessness Strategy based on the findings from the review.

Strategic Review of Homelessness

The review was conducted over a period of nine months and involved active engagement with service users, service providers and all partner agencies and members. Draft findings were discussed and agreed with key stakeholders before the report was finalised.

The review provides clear direction for preventing and addressing homelessness in Halton and reflects on the factors known to affect future homelessness. Its findings and recommendations are the basis for the development of this new Homelessness Strategy for Halton over the next five years.

This strategy will build upon the success of its precursor (2009–2013) which focused upon four important issues:

1. Understanding the Problem
2. Prevention
3. Increasing Access to Housing Choice
4. Providing Support

Understanding the problem (homelessness and housing need)

Significant progress has been made in determining the levels of homelessness, the reasons why people become homeless and which household group it affects most. This progress has been achieved through a range of measures including: analysis of the move from short term supported accommodation and research into households requiring resettlement services.

Prevention

The introduction of a preventative approach among statutory homeless households has proved successful. This change from reactive assessment to proactive prevention, coupled with a housing options service, proved to be a significant factor in improvement.

Increasing access to housing choice

Progress has been made in allowing customers choice and enabling them to access properties owned by accredited private sector landlords. This progress is likely to continue now that 'Property Pool Plus' has been introduced.

Providing support

Floating support services have been re-tendered. This has resulted in more streamlined and better support for households which are vulnerable to homelessness. With all of this successful work already undertaken and acting on the findings of the review, this new strategy will continue to strive to respond to evolving pressure on existing service provision. This will ensure that Halton is best placed to meet the needs of individuals at risk of being or who already are currently homeless.

Homelessness is increasing across the country and it is anticipated that this trend will continue. This will place additional pressure on services. To address this national problem, the Government has published 'Making Every Contact Count.' This recognises that early intervention to prevent homelessness is the key. It does this through 'social justice' by supporting the most disadvantaged individuals and families. It tackles many of the underlying problems that, if left unchecked, can increase the likelihood of the individual or family becoming homeless.

The ultimate goal, nationally and locally for Halton, is to ensure that people have settled homes. This stability will then enable individuals to build settled lives.

3. Homelessness in Halton

Halton is experiencing a gradual increase in homelessness presentations and of those being accepted as statutory homeless. The main causes are loss of home due to family exclusions, relationship breakdown or the loss of a private sector tenancy.

There are many groups of people who are not deemed statutory homeless, but still have pressing housing needs and no settled home. The Housing Solutions team work extensively with these groups and offer temporary accommodation for a limited period, to allow the crisis to be averted and suitable options explored and implemented.

People on low incomes without regular work, lack of proven track record, previous failed tenancies, mental health or substance misuse are unlikely to meet letting agents/landlords vetting procedures and so cannot obtain a private tenancy.

Poor discharge planning for ex-offenders and those with mental health needs have been cited as additional factors contributing to homelessness. Those with complex needs, addiction, negative behaviour, and poor parenting and life skills face particular problems in attaining settled homes and can often fall through the net of services and accommodation provided.

Welfare benefit reforms, especially limiting Housing Benefit for younger people and the effect of the 'Benefit Cap' on larger families, will increase the risk of homelessness for these groups in the future.

Rough Sleeping in Halton is not identified as a major problem; however, the majority of people identified as sleeping on the streets of Halton are aged between 26 and 50. The council developed a sub-regional prevention service to tackle rough sleepers and the outreach service will ensure that all clients have access to services and if necessary are relocated back to their local connection area.

Homelessness issues

Key issues influencing the Strategy are examined in detail within the Homelessness Review Consultation Report (2013). They are summarised in the following table under three themes (People, Health and Wellbeing and Communities). Each underpins the overarching aims and the six strategic objectives and accompanying priorities.

People	Health & Wellbeing	Communities
National evidence of impact on health and wellbeing due to homelessness National evidence indicates additional costs due to children entering the care system Impact on young people and families experiencing/ threatened with homelessness Lack of settled accommodation and support can prove detrimental and lead to repeat homelessness Domestic violence within Halton is evident and analysis confirms 11% of acceptances compared to 3% in England	National evidence of poor health or neglect of physical needs related to homelessness Mental Health and substance misuse problems are contributable factors towards homelessness Impact on health and social care services due to homelessness and rough sleeping National evidence that homeless people have significantly higher levels of premature mortality, mental and physical health needs than the settled population	Impact of anti-social and offending behaviour due to increased homelessness National evidence indicates dependency on drugs and alcohol amongst rough sleepers Criminal activity can be both the cause of and a consequence of homelessness High incidence and turnover of temporary accommodation within an area can lead to neighbourhood decline

Homelessness characteristics

- Families or friends unwilling to accommodate.
- Domestic violence
- Relationship breakdown
- Health – addictions, drug/alcohol misuse
- Offending, anti-social behaviour
- Issues with private rented property (disrepair, loss of assured shorthold tenancies)
- Debt, money problems, rent arrears, often due to benefit issues

Prevention and relief

- Housing Solutions community focused service
- Partnership working with registered providers and private landlords
- Joint working between various agencies.
- Benefit and legal advice
- Floating support
- Supported temporary accommodation
- Effective and accelerated Move On approach to secure accommodation

4. Achievements from Previous Strategy

There have been many successes in the last five years in spite of the high housing demand in Halton. Nationally, the number of individual cases accepted as homeless increased by 16% and there has been a 44% increase in the use of bed and breakfast accommodation in the year ending March 2012. However, in Halton over the same period, there were no households in bed and breakfast accommodation and the borough has managed to maintain an annual decrease in its use of temporary accommodation.

This is an outstanding achievement given the intense housing pressures in Halton. It has been achieved through the high priority placed on homelessness prevention in the borough and the continuing work in delivering practical homelessness solutions. As a consequence, a strong network of partnerships and services has been developed to support those who are either threatened with or experiencing homelessness.

Since the previous strategy there have been significant changes in legislation such as the Welfare Reform and Localism Act 2011. This combined with the considerable cuts to local authority budgets have led to significant challenges for the borough. Yet despite this, there have been a number of major achievements, as described in the following sections.

Statutory homelessness

Achievements	2008/ 09	2009/ 10	2010/ 11	2011/ 12	2012/ 13
Statutory homelessness presentations	241	216	78	154	168
Statutory homelessness acceptances	166	158	37	64	86
Use of temporary Accommodation.	54	41	35	23	39
Use of Bed & Breakfast	7	1	0	0	1
Homelessness Prevention	Not recorded	625	550	492	431
Advice and assistance	803	1800	2228	2488	2051

The following key points can be observed from the data displayed in the table above:

- Over the past five years, there has been a reduction in the number of households presenting as statutory homeless.

- Significant reductions in the use of temporary accommodation which meet and go beyond the March 2010 target set by CLG.
- A decrease in the use of bed and breakfast accommodation. This has improved the quality of life for homeless households and reduced the cost to the public purse.
- An increase in homelessness prevention (advice and assistance) and developed initiatives. The priority is on preventing homelessness occurring by helping people resolve their housing problems. In addition people are helped to tackling barriers which would prevent them from either obtaining or retaining sustainable accommodation.

Youth homelessness

- The Southwark Protocol was developed and implemented in 2010/11 and is currently being reviewed. The aim is to provide a co-ordinated response to the prevention of homelessness amongst 16-17 year-olds. It ensures they receive the right level of support and are able to access appropriate and suitable accommodation where necessary. The protocol was a response to judgements by the House of Lords which reaffirmed and clarified that the duty under Section 20 of the Children Act 1989 takes precedence over the duties within Part 7 of the Housing Act 1996 in providing for children in need who require accommodation.
- Made use of extra funding to create a dedicated Youth Officer post. This role involves joint working with Children's Services in connection with the Southwark Protocol. It will focus on homeless prevention and mediation among 16-17 year-olds.
- 85% of young people presenting as homeless were facilitated successfully back home.

The age-groups 16-24 and 25-44 contain the highest numbers of statutory homeless individuals. This national pattern is also reflected in data for Halton. The table below shows the percentage statutory homeless (national and local) for the year 2011-2012 by age-groups:

Age group	% accepted as statutory homeless	
	Halton	England
16-24 years	34%	35%
25-44 years	52%	51%
45-59 years	13%	11%
60-64 years	2%	1%
65-74 years	0%	1%
75+ years	0%	1%

- A 'Home Essentials Fund' was launched to help young people between the ages of 18 – 35 to move on from hostel accommodation and sustain their tenancy by providing help towards the cost of setting up a home. The scheme provides assistance to purchase household items such as microwaves, bedding, crockery and cookery items up to the value of £300, .which is not repayable.
- 55 Gift applications were received in 2011/12
- 38 applications were approved and received assistance under the scheme
- 75% of clients have successfully sustained their tenancies since 1st April 2012

Case study: youth homelessness

Melissa is a 17 year old female who approached the Housing Solutions Service to present as homeless.

Melissa claimed that due to constant arguments with her mum, she was ordered to leave the family home and not able to return.

Melissa was referred to the Housing Solutions Youth Adviser and a full homeless assessment was completed, although, Melissa stressed that she wished to be accommodated within the hostel where her friends had been placed.

The Youth Officer conducted a home visit to discuss the situation with Melissa's mum and negotiate for Melissa to return home, but mum refused.

Melissa was referred to the Nightstop service and reluctantly took up the temporary accommodation.

Mediation was put in place and after a number of home visits and telephone discussions; both Mum and Melissa agreed to work with the officers to resolve their issues.

Unfortunately, Melissa failed to engage with training/education programmes, which jeopardised her placement.

The officer dedicated, considerable time to work with Melissa and mum to address their issues, and encouraged them to discuss how they could work together to resolve them.

OUTCOME: After regular contact with Melissa and her mum, an intense support package was agreed and implemented. Melissa was allowed to return home and is actively engaging in training and there has been improvement in her relationship with her mum.

Mortgage rescue

- Development of a Repossessions Action Plan. This was in response to Halton being identified as a national 'hotspot' for mortgage repossessions. To achieve this, the council introduced a 'task and finish' working group. This brought together the work of various agencies in the borough to prevent repossessions.
- In addition, the Housing Solutions Team established a dedicated Mortgage Rescue Advisor. This post provides tailored advice to those at risk of repossession and can negotiate with lenders and at court hearings.

Case study: mortgage rescue

Mrs L approached the Housing Solutions Team as she had suffered a relationship breakdown and could not afford her mortgage on her income alone.

Mrs L stressed that her son had recently been offered a placement on a speech and learning therapy course that was located within the vicinity and to move from her present home would affect his health and be detrimental to his progress.

The Housing Solutions Adviser completed a Mortgage Rescue application which was submitted to Riverside for review in September 2013.

In October 2013, Mrs L received confirmation that her application had been successful and she would be allowed to remain within the family home.

OUTCOME: The acting agent completed the buyback process, allowing Mrs L to remain in her property as the tenant at an affordable rent and close to all the support networks for her son's needs.

Service improvement

- Progress made with the development and implementation of the Housing and Support Gateway. This will provide a single point of access into support services for individuals with housing support needs.
- Improved information for local people through the development of a pack of leaflets on such topics as homelessness, housing options, the 'Bond Guarantee Scheme' and a guide for private tenants.
- Developed and promoted a customer satisfaction survey. This gathers feedback on the quality of the service and identifies areas for improvement.
- Towards the end of 2009, a mystery shopping exercise was carried out. This led to improvements being made to the way customers were dealt with via the contact centre and one-stop-shops.
- Designated Housing Solutions Officers located at local one-stop-shops to provide immediate advice for those facing homelessness. This saves time by reducing the need for an appointment among homeless or those threatened with homelessness. This initiative stemmed from an internal review of the Housing Solutions Team was taken late in 2011.

Sub-regional approach

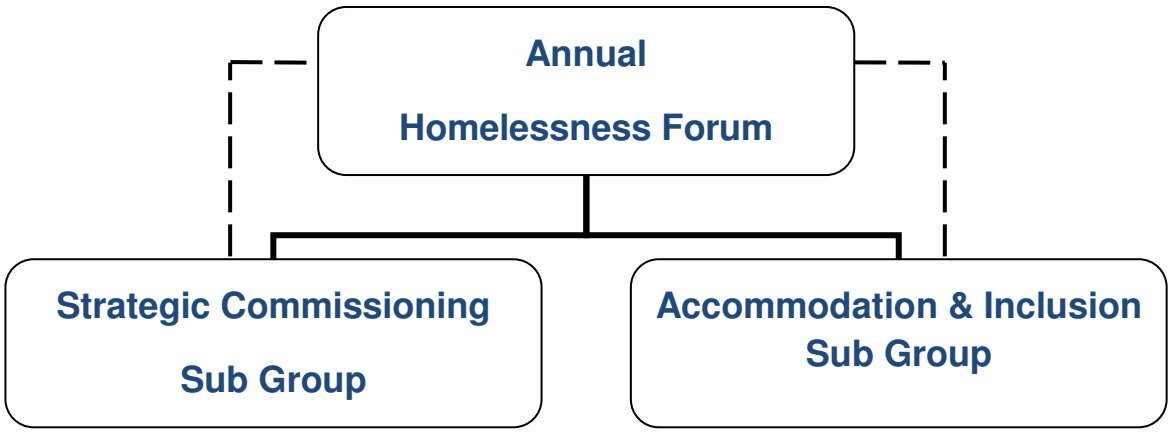
- Partnership working with Merseyside authorities led to the development of the 'No second night out' initiative. In its strategy – 'Vision to end rough sleeping: no second night out', the

government called on local authorities to implement this initiative (previously successfully piloted in London). This provides a quick and effective response from relevant services to help individuals off the streets.

- In Merseyside, local authorities have collaborated to deliver the vision that by the end of 2012 no-one will live on the streets of the Liverpool City Region and no individual arriving on the streets for the first time will sleep out for more than one night. The scheme involves widespread promotion of the one telephone number to call to report someone sleeping rough in the sub-region.

Homelessness Forum structure

- A re-structured homelessness forum from one large meeting into an annual meeting plus two sub groups to focus on Strategic Commissioning and Accommodation & Service Inclusion.



Homelessness Scrutiny Group

- A set of recommendations arising from a scrutiny review led by Elected Members (2011-12). This resulted in efficiencies being achieved through a new contract with Halton YMCA for the YMCA hostel and 'Nightstop', the de-commissioning of the 'Y's Up' advice and guidance service, a new contract with Plus Dane for floating support services. Efficiencies have also been achieved through the reconfiguration of hostel provision for single homeless people. Access to services has been prioritised to those who are owed a statutory duty. There is also an increased focus on prevention to help people to resolve their housing issues.

However, despite these achievements, Halton is not complacent and acknowledges that the challenges ahead will be considerable. Halton will continue to review and adapt its service provision to prevent future homelessness in the most effective way.

We are witnessing fundamental changes in the housing market and in social and welfare reform. The successes of the past five years will be even more difficult to replicate in the years ahead.

5. Context

Halton's Homelessness Strategy has been developed in the context of a wide range of national, regional and local policies, strategies and plans. These are summarised in the diagram below. Further details of how this influences the Strategy can be found in the evidence paper Strategic Review of Homelessness in Halton 2012/13.

Homelessness services are essential in meeting Halton's priorities set out in the 'Sustainable Community Strategy', as demonstrated below:

A Healthy Halton	• Homeless people have significantly higher levels of premature mortality, mental and physical ill health than among the settled population and are more likely to have a drug or alcohol addiction. • Net cost estimated to be £64m per year over and above health costs for same number of general population.
Employment, Learning and Skills in Halton	• The lack of a settled home can be a significant barrier for those seeking permanent employment and training opportunities. • Additional costs of providing support to homeless people to enable them to find a job and live independently.
A Safer Halton	• Criminal activity can be both a cause of and a consequence of homelessness. • Research shows that homeless prisoners are more likely to re-offend within the first year of release than those who had settled accommodation before custody.
Children and Young People in Halton	• Research shows that frequent adverse residential mobility (e.g. due to homlessness) can have a detrimental effect on educational attainment. • Additional costs resulting from children entering the care system due to the lack of a settled home.
Environment and Regeneration in Halton	• Environmental impact of rough sleeping and its potential impact on economic investment in an area. • High incidence and turnover of temporary accommodation in an area can lead to neighbourhood decline.

Making Every Contact Count: a joint approach towards homelessness prevention

In August 2012, the Department for Communities and Local Government (CLG) published this report produced by the Ministerial Working Group on Homelessness. It states clearly that 'there is no place for homelessness in the 21st century'.

The report sets out the Government's approach to homelessness prevention by focusing on the contribution that a commitment around troubled families, health, crime prevention and employment

and skills can make. The report calls for central Government, local authorities, government agencies and the voluntary sector to work together to support those at risk of homelessness.

It also gives an indication of the Government's direction and expectations for homelessness prevention. This emphasises a number of important factors, including; greater integration of local authority services (Housing, Social Services, Welfare Rights etc.); increased focus on a payment by results approach to funding; increased reliance on the private rented sector; and a focus on wrap-around services to tackle youth homelessness (such as those provided by Youth Hubs).

The report also set ten local challenges, which the government has recommended local authorities should take forward. This strategy recognises the importance of these challenges and acknowledges existing work already undertaken or underway in response to them. Halton will ensure that the ten **'Gold Standard Pledges'** remain key to its targeted approach in addressing homelessness prevention and homelessness. The Strategy identifies key themes, with emphasis placed upon reducing homelessness and increasing future prevention initiatives. The Gold Standard ten-point challenges will be to maximise opportunities arising from the Government commitments and will be **reflected within the six strategy objectives an their accompanying priorities and the strategy action plan.**

Link between Strategy Objectives and Gold Standard

Strategy objective	Gold standard
1. Collaborative and integrated approach to commissioning improved outcomes	• Have a homelessness strategy which sets out a pro-active approach to preventing homelessness and is reviewed annually so that it is responsive to emerging needs • Adopt a 'no second night out' approach or an effective local alternative • Actively engage in preventing mortgage repossessions including through the mortgage rescue scheme
2. Health and homelessness	• Offer a housing options prevention service, including written advice, to all clients
3. Minimise the impact of welfare reform	• Offer a housing options prevention service, including written advice, to all clients
4. Improve the provision of a range of housing options and services to reduce homelessness	• Develop a suitable private rented sector offer for all client groups, including advice and support to both clients and landlords
5. Increase and improve communication and partnership working	• Actively work in partnership with voluntary sector and other local partners to address support, education, employment and training needs • Have housing pathways agreed or in development with each key partner and client group that includes appropriate accommodation and support
6. Minimise the use of temporary accommodation by facilitating the supply of secure move-on accommodation	• Not place any young person aged 16 or 17 in Bed & Breakfast accommodation • Not place any families in Bed & Breakfast accommodation unless in an emergency and then for no longer than six weeks

Health

Local authorities complete a quarterly statistical report (P1E) which identifies levels of homelessness and prevention outcomes achieved. The report is submitted to Communities and Local Government (CLG) in relation to their activities to ensure compliance with the relevant homelessness legislation. The new Public Health Framework sets out the desired outcomes and how they will be measured, which includes two homelessness indicators – statutory homeless acceptances and households in temporary accommodation.

There is an encouraged focus on the health of the local homeless population and a real commitment within Halton to ensure health services assist in identifying those at risk and prevent homelessness by making every contact count.

The health of people who are homeless is generally much poorer than that of the general population. There is limited data available at a local level and it is not routinely collected and analysed, consequently, it is not possible to determine the exact health issues facing people who are homeless. The National Audit found that homeless people have a higher usage of healthcare services than the general population and established;

- 41% had gone to A&E at least once;
- 31% had been admitted to hospital at least once (compared to 7% of the general population in a typical year);
- 28% had used an ambulance at least once;
- 82% had been to a GP at least once;
- Only quarter of homeless people admitted to hospital had help with housing;
- Average length of stay of 6.2 days for homeless people (compared to 2.1 days for the general population);
- Most common reasons for admission include toxicity, alcohol or drugs and mental health problems.

To allow further understanding of the public health needs and pressures placed on services, the Liverpool Public Health Observatory has been commissioned to complete a Health Needs assessment. The commissioned piece of work will look at qualitative methods of gathering intelligence to determine health experience, access to services and homelessness status.

Health & Well Being

The 'Health and Well Being' needs of the homeless in Halton can vary significantly between individuals, and is frequently related to their particular status. This ranges from households fleeing domestic abuse and identified as a priority need for accommodation, to the hidden homeless, single non-priority persons who are rough sleepers, 'sofa surfers' and night shelter residents.

Priority groups for housing include young families, who usually retain access to primary care services and GP to ensure their physical and mental health needs can be met. However, the hidden homeless are particularly vulnerable, with complex physical and mental needs leading to an extremely high level of mortality and an average life expectancy of 40. They can often prove extremely hard to reach through mainstream provision.

Information taken from National Audit carried out by Homeless Link during 2010/11 gave a proxy analysis of the health needs of homeless people in Halton found:

- 8 out of 10 clients have one or more physical health needs and 1 in 5 confirmed they found it difficult to cope and required support;
- The most common conditions mentioned were chest/breathing, pain, joint and muscular problems, dental and eye sight problems. The proportion of homeless people citing these conditions was much higher than prevalence of general population;

- 56% reported long term health conditions compared to 29% in general population;
- 72% have mental health needs compared to 30% of the general population;
- 1 in 3 regularly eat less than 2 meals a day and only 7% consume the recommended 5 portions of fruit or vegetables a day compared to 21% of the general population;
- 77% were smokers and had been offered smoking cessation advice;
- 52% indicated they used one or more type of illegal drugs.

Whilst it is essential that the strategic focus remains on preventing homelessness, there is now a new council responsibility under the Health & Social Care Act 2012. This is to reduce premature mortality and tackle health inequalities. Hence the council is strongly committed to supporting a system where vulnerable single homeless persons have equal access to its health and social care services.

The welfare reform and wider economic pressures are likely to increase the numbers of hidden homeless in Halton, further increasing demand on existing health and support services. Following the NHS reform, Public Health now sits within Halton Borough Council. This provides a unique opportunity to review and reposition all disparate homeless health provision investments through Section 75 agreements with Public Health Services. Joint commissioning of a new integrated homeless service could then be more easily achieved. This would meet the spectrum of health needs of the hidden homeless along with those identified for priority accommodation.

Halton intends to build upon the partnership links made with other agencies, including health and mental health services and will remain vigilant in its search for joint working opportunities that improve outcomes for service users.

6. The Journey Ahead

The magnitude and complexity of the issues that face us in the next 5 years must not be under-estimated. However, Halton will continue to plan ahead and will work in partnership with others who can assist in delivering solutions. We have prioritised issues and proposed actions to build on our past success, mitigate the impacts of changing housing markets, social and welfare reform but, above all, prevent homelessness.

Halton's future goals

- Early intervention to prevent homelessness before a crisis point is reached.
- Provision of appropriate advice, accommodation and support if crisis occurs.
- Prevention of repeated homelessness to ensure people have settled and sustainable homes.
- Improve clear links between Health, Homelessness, Housing and Social Care.

Key challenges

The outcome of the consultation held for reviewing and developing the new strategy with stakeholders highlighted the key challenges Halton is facing. Key issues and priorities identified were:

- Adverse impact of welfare reform;
- Funding;
- Affordable housing need;
- Increasing pressures on household incomes in the current and future economic climate;
- Single non priority and intentionally homeless households;
- Young people;
- People at risk of domestic abuse;
- Difficulty in meeting the needs of households with more complex needs;
- Service integration to develop and improve health care for homeless people;
- Increasing problems accessing private rented accommodation for homeless and potentially homeless households;
- Developing solutions to meet gaps in future funding including accommodation based services for rough sleepers.

Factors that may affect future homelessness levels

- Lack of affordable housing;
- Housing and Welfare Reforms;
- Increase in Landlord and Mortgage repossession claims.

How Halton will deliver its objectives in response to these pressures is contained within the Homelessness Strategy Action Plan. This sets out clear tasks and targets within identified areas of

work.

7. Our vision, objectives and priorities

The vision is to assist and prevent people who are threatened with homelessness in Halton. To provide a community focused and accessible service to ensure people know where and how they can seek help and assistance to prevent them becoming homeless and receive a quality and confidential housing options service.

The Strategy aims to:

- **Reduce Homelessness presentations and acceptances; and**
- **Increase and improve Homelessness prevention and access to housing services.**

Further emphasis is placed upon prevention, support and partnership working to deliver an efficient and coordinated approach towards reducing the levels of statutory homelessness within Halton.

To help achieve these aims, we have adopted the following six strategic objectives. Each contains a set of priorities detailed below, which are linked to the Gold Standard pledges. The Strategy explains why each priority has been selected, what we hope to achieve and how we plan to achieve it.

Strategic objective 1:

Collaborative and integrated approach to commissioning improved outcomes for people experiencing homelessness

- Priority 1A: Develop and co-ordinate services to deliver a comprehensive approach towards homelessness and prevention
- Priority 1B: Develop a marketing plan with partners to raise awareness of the Housing Solutions service to ensure that the homelessness services strive to meet the National Gold Standard
- Priority 1C: Promote a range of prevention options, including the GIFT initiative, prevention fund, and mortgage rescue scheme to enable clients to remain within their homes
- Priority 1D: Respond to and prevent rough sleeping

Strategic objective 2:

Health and homelessness

- Priority 2A: Ensure that homelessness is recognised as a priority for action within the Health and Wellbeing Board
- Priority 2B: Develop a business case to formalise a single practice approach to address the housing and health care needs of vulnerable homeless people

Strategic objective 3:

Minimise the impact of welfare reform

- Priority 3A: Agree a joint approach with the Housing Benefits service for the future use of Discretionary Housing Payments to ensure they are used effectively to prevent homelessness and to determine future areas of action
- Priority 3B: Develop under-occupation schemes with housing providers to free up family homes and encourage shared housing

Strategic objective 4:

Improve the provision of a range of housing options and services to reduce homelessness

- Priority 4A: Improve access to housing using the private rented sector and shared housing options
- Priority 4B: Improve working with private sector landlords and promote the Bond Guarantee Scheme

Strategic objective 5:

Increase and improve communication and partnership working

- Priority 5A: Develop an effective multi-agency approach to support vulnerable and complex needs households to sustain and secure affordable accommodation to prevent homelessness
- Priority 5B: Support young people and facilitate the delivery of integrated housing, care and support for young people at risk, care leavers, young offenders and teenage parents
- Priority 5C: Improve partnership working and communication with key agencies, police, probation and housing providers to address the growing housing need for offenders
- Priority 5D: Joint partnership working with agencies, police and housing providers to offer options and solutions to victims of domestic abuse to support them to remain within their home

Strategic objective 6:

Minimise the use of temporary accommodation by facilitating the supply of secure move-on accommodation

- Priority 6A: Reduce the use of temporary accommodation (including B&B) to maximise the use of prevention options available to reduce homelessness

The following tables report the findings of the Strategic Review of Homelessness within Halton. These findings have been incorporated within the strategy document and comply with the government's approach to homelessness prevention while focusing upon partnership working to support those at risk of homelessness.		
Why this is a priority?	**What do we want to achieve?**	**How do we plan to achieve it?**
The Homelessness Act 2002 requires that every five years, local authorities must carry out a strategic review of homelessness, formulate and publish a homelessness strategy based on its findings.	Determine the future levels, trends and demands of homelessness within Halton. Prevent homelessness within the Halton district and raise awareness of the wide range of services available.	Adopt a corporate commitment to reduce and prevent homelessness, which has a buy in across all local authority services. Early intervention in the homelessness risk assessment process to prevent homelessness and deliver a range of housing options. Develop a Housing and Support Gateway service that will offer an accelerated process and improve access to the homeless and support services within the district.

Strategic objective 1: Collaborative and integrated approach to commissioning improved outcomes for people experiencing homelessness

GOLD STANDARD:

- Have a homelessness strategy which sets out a pro-active approach to preventing homelessness and is reviewed annually so that it is responsive to emerging needs
- Adopt a 'no second night out' approach or an effective local alternative
- Actively engage in preventing mortgage repossessions including through the mortgage rescue scheme

Priority 1A: Develop and co-ordinate services to deliver a comprehensive approach towards homelessness and prevention

Why is this a priority?	What do we want to achieve?	How do we plan to achieve it?
Develop a homeless strategy that sets out a pro-active approach to preventing homelessness and is reviewed annually to ensure it is responsive to emerging trends.	Put a robust framework for measuring the effectiveness of interventions in place and implement the review recommendations by April 2014. Actively encourage partnership working with statutory and voluntary partners, including other Local Authorities to improve service delivery and address support, education, training and employment.	Conduct a review of the current homeless prevention using the Communities and Local Government (CLG) toolkit. Develop housing pathways with key partners and client groups that include appropriate accommodation and support. Continue to work with Supported Housing providers to strengthen the outcomes on prevention and long term tenancy sustainment.

Priority 1B: Develop a marketing plan with partners to raise awareness of the Housing Solutions service to ensure that the homelessness services strive to meet the National Gold Standard		
Why is this a priority?	**What do we want to achieve?**	**How do we plan to achieve it?**
To ensure key agencies and partners have an understanding of the homelessness assessment process, applied legislation and prevention agenda to reduce the levels of homelessness. To increase access to prevention services and resources across the district.	Conduct review of current homeless prevention using CLG toolkit. Improve awareness of the Housing Solutions Team and promote the range of housing options and resources available to clients. Reduce the level of homelessness and increase positive prevention outcomes.	Develop a robust framework for measuring the effectiveness of interventions in place to determine trends and review recommendations annually. Commission a range of learning, development and role shadowing opportunities for staff and partners to improve knowledge and understanding around the issues of homelessness and prevention. Increase the number of 'Housing Solutions' drop in advice sessions across the district to further develop a community focused and accessible service. Increase/ develop prevention initiatives to promote client choice and access to services.

Priority 1C: Promote a range of prevention options, including the GIFT initiative, prevention fund, and mortgage rescue scheme to enable clients to remain within their homes		
Why is this a priority?	**What do we want to achieve?**	**How do we plan to achieve it?**
Work in accordance with the Prevention agenda to develop and improve homelessness prevention initiatives.	Continuous improvement and delivery of prevention services with the priority on helping people to resolve their housing problems and tackle barriers to obtaining accommodation.	Ensure the service is accessible and transparent and people facing crisis are fully aware of the options and services available to them.
Reduce the levels of future homelessness presentations and acceptances.	Continue the delivery of the Mortgage/ Repossession role and ensure the MRS fund is fully utilised.	Increase the number of those accessing the Mortgage Rescue Service by 20%. Further improve joint working with all housing partners to offer an accelerated process for clients facing repossession due to rent arrears. Further develop county court service and attend court action group to be aware of changes within the legal setting.
	Review and promote the GIFT scheme for young people to ensure it is made available to clients in crisis / homeless.	Review information leaflets and circulate across the district. Update council website to illustrate the level of services and assistance available to clients. Develop as part of move on process to ensure service is fully utilised and clients have access to the relevant funding to take up a tenancy.
	Deliver a programme of training to promote homelessness prevention and the impact of the Localism Act, Welfare Reform and other initiatives with partners.	Deliver joint staff training between partners and agencies every quarter commencing December 2013. Co-ordinate sub regional training programme to share resources and reduce costs.

Priority 1D: Respond to and prevent rough sleeping		
Why is this a priority?	**What do we want to achieve?**	**How do we plan to achieve it?**
Ensure that no client spends more than one night rough sleeping.	Implement a sub-regional approach to tackling the problem of rough sleeping across Merseyside and Cheshire. Develop and improve a co-ordinated approach that is consistent across all Local Authorities when assisting clients sleeping rough.	Review the no second night out service to determine current trends and future funding to retain service provision Ensure sufficient specialist accommodation and support is available to meet the needs of single homeless clients in the borough. Ensure that the reconnection policy for 'out-of-borough' clients is fully supported when they return to their local connection district.

Strategic objective 2: Health and homelessness		
GOLD STANDARD: • Offer a housing options prevention service, including written advice, to all clients		
Priority 2A: Ensure that homelessness is recognised as a priority for action within the Health and Wellbeing Board		
Why is this a priority?	**What do we want to achieve?**	**How do we plan to achieve it?**
Make every contact count and ensure individuals and/ or families affected by homelessness can access appropriate advice, support and accommodation.	Ensure that homelessness services are appropriately linked into Health Care services and fully informed of the options available to maximise resources, prevent homelessness and improve Health and wellbeing. To promote and encourage integration between homelessness and public health care services to allow a broader understanding of the priorities and challenges faced by each service Review the Hospital discharge policy to incorporate procedural practice changes to the service.	Present Homelessness Strategy to Health & Well Being Board to raise awareness of the Housing Solutions Service. To ensure Homelessness is identified as a Priority and to build upon joint Strategic Needs Assessments to determine future service delivery. To forge close working relationships with Health Care services and outline future trends and challenges of homelessness and the impact and cost it will have on future health care. Joint partnership approach to review and develop a Hospital Discharge Policy which will enable vulnerable clients to be discharged from hospital more quickly. This would put their home less at risk.

Priority 2B: Develop a business case to formalise a single practice approach to address the housing and health care needs of vulnerable homeless people		
Why is this a priority?	**What do we want to achieve?**	**How do we plan to achieve it?**
Homelessness people are at the bottom of any graph of health inequalities, putting the average age of death of homeless people some 30 years below that of the general population. Homelessness is therefore a Healthcare issues	Integrated service approach to develop a National Practice for homelessness people that is flexible and easily accessible. Reduce homelessness and repeat hospital admissions by taking a holistic approach to reach the clients and address all their needs to improve the quality and experience of these groups Collect and record data to support local commissioners and health care partners to shape services around the health needs of the most vulnerable and marginal groups, that are often invisible.	To transform health outcomes for homeless people and other multiply excluded groups. Develop Healthcare pathway with integrated care co-ordination team that will include homelessness, to improve outcomes for homeless people. Conduct needs assessment and collect data on levels of hidden local health need and health inequalities within the defined population.

Strategic objective 3: Minimise the impact of welfare reform		
GOLD STANDARD: • Offer a housing options prevention service, including written advice, to all clients		
Priority 3A: Agree a joint approach with the Housing Benefits service for the future use of Discretionary Housing Payments to ensure they are used effectively to prevent homelessness and to determine future areas of action		
Why is this a priority?	**What do we want to achieve?**	**How do we plan to achieve it?**
To ensure that the council is fully compliant with changing legislation and responsible for the administration of public funds.	Develop a co-ordinated approach to providing advice on housing and welfare benefit, debt and money advice by working with and fully supporting partner agencies. Agree a joint approach to the future use of Discretionary Housing Payments	Review current services to ensure that the level of advice offered on benefits, debt and money advice is accessible and efficient and to determine gaps in service delivery. Develop evening / weekend advice services and consider on-line advice services. Review and monitor future allocation of Discretionary Housing Payments (DHP) to determine future areas of action. Request for Housing Solutions Officer to attend DHP application panel assessments.

Priority 3B: Develop under-occupation schemes with housing providers to free up family homes and encourage shared housing		
Why is this a priority?	**What do we want to achieve?**	**How do we plan to achieve it?**
To prevent and reduce future homelessness for clients affected by the Welfare Reform Act.	A joint approach to administering the allocated DHP funding to reduce the impact of the Welfare Reform Act and minimise penalties in order to prevent and reduce homelessness. Target social tenants likely to be affected by the under-occupation penalties enforced through the welfare reform.	Develop a coordinated approach to offering advice and support for housing welfare benefit, debt and money management. This will increase early access to advice services and further promote financial inclusion. Targeted support to those likely to become homeless as a result of the under-occupation penalties and social rent conversions. Consult with all housing partners to develop a move on/ transfer scheme for clients affected by under –occupation penalties. Joint partnership approach to develop and promote shared housing scheme. Advertise and promote shared housing on the PPP housing register.

Strategic objective 4: Improve the provision of a range of housing options and services to reduce homelessness		
GOLD STANDARD: • Develop a suitable private rented sector offer for all client groups, including advice and support to both clients and landlords		
Priority 4A: Improve access to housing using the private rented sector and shared housing options		
Why is this a priority?	**What do we want to achieve?**	**How do we plan to achieve it?**
Enable Halton Borough Council to take advantage of powers available to them under sections 148 and 149 (Chapter 20, Part 7 of Localism Act 2011). The powers allow the local authority to make an offer of suitable private rented accommodation to persons who have a priority need and are not intentionally homeless. Review the Allocations Policy to cover new powers introduced by the Localism Act 2011 and Welfare Reform Act.	Agree approaches to using the new homelessness discharge duty in accordance with PRSO policy and Improve access to housing via Property Pool Plus to increase private rented sector and shared housing options. Develop and review initiatives to make better use of social housing stock.	Encourage private sector landlords to advertise their accommodation on Property Pool Plus and work with the LA to secure accommodation for homeless households. Increase supply of homes to homelessness and vulnerable households by bringing empty homes back into use Promote and facilitate mutual exchanges to clients. Work with housing providers to develop incentives to free up stock and meet housing demands. Continue to work with floating support services to strengthen prevention outcomes and tenancy sustainment.

Priority 4B: Improve working with private sector landlords and promote the Bond Guarantee Scheme		
Why is this a priority?	**What do we want to achieve?**	**How do we plan to achieve it?**
Reduce and prevent homelessness and enable the local authority to discharge its statutory housing duty using the private rented sector.	Increase housing options and choice to meet increasing housing demand to prevent homelessness and reduce the use of temporary accommodation. Improve partnership working with letting agents to improve the service available. Improve advice and support offered to landlords and clients.	Increase sustainable move on options and support from temporary accommodation to make full use of the bond guarantee scheme and promote independent living. Improve overall approach to working with private landlords to promote the 'Bond Guarantee Scheme' and increase number of lets with rental bond by 10% by April 2014. Make full use of DHP for rent in advance required for private renting. Encourage letting agents to work with the council to fully utilise the accommodation available. Undertake awareness and publicity campaign to inform landlords and tenants of services available. Encourage and support people to let out their property or rooms.

Strategic objective 5: Increase and improve communication and partnership working		
GOLD STANDARD: • Actively work in partnership with voluntary sector and other local partners to address support, education, employment and training needs • Have housing pathways agreed or in development with each key partner and client group that includes appropriate accommodation and support		
Priority 5A: Develop an effective multi-agency approach to support vulnerable and complex needs households to sustain and secure affordable accommodation to prevent homelessness		
Why is this a priority?	**What do we want to achieve?**	**How do we plan to achieve it?**
People experiencing homelessness are generally in contact with a range of other public services. Providing access to advice, information and support will ensure that the right help at the right time is provided.	Integrated approach to addressing the housing and social needs of vulnerable and complex households to prevent homelessness. Deliver a planned approach involving key agencies. Respond to the needs of vulnerable and complex care households experiencing homelessness. Develop an effective multi agency approach to support vulnerable and complex needs households to sustain and secure affordable accommodation to prevent homelessness.	Review intelligence which will identify arising needs for vulnerable and complex needs households Agree and develop a joint working protocol between Housing Solutions service and; • Health & Social Care • Mental Health • Local Hospitals • Probation • Job Centre Plus. Provide emergency temporary housing provision and tailored support for vulnerable client groups experiencing homelessness.

Priority 5B: Support young people and facilitate the delivery of integrated housing, care and support for young people at risk, care leavers, young offenders and teenage parents		
Why is this a priority?	**What do we want to achieve?**	**How do we plan to achieve it?**
Ensure that all young people in Halton have support, life skills and opportunities to thrive physically and emotionally to prevent homelessness.	Scope and identify opportunities to improve access to education, training and housing options for young people. Ensure that staff working with young people affected by homelessness, have the appropriate skills, knowledge and safeguarding training. Collaborate with the skills and work programme providers. Review the joint protocol with Children's services and youth offending team to ensure the council complies with legal judgements and case law. Explore the development of emergency respite accommodation for 16 – 21 year olds.	Continue to develop joint working between the Housing Solutions Team, Children's services and the team around the family. Ensure that the housing solutions team access children's and adults safeguarding training to raise awareness of key issues and reporting process, Provide learning and development opportunities on Homelessness legislation and applied criteria to all key services that work with young people. Increase the number of referrals to training, employment and education providers by 15% annually. Support housing providers to develop a coordinated approach to delivering life skills sessions to young people. Further review and develop the joint working protocol for 16/17 year olds, enabling transition towards independent living with tailored support. Develop crisis intervention centre for young people threatened with homelessness. Offer a holistic approach to working with young people and their

		households as a means of them returning back to the family home.

Priority 5C: Improve partnership working and communication with key agencies, police, probation and housing providers to address the growing housing need for offenders		
Why is this a priority?	**What do we want to achieve?**	**How do we plan to achieve it?**
Ensure the current housing accommodation and support for all offenders is appropriate and that pathways to specialist services are available to reduce the level of re-offending and enable Housing Solutions advisers to work with offenders as part of a wider package of support.	Review current housing policies to identify gaps in provision and agree the information required by Registered Providers to enable them to rehouse offenders. Reduce the number of prisoners being released from prison without a resettlement plan to prevent homelessness and re-offending.	Investigate Registered Providers reluctance to house Schedule 1 offenders and those subject to MAPPA. Work with shelter to develop joint protocol to maximise notice periods for prisoners requiring accommodation on release. To ensure offenders are registered with Housing Solutions and Property Pool Plus at earliest opportunity.

Priority 5D: Joint partnership working with agencies, police and housing providers to offer options and solutions to victims of domestic abuse to support them to remain within their home		
Why is this a priority?	**What do we want to achieve?**	**How do we plan to achieve it?**
To ensure the council works in compliance with Homelessness Act 2002 and provides temporary /secure accommodation for victims of violence and abuse. To ensure that service provision is sufficient to meet with and tackle the issues of domestic abuse.	Work in partnership with National Domestic Abuse Organisations, Police, registered Housing providers and key agencies to offer a range of rehousing options and solutions to victims of domestic abuse Improve partnership working with Sanctuary scheme providers to promote safety housing options and solutions to victims of abuse. Improve referral and data sharing processes across organisations to ensure consistency and accuracy and better service delivery	Multi-agency approach to deliver a holistic prevention service. This will ensure that the right support and services are made available to the household. Develop a range of housing accommodation provisions to meet the needs of victims of abuse. Ensure that families with dependent male children and male victims can be accommodated within the district. Support Sanctuary scheme to reduce the number of men and women becoming homeless because of domestic abuse. Agree a pathway action plan with Key agencies to deal with the crisis and empower the individual to achieve positive outcomes and sustain long term tenancy.

Strategic objective 6: Minimise the use of temporary accommodation by facilitating the supply of secure move-on accommodation		
GOLD STANDARD: • Not place any young person aged 16 or 17 in Bed & Breakfast accommodation • Not place any families in Bed & Breakfast accommodation unless in an emergency and then for no longer than six weeks		
Priority 6A: Reduce the use of temporary accommodation (including B&B) to maximise the use of prevention options available to reduce homelessness		
Why is this a priority?	**What do we want to achieve?**	**How do we plan to achieve it?**
In accordance with homelessness legislation the council cannot place families into B&B accommodation for more than 6 weeks.	Continue to reduce the use of B&B and temporary accommodation and make better use of housing stock within the district. Continued achievement to reduce the use of temporary accommodation. Review the level of temporary accommodation within the district to ensure it meets current and future housing demands Temporary accommodation provision made available for non-statutory homeless households in crisis.	Early intervention and promoting a community focused service, made more accessible to households threatened with homelessness. Reduce the number of households in temporary accommodation by 20% by April 2014. Support temporary accommodation providers Promote housing services available and facilitate move on options. Evaluate and develop temporary accommodation provision within the district to ensure it meets the needs of statutory homeless households and reduce the level of voids and rent loss. Improve access to appropriate temporary hostel accommodation for short periods to allow housing solutions and key agencies to address the issues and facilitate move on to alternative suitable accommodation.

8. National & Local Policy

Local authorities have statutory duties under the Housing Act 1996 (as amended by the Homelessness Act 2002). This includes a duty to provide advice and assistance to all people who are homeless or threatened with homelessness.

Following the Homelessness Act 2002, preventing homelessness has become a central component of national and local policy direction. The Act imposes a statutory duty on local authorities to produce a homelessness strategy for addressing prevention and recurrence of homelessness. This includes a requirement to assist 16 and 17 year olds and other vulnerable groups. In carrying out these functions the council must consider both the objectives of central government and local priorities, as determined by the corporate housing strategy and other key council policy documents.

- **Localism Act -** The Localism Act 2011 introduced a range of measures to give more powers to individuals, communities and local authorities enabling them to make decisions, and influence policies in their own local areas with a diminishing central government role. The main implications for homelessness are changes to the local authority duty to accommodate households assessed as 'statutory homeless' and to allow the discharging of homelessness duty to the private rented sector.

  The new legal powers will have implications for the Housing Solutions Team. For example, reliance upon private rented accommodation would form an important part of the service, alongside the existing focus on homeless prevention. This would increase pressure on the council to ensure there was better private sector stock provision by increasing enforcement activities, extending bond schemes, licencing and prioritising referrals to accredited landlords.

- **Welfare Reform –** The introduction of the Welfare Reform Act 2012 has major implications for Halton residents and there are concerns that it could lead to an increase in homelessness. The reforms proposed are intended to protect the most vulnerable, create the right incentives to get more people into work resulting in a fairer benefit and tax credit system. However, our initial analysis indicates that welfare reform will have a detrimental effect on many of the vulnerable and high risk client groups.

A number of changes to housing benefit have already been implemented and will continue until 2014/15. Universal Credit will replace the current system of means tested working age benefits and tax credits and came into effect in October 2013 (in piloted areas). The measures to reduce Local Housing Allowance (LHA) rates would ultimately result in people's inability to find suitable affordable housing in the private sector and may threaten the ability of some households to continue to afford their current home. To help households manage the transition, the Government has awarded increases in the Discretionary Housing Payments (DHP) fund. The council will use the increase in DHP to target vulnerable households with the most need and to address the 'bedroom tax'; however, there is a risk that the allocation may not be sufficient.

- **No Second Night Out (NSNO) –** The ministerial working group on homelessness published its first report in 2011. This addresses the complex causes of homelessness more effectively and tackles the problem of rough sleeping out on the streets. NSNO was a Merseyside sub-regional approach that has been operating successfully since 2011

9. Delivery of the Strategy

To achieve the strategic priorities and objectives an Action Plan has been developed in partnership with partners and stakeholders to outline key objectives and tasks to be delivered over the 2013 - 2018 period. The action plan is reviewed annually and targets set are evaluated to incorporate legislation and policy changes.

Governance and monitoring

Progress and delivery of the strategy and action plan will be monitored and updated quarterly by the *Strategic Commissioning Group* and annually by the *Halton Homelessness Forum* to celebrate the achievements and remove any barriers, address new challenges and ensure efficient service delivery. It is considered important to have the involvement of stakeholders and partners in the delivery of the targets set in the strategy action plan. The monitoring of the homelessness strategy targets is shown in the table below:

Monitoring Homeless Strategy Targets

Stakeholders and Partners	Homeless Strategy Targets
Halton Homelessness Forum	Annual conference to inform stakeholders and partners of the progress made towards delivering the set targets identified within the Strategy Action Plan.
Strategic Commissioning Group	Through quarterly meetings the strategy action plan will be updated and progress recorded for each action. Any new developments at local and regional level will be considered and the implications will be evaluated.
Halton Housing Partnership	Progress on the homelessness strategy action plan to be reported to HHP on an annual basis, however, exceptions could be reported to its monthly meetings.
National Performance Indicators:	The new CLG single data list require the following data for homelessness: • **Mortgage Rescue** quarterly return - monitors the number of households at risk of homelessness who are assisted by the Housing Solutions Team • **Rough Sleeper** annual return - records the number of people reported to be sleeping rough in the Local Authority on a given night between October and November each year • **P1E quarterly return** - covers all areas of Local Authority activity under the homelessness provisions of Housing Act 1996.

Stakeholders and Partners	Homeless Strategy Targets
Local Performance Indicators:	Halton will continue to monitor performance against certain local performance indicators relating to housing and homelessness. These are: **LPI** – relates to the *number of households who are considered homeless or threatened with homelessness within 28 days, who approached the Local Authority Housing Solutions Service, and for whom housing advice casework and intervention has resolved their situation*. This data is recorded on the 'Housing Advice' database and reported through section E10 of the P1E **LPI** – Shows the *average length of stay in B&B accommodation for households with dependent children or expectant mothers that are unintentionally homeless and in priority need*. **LPI** – This indicator measures the *number of households living in temporary accommodation provided under the homelessness legislation*. This indicator is no longer reported to Government but is monitored locally.

Risk elements to delivery of Homelessness Strategy

The key risks to the delivery of the homelessness strategy have been analysed to ensure there are mechanisms in place to mitigate or manage their impact.

Access to resources

The CLG Homelessness Grant funding makes an important contribution to the delivery of a range of homeless services in Halton. This fund is currently frozen and arrangements for distribution of the grant for the financial years 2014/2015 are unclear. If the homelessness grant funding were to be reduced or ceased completely, it would adversely affect the ability of the Housing Solutions team to offer a range of housing options and would impact upon performance and service delivery.

10. Action Plan

Homelessness Strategy for Halton (2013 – 2018) – Action Plan

Strategic objective 1: Collaborative and integrated approach to commissioning improved outcomes for people experiencing homelessness					
Priority	**Action**	**By when**	**Responsibility**	**Resources**	**Success measures and outcomes**
1A: Develop and co-ordinate services to deliver a comprehensive approach towards homelessness and prevention	Review/ improve current homelessness prevention using CLG toolkit.	2014	PHO, Health & Social Care Commissioner	Officer time, P1E, CLG Homelessness Grant	Robust framework measuring effectiveness of interventions. Develop and implement the Action Plan recommendations.
	Adopt a corporate commitment to reduce and prevent homelessness in which all Local Authority services are involved.	2015 Over strategy period	Merseyside and Cheshire sub-regional groups, Health & Social Care	CLG sub-regional Prevention Fund. P1E	Joint approach to develop and implement quality and cost-effective services across neighbouring authorities.
	Review mechanisms to introduce meaningful and cost-effective satisfaction and customer experience feedback – including independent facilitation.	Annually Over strategy period	PHO, Policy Officer (Communities)	Officer and staff time, CLG Homelessness Grant	Improve listening and learning from homelessness people to further develop; • Community focused service • Procedural practice • Service provision • Accessibility • Integrated partnership approach to improve service delivery.
	Increase awareness of realistic housing options for agencies working with homeless clients.	Quarterly via regular partnership meetings	PHO Housing Solutions team	Officer and staff time. P1E	Identify gaps and actions from trends and changes, promoting wider public awareness of homelessness and supply and

Strategic objective 1: Collaborative and integrated approach to commissioning improved outcomes for people experiencing homelessness					
Priority	**Action**	**By when**	**Responsibility**	**Resources**	**Success measures and outcomes**
	Continue to work with Supported Accommodation providers to strengthen prevention outcomes and 'move on' processes.	Over the strategy period	PHO, SDO, Accommodation Providers	Officer time, CLG Prevention Fund, P1E	demand for social housing. Improved partnership working with accommodation providers to improve prevention outcomes and comply with contract requirements. Develop housing pathways with key partners and client groups that include appropriate accommodation and support to promote independent living.
1B: Develop a marketing plan with partners to raise awareness of the Housing Solutions service to ensure that the homelessness services strive to meet the National Gold Standard	Revise procedures, staff awareness and training to incorporate any policy and legislative changes. Review best practice and performance to strive towards continual improvement to meet the Gold Standard. Deliver a programme of training to promote homelessness prevention and the impact of Localism and Welfare Reform with partners. Develop Gateway for homeless accommodation and support services.	Over the strategy period 2014/15 Quarterly Over Strategy Period May 2014	PHO, Policy Officer, HST DM Commissioning, PHO, SDO, Policy Officer PHO, Homelessness Forum, Partners DM Commissioning, PHO, SDO, Capita	Officer time, training fund, P1E Officer time, sub-regional groups Regular strategic partnership meetings, NHAS CLG Sub Regional Funding	Maximise homelessness prevention by 10%. Fully utilise all resources and develop new initiatives to offer choice and prevent future homelessness. Participate in national benchmarking to improve service planning and ensure cost effectiveness of homelessness services. Increase the number of key agencies accessing homelessness training. Gaining better understanding of the service, the applied processes and priorities.

Strategic objective 1: Collaborative and integrated approach to commissioning improved outcomes for people experiencing homelessness					
Priority	**Action**	**By when**	**Responsibility**	**Resources**	**Success measures and outcomes**
	Develop and implement information recording and evidence base for homelessness.	2014	PHO, SDO, Capita	SP Budget, P1E	Improved data recording and access to develop accelerated process to accommodation and support services. Maximised efficiency of recording systems to collect homeless data to monitor trends that will inform future policy and service development.
1C: Promote a range of prevention options, including the GIFT initiative, prevention fund, and mortgage rescue scheme to enable clients to remain within their homes	Review and promote GIFT scheme initiative and make available to clients aged 18-35. Continue the delivery of Mortgage Repossession Prevention Scheme.	2013/14 Over the strategy period	PHO HST. DM Commissioning, PHO, MRS Officer	CLG Home Grant. P1E Officer time, SP Budget CLG Homelessness Grant	Increase access to funding to enable single homeless clients to take up and sustain new tenancies. 55 applications 2011/12 to increase annually by 5% Undertake advertising campaign to raise awareness of MRS and prevention options. Annual increase in number of households accessing mortgage rescue and advice by 10% to prevent and reduce homelessness.
1D: Respond to and prevent rough sleeping	Review impact of the '*No Second Night out'* outreach service.	Annually	PHO, Merseyside sub-regional group Whitechapel	CLG sub-regional, budget, P1E	Reduction in number of new rough sleepers spending 2nd night on the streets.

Strategic objective 1: Collaborative and integrated approach to commissioning improved outcomes for people experiencing homelessness					
Priority	**Action**	**By when**	**Responsibility**	**Resources**	**Success measures and outcomes**
	Review operational procedures to ensure they are consistent and clear to all sub-regional authorities.	Quarterly	PHO, Merseyside sub-regional group Whitechapel	Officer time, Merseyside sub-regional budget	Rough sleepers with no local connection are reconnected to services in their local area.
	Develop and implement services to tackle issues of habitual rough sleepers.	2014	PHO, Health & Social Care, sub-regional partners	Staff time, CLG sub-regional budget	An assertive, personalised approach to target habitual rough sleepers and empower them to access alternative accommodation options.
	Improve pathways through supported accommodation for former rough sleepers.	Over the strategy period	PHO, SDO, Whitechapel	Officer time	Improved move on options from supported hostel accommodation, with a constant review to deliver and achieve positive outcomes.

Strategic objective 2: Health and homelessness					
Priority	**Action**	**By when**	**Responsibility**	**Resources**	**Success measures and outcomes**
2A: Ensure that homelessness is recognised as a priority for action within the Health and Wellbeing Board	Present Homelessness Strategy to Health & Wellbeing Board to raise as priority for future action.	2014	DM Commissioning, PHO, CCG	Officer time	To ensure that Homelessness is identified as a priority and the board have an understanding of future challenges and funding requirements.
	Attend and contribute to meetings, events and regular performance reports.	Quarterly Performance reports	DM Commissioning Health & Social Care, PHO, Policy Officer	Officer time within existing resources	Maximise opportunities for joint commissioning to include health, DAAT, probation and key professionals.
	Review and develop sub-regional hospital discharge policy.	2013/14	PHO, sub-regional partners, Health & Social Care, Policy Officer, Accommodation Providers	Partnership working, Crisis Bid Fund, Merseyside sub-regional budget	Policy offering accelerated process for vulnerable clients discharged from hospital. A cost-effective, timely and proactive approach to reducing crisis-led homelessness and repeat admissions.
	Review and revise protocols and working arrangements with key partners.	2014–2015	PHO, Health, Policy Officer, Key partners	Officer time	More efficient and timely interventions from using a multi-agency approach to achieve positive sustainable outcomes.
	Develop housing options for substance misuse clients to move on after rehabilitation and ensure they can sustain a tenancy.	2014-2015	PHO Commissioning Managers, HSO, substance misuse services	CLG Homelessness Grant, Health Budget	Effective move on and outreach support process for substance misuse clients to address social issues and reduce repeat homelessness.

Strategic objective 2: Health and homelessness					
Priority	**Action**	**By when**	**Responsibility**	**Resources**	**Success measures and outcomes**
	Review housing options for clients with low to moderate learning difficulties to inform future commissioning of support and appropriate housing.	2015/ 2016	Adult Comm. DM Commissioning, PHO	Officer time, SP & Health budgets	Develop model to provide accommodation and support provision to address the needs of clients with a learning disability and/ or Autism, to empower them to live independently.
2B: Develop a business case to formalise a single practice approach to address the housing and health care needs of vulnerable homeless people	Develop a Healthcare pathway that offers an integrated multi - disciplinary approach and is fully inclusive and builds relationships around individuals, between the statutory and non-statutory services engaged in their care	2014/2015	CCG Commissioners, Health & Social Care, PHO, HST	Budget TBC Officer time	A developed model to transform and improve health care and homelessness service outcomes. A pathway that integrates health, and other services around vulnerable people. A process used to review all elements of an individual's care, across housing, social care, mental health, drug & alcohol services and personally, thus allowing the individual to reflect and choose a pathway that is right for them.
	Improve health care for patients who cross the boundaries of traditional GP practice areas.	2014/2015	CCG Commissioners, GPs, Health & Social Care, PHO	TBC, officer time, Multi-agency partners	Ensure that patients who are not registered with a GP and those with extensive and complex needs are identified and addressed through a multi-agency response.
	Improve arrangements for health care delivery for vulnerable homeless people.	2014/2015	Health & Homelessness services, key partner	Training budget, officer time	Empower front line staff and homeless officers to work with Public Health and service colleagues to develop a

Strategic objective 2: Health and homelessness					
Priority	**Action**	**By when**	**Responsibility**	**Resources**	**Success measures and outcomes**
			agencies		comprehensive and integrated health response to homelessness, configured around a community of need and shared set of standards.
	Participate in the Housing Needs Assessment commissioned from Liverpool Public Health Observatory	April 2014	CCG Commissioners, DM Commissioning, PHO, S.R. Partners	Health care budget, officer time	The HNA will identify the health needs of the homeless population and assess whether their needs are being met, with recommendations to improve service provision.
	Collect and record data to support local commissioners and health care partners to shape services around the health needs of the most vulnerable and marginal groups, that are often invisible.	2014/2015	CCG Commissioners, Officers	Budget TBC, officer time	Determine qualitative methods of gathering intelligence on the subject of health experience, homelessness and access to services.

Strategic objective 3: Minimise the impact of welfare reform					
Priority	**Action**	**By when**	**Responsibility**	**Resources**	**Success measures and outcomes**
3A: Agree a joint approach with the Housing Benefits service for the future use of Discretionary Housing Payments to ensure they are used effectively to prevent homelessness and to determine future areas of action	Joint approach to review and monitor future Discretionary Housing Payments with Housing Solutions representative at panel assessments.	April 2014 Over strategy period	PHO, HB Manager	Officer time, DWP budget	Increase the number of approved DHP applications to assist homeless clients into suitable accommodation.
	Develop financial inclusion strategy, with integrated financial management, budgetary skills and benefit advice.	2014	DM Commissioning, PHO, HB/DWP, key agencies	Officer staff and partner agency time	Improved referral process and access for debt advice and money management to promote financial inclusion.
3B: Develop under-occupation schemes with housing providers to free up family homes and encourage shared housing	Review & monitor social tenants affected by the under occupation penalties enforced through the welfare reform.	2014 Reviewed quarterly.	PHO, SDO, RPs and partner agencies	Officer and partner agency time. DHP budget	Early intervention and targeted support for households affected by the under-occupation penalties and social rent conversions to prevent homelessness and promote tenancy sustainment.
	Consult with housing providers to develop a transfer/ shared housing scheme for clients affected by under-occupation penalties.	April 2014	DM Commissioning , PHO, HHT & housing partners	Officer time, housing budget	Increasing housing provision available to meet future housing needs and encouraged shared housing to reduce homelessness within the district.

Strategic objective 4: Improve the provision of a range of housing options and services to reduce homelessness					
Priority	**Action**	**By when**	**Responsibility**	**Resources**	**Success measures and outcomes**
4A: Improve access to housing using the private rented sector and shared housing options	Develop and implement Private Rented Sector Offer policy which relates to new powers within the Localism Act 2011. This will allow the council to discharge full homeless duty into the private rented sector.	April 2014 Reviewed over strategy period	DM Commissioning, PHO, Landlord Accreditation Officer	Within existing resources	Increase supply and choice of housing available to homeless households.
	Develop a housing pathway toolkit to direct homeless clients into the private rented sector and revise procedures and training to incorporate policy change.	April 2014	PHO, HST	Within existing resources	Devise assessment process and measures to encourage and support private landlords to accept homeless households. Offer staff/ agency awareness training of PRSO policy and impact on homelessness services.
	Produce a report and options analysis to consider the outcomes of landlord surveys and views of PPP to undertake a gaps and options analysis to include: • Possibility of creating a social lettings agency. • Review incentives offered to landlord. • Effectiveness of Bond Guarantee. • Out of area moves where appropriate.	2014/2015 Over the strategy period	PHO, Landlord, Accreditation Officer, Environmental Health, RPs	Within existing resources DM Commissioning, PHO, SDO	Review analysis of current activity and performance to determine future trends and demand within the private rented sector. Develop social letting agency to facilitate and manage PRS accommodation and reduce future homelessness. Improve advice and support services available to landlords and clients.
4B: Improve working with	Liaise with and support agencies and supported housing providers to identify private sector housing	2013/14 Reviewed over strategy period	PHO, Landlord Accreditation Officer,	CLG Homelessness Grant, DHP, BGS	Increase accelerated move on process to empower individuals to secure suitable accommodation

Strategic objective 4: Improve the provision of a range of housing options and services to reduce homelessness					
Priority	**Action**	**By when**	**Responsibility**	**Resources**	**Success measures and outcomes**
private sector landlords and promote the Bond Guarantee Scheme	options for vulnerable people.		Accommodation providers		and reduce dependency upon hostel accommodation provision.
	Develop sustainment and prevention roles with private landlords.	Over the strategy period	Landlord Accreditation Officer, Landlord Forum	Within existing resources	Encourage and increase involvement with private landlords to work with the council to address and resolve housing/ homelessness.
	Develop a multi- agency approach for bringing empty properties back into use. Exploring the potential through initiatives and as funding becomes available with voluntary and community Sector agencies.	Reviewed throughout period of strategy	DM Commissioning, PHO Manager, Environmental Health, HHT, private rented sector	Empty Homes Fund, CLG Homelessness Grant, housing budget	Encourage key partners and agencies to develop financial and option incentives. This will free up housing stock to reduce and prevent future homelessness.
	Undertake publicity campaign to raise awareness and inform landlords, letting agents and tenants of services available.	April 2014	Landlord Accreditation Officer, Environmental Health	CLG Homelessness Grant, Cheshire sub-regional prevention fund	Improved advice and support offered to landlords, letting agents and tenants to improve service delivery.
	Maintain register of reputable accredited private sector landlords with affordable good quality properties. To publicise using Property Pool Plus as a mechanism for moving within the existing social sector.	Review over strategy period.	Landlord Accreditation Officer, Environmental Health, Landlord Forum	Within existing resources	Encourage and support people to let out their property or rooms. Private rented sector properties advertised on Property Pool Plus scheme to increase housing provision available and prevent

Strategic objective 4: Improve the provision of a range of housing options and services to reduce homelessness					
Priority	Action	By when	Responsibility	Resources	Success measures and outcomes
					homelessness.

Strategic objective 5: Increase and improve communication and partnership working					
Priority	Action	By when	Responsibility	Resources	Success measures and outcomes
5A: Develop an effective multi-agency approach to support vulnerable and complex needs households to sustain and secure affordable accommodation to prevent homelessness	Review intelligence which will identify arising needs for vulnerable and complex needs households.	Over the strategy period	DM Commissioning, Adult Comm., PHO, SDO	Within existing resources	Maximise efficiency to deliver a planned approach to respond to the needs of vulnerable clients. Ensure adequate housing and support is made available to address future demands.
	Work in partnership to develop supported accommodation project for single adults with complex needs and due to be discharged from hospital.	April 2014 Review	PHO, DM Commissioning, Health & Social Care, Whitechapel, YMCA	Budget TBC, officer and agency time	Efficient and timely approach to provide suitable self -contained accommodation and outreach support to address the needs of vulnerable clients.
	Develop complex needs /hospital discharge pathway plan and devise multi agency priority panel to review and monitor complex needs client group.	January 2014	PHO, DM Commissioning, Health & Social Care, Whitechapel	Officer time	Multi agency approach to identify key responsibilities to increase access to suitable accommodation and support for complex needs groups to achieve successful outcomes and prevent repeat homelessness.
	Amend Allocations policy to ensure that Armed Forces are identified as priority client group.	Over the strategy period	Cheshire sub-regional group, Commissioning, PHO, RP	Within existing resources	Provide integrated and accessible services to ensure priority is given to Armed Forces personnel due to be discharged from service.

Strategic objective 5: Increase and improve communication and partnership working					
Priority	**Action**	**By when**	**Responsibility**	**Resources**	**Success measures and outcomes**
			Partners		
5B: Support young people and facilitate the delivery of integrated housing, care and support for young people at risk, care leavers, young offenders and teenage parents	Develop social enterprise opportunities in education, training and employment to meet the needs of single homeless people in Halton.	Over the strategy period	PHO, YPT, HST, training providers	Officer time	Improved partnership working to improve access to training, education and housing services for young people.
	Identify lead agencies to seek funding and improve services available for young people.	Over the strategy period	DM Commissioning, PHO, YPT, regional partners/ agencies	Officer time, SP budget	To develop and sustain opportunities for young people to increase skills and prevent future homelessness.
	Develop specialised mediation service to work with young people and families.	2014 Over the strategy period	PHO, YPT, partner agencies	Budget TBC, officer time	Improve services for young people and families to work through housing and social issues and promote positive outcomes.
	To ensure that all staff working with young people affected by homelessness have the appropriate skills, knowledge and safeguarding training.	2014 Over the strategy period	PHO, homelessness forum members, regional partner agencies	Training budget, officer time	Increase learning and development training opportunities to raise awareness of key safeguarding issues and reporting process.
	Review joint (Southwark) protocol with Children's Service and YOT to ensure the council is fully compliant with legal case law judgements and legislation.	2014/15	PHO, YPT, YOT	SP budget, officer time	To improve joint working between services for 16/17 year olds, enabling transition towards independent living with tailored support to reduce repeat homelessness.
	Promote young person involvement to fully participate in the delivery of	2014/ 2015	PHO, YPT, forum members,		

Strategic objective 5: Increase and improve communication and partnership working					
Priority	**Action**	**By when**	**Responsibility**	**Resources**	**Success measures and outcomes**
	youth service. Develop emergency respite accommodation for 16 – 21 year olds to provide multi agency approach to prevent homelessness.		accommodation providers DM Commissioning, PHO, SDO, YPT Policy Officer	S/ P Budget. Budget TBC	To be actively involved with Homeless Forum and identify and deliver effective services for young people. A crisis intervention centre made available for young people threatened with homelessness, offering a holistic approach to facilitate them retuning back home and preventing homelessness.
5C: Improve partnership working and communication with key agencies, police, probation and housing providers to address the growing housing need for offender	Review current housing policy and procedures to identify gaps in provision and information required from providers to increase housing accommodation for offenders. Investigate Registered Providers' reluctance to house Schedule 1 offenders To continue the integrated approach to offender management between criminal justice agencies and Homelessness services.	2014/ 2015. April 2014. Over the strategy period	PHO, Probation, PPO, Policy, RPs PHO, SDO, Probation, RPs PHO Probation, Cheshire Police RPs	Within existing resources Within existing resources Staff time	Identify and address barriers to increase the availability of housing provision for offenders. Increase involvement with MAPPA to gain a better understanding of the housing issues faced by offenders. To reduce the risks to the community posed by those individuals who are homeless and have a pattern of prolific, drug related offending.
5D: Joint partnership working with agencies, police and housing	Increase partnership working with domestic abuse services, Police and registered providers to offer a range of rehousing options and solutions to homeless victims of abuse.	Over the strategy period	PHO, SDO DV Co-ordinator Policy officer, DA service providers	Within existing resources	Improve access to suitable accommodation options and improve service delivery to support victims of abuse to prevent homelessness.

Strategic objective 5: Increase and improve communication and partnership working					
Priority	**Action**	**By when**	**Responsibility**	**Resources**	**Success measures and outcomes**
providers to offer options and solutions to victims of domestic abuse to support them to remain within their home	Develop temporary dispersed housing provision to accommodate families with dependent male children and male victims fleeing domestic abuse.	Over the strategy period	DM Commissioning. PHO, SDO, DV Co-ordinator, RPs	Budget to be identified.	Increased housing provision for victims of abuse to provide safe accommodation with tailored support.
	Work in partnership with Sanctuary Scheme to develop safe security options to facilitate victims of abuse to remain in or return to their homes.	Over the strategy period	DM Commissioning, PHO, SDO, Sanctuary Scheme providers	SP Funding	Reduce the number of male/females becoming homeless due to domestic abuse.
	Improve the substance misuse service response to drug and/or alcohol related domestic abuse.	2014/ 2015	Substance Misuse Service, Domestic Abuse Service, PHO	Budget TBC	The improvement of identification of victims and perpetrators of domestic abuse provided by substance misuse service staff and detailed within homeless assessment.
	Agree a referral criteria and pathway plan between the substance misuse, domestic abuse and Housing Solutions Services.	April 2014	PHO Commissioner, Substance Misuse Service, Domestic Abuse Service	Within existing resources	To reduce the impact of parental substance misuse and domestic abuse on children and young people.

Strategic objective 6: Minimise the use of temporary accommodation by facilitating the supply of secure move-on accommodation					
Priority	**Action**	**By when**	**Responsibility**	**Resources**	**Success measures and outcomes**
6A: Reduce the use of temporary accommodation (including B&B) to maximise the use of prevention options available to reduce homelessness	Continued achievement of performance -indicator to reduce the use of temporary accommodation.	P1E – over strategy period	PHO HST	Within existing resource.	Reduce homeless levels and dependency upon temporary accommodation services.
	Reduce the number of households in temporary accommodation by 10% annually.	P1E – over strategy period	PHO HST	Within existing resources	Reduced level of homeless households placed in temporary accommodation by fully utilising prevention service options available to reduce homelessness.
	Evaluate and develop temporary accommodation provision within the district to ensure it meets the needs of statutory homeless households.	2015 Reviewed quarterly	DM Commissioning, PHO, SDO, Policy Officer	Budget TBC	Reduced /remodelled supported housing provision to address future housing trends and meet the needs of statutory homeless households. Reduce level of voids and rent loss.
	Deliver sufficient, appropriate temporary accommodation suitable for homeless prevention at crisis point.	2013/2014	PHO, Supported Housing Providers	Within existing resources	Improved prevention assessment process to tackle homeless crisis and developed change in service/accommodation provision to promote prevention solutions, including private rented sector.

11. Glossary

Benefit cap	There's a limit on the total amount of benefit that most people aged 16 to 64 can receive. This is called the benefit cap. It is £500 for couples with or without children living with them; £500 for single parents with children living with them; and £350 for single adults who don't have children or whose children don't live with them.
BGS	Bond Guarantee Scheme This scheme is aimed to help those who are homeless or threatened with homelessness and can provide a landlord with a bond guarantee certificate, which confirms the deposit amount will be paid should it be reasonably required at the end of the tenancy.
CCG	Clinical Commissioning Group CCGs are responsible for implementing the commissioning roles as set out in the Health and Social Care Act 2012. They are groups of GP practices that are responsible for commissioning health and care services for patients.
CLG	Communities and Local Government
DHP	Discretionary Housing Payment These can be made by the council if a person's housing benefit or council tax benefit is less than the full amount of their rent or council tax.
DM	Divisional Manager Refers to the Divisional Manager of the Commissioning section of the council, where the Housing Solutions Team sits.
DV	Domestic Violence
DWP	Department for Work and Pensions
GIFT Initiative	Halton Borough Council operates a 'gift' initiative for 18 – 25 year olds, which provides some essential items to assist in furnishing their home.
Gold standard	In its report 'Making every contact count: a joint approach to preventing homelessness' CLG set local authorities ten local challenges, which will lead to homelessness teams delivering a 'gold standard' service. The council pledges, through implementation of this strategy, to meet this gold standard.
HHT	Halton Housing Trust The council transferred its housing stock to HHT in 2005.
HSO	Housing Solutions Officer
HST	Housing Solutions Team The team carry out assessments under statutory homelessness legislation and carry out homelessness prevention work.

Local connection	Halton Borough Council will only have a duty to assist someone under homelessness legislation if that person has a local connection to the borough. If their normal place of residence is in another authority area then Halton will refer them to that authority.
Localism Act (2012)	This provides new freedoms and flexibility for local government; new rights and powers for communities and individuals; a much more democratic planning system and decisions about housing are taken locally.
MAPPA	Multi-Agency Public Protection Arrangements The principal multi-agencies are the Probation Service, Prison Service, Police and Local Authorities and collectively they are known as 'Responsible Authorities.' The arrangements are a set of procedures for dealing with registered sex offenders and other violent individuals who pose a threat of serious harm to the public.
Mortgage Rescue	The Housing Solutions Team has a dedicated Mortgage Rescue Adviser to help those who are facing repossession. It provides advice on the help available, negotiating with mortgage lenders and attending court hearings.
NHAS	National Homelessness Advisory Service
Nightstop	A supported lodgings scheme which enables young people to stay with a volunteer host family for an emergency period, whilst more suitable short-term housing is found or until mediation leads to the young person returning to their family home.
NSNO	No Second Night Out A campaign to ensure no-one spends more than one night on the streets in the Liverpool City Region. Halton participates in this scheme along with six other councils in the city region. As part of the scheme, people are urged to call a helpline if they see someone sleeping rough. The relevant agencies are then alerted in order to find somewhere for the person to sleep.
PHO	Principal Housing Solutions Officer
PPO	Persistent and Prolific Offenders
PPP	Property Pool Plus This is the Choice Based Lettings (CBL) scheme used by Halton, Knowsley, Liverpool, Sefton and Wirral councils and over 20 housing associations to advertise and let their vacant properties. Housing Associations advertise their available vacancies every week through Property Pool Plus. The scheme offers increased choice allowing applicants who are looking for affordable housing to see what vacant properties are available, and express an interest in selecting a suitable new home. PPP informs applicants what priority banding they have, based on the urgency of their need to move from their current property. Properties are advertised and applicants are invited to place a bid (express an interest). The system then puts people into priority order for the property they have bid for, based on their priority band and application date.
PPP Housing Register	The register has been developed by Halton, Knowsley, Liverpool, Sefton and Wirral Councils in partnership with over 20 Housing Associations across Halton and Merseyside. A single application to join the Housing Register allows individuals to be considered for properties advertised by all the participating housing associations.

PRSO Policy	Private Rented Sector Offer Policy Since November 2012 local housing authorities have been able to discharge their duty to secure settled accommodation to homeless households by using privately rented accommodation, as well as homes owned or managed by social landlords. This creates a greater range of options for local families, however the local housing authority must ensure that decisions of suitability are made objectively and take into account both the circumstances of the family and the availability of homes in the area.
RP	Registered Provider (of social housing) RPs are more commonly known as housing associations and have previously been referred to as Registered Social Landlords (or RSLs). They are independent societies, bodies of trustees or companies established for the purpose of providing low-cost social housing for people in housing need on a non-profit-making basis.
Sanctuary Scheme	This is a multi-agency initiative that is focused on victims of domestic violence. Its aim is to enable households where the person is at risk of violence to remain safely in their own homes by installing sanctuary measures.
SDO	Service Development Officer
Southwark Protocol	The protocol aims to provide a co-ordinated response to the prevention of homelessness amongst 16-17 year-olds, ensuring they receive the right level of support and can access appropriate and suitable accommodation where necessary. The protocol was a response to judgements by the House of Lords which reaffirmed and clarified that the duty under Section 20 of the Children Act 1989 takes precedence over the duties within Part 7 of the Housing Act 1996 in providing for children in need who require accommodation.
SP	Supporting People Originally ring-fenced to fund housing related support services for vulnerable adults, including homeless people. In 2009 local authorities were no longer required to spend this funding on housing related support. In 2011 decisions about where to allocate funds became entirely at the discretion of the local authorities. Thus, SP no longer exists in a defined way and is managed in different ways by different local authorities.
Statutory homelessness	This is where a household is deemed to be in priority need and unintentionally homeless under the relevant legislation and in this case the council has a duty to find accommodation for the household.
Youth Hubs	These are venues for young people (aged 13-19) youth groups, voluntary organisations and partners, where young people can have a say in activities in their local area.
YOT	Youth Offending Team This is a multi-agency team that is co-ordinated by a local authority with the intention of reducing the risk of young people offending and re-offending, and to provide counsel and rehabilitation to those who do offend. YOT engages young offenders in a wide range of tasks designed to put something positive back into the local community through unpaid activities.

Agenda Item 9

REPORT TO: Health and Wellbeing Board

DATE: 12th March 2014

REPORTING OFFICER: Strategic Director - Communities

PORTFOLIO: Health and Wellbeing

SUBJECT: Urgent Care – Progress

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 Present Members of the Board with an update report in relation to the current projects/areas of work associated with improvements in Urgent Care.

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

3.0 SUPPORTING INFORMATION

National Context

3.1 Demand on NHS hospital resources has increased dramatically over the past 10 years, with a 35% increase in emergency hospital admissions and a 65% increase in secondary care episodes for those over 75 years.

- Last year, there were over 21 million visits to A&E or nearly 60,000 attendances every day
- There were 6.8 million attendances at walk in centres and minor injury units in 2012/13, and activity at these facilities has increased by around 12 per cent annually since these data were first recorded a decade ago
- The average number of consultations in general practice per patient rose from 4.1 to 5.5 per year between 1999 and 2008
- Last year, there were 51.4 million GP appointments, one in five due to minor ailments such as coughs, colds and hair lice
- Attendances at hospital A&E departments have increased by more than two million over the last decade
- The number of calls received by the ambulance service over the last decade has risen from 4.9 million to over 9 million
- Emergency admissions to hospitals in England have increased year on year, rising 31 per cent between 2002/03 to 2012/13

3.2 A combination of factors, such as an ageing population, out-dated management of long-term conditions, and poorly joined-up care between adult social care, community services

and hospitals are seen to account for this increase in demand over time.

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

3.4 Following the publication of the key findings and recommendations of the second Francis Inquiry which outlines the story of the appalling suffering of many patients at the Mid Staffordshire Hospital, we have recently seen a radical change in how the Care Quality Commission inspects acute hospitals, which includes the introduction of hospital inspection teams.

3.5 Sir Bruce Keogh, the National Medical Director of NHS England, has also recently proposed a fundamental shift in the provision of urgent care, with more extensive services outside hospital and patients with more serious or life threatening conditions receiving treatment in centres with the best clinical teams, expertise and equipment.

3.6 These and other national developments are all having an impact on the whole of the urgent care system, both nationally and locally.

Local Context

3.7 Halton Borough Council (HBC) and NHS Halton Clinical Commissioning Group (HCCG) are continuing to actively work together in conjunction with our partners on Halton's Urgent Care Working Group (UCWG) (new name for Urgent Care Partnership Board) to lead on the development and management of the Urgent Care system used by the Borough's population. Attached at ***Appendix 1*** is the governance structure associated with the Urgent Care system in Halton.

3.8 The Urgent Care agenda is a complex and challenging one; we need to ensure that there is a system wide approach to Urgent Care which requires high quality and accessible primary, community and social care services to be in place to provide alternatives to A&E attendance and admittance to hospital for the local population.

3.9 Locally we have seen :-

- A 3.4% increase in A&E attendances for the Halton population across the 2 local acute trusts between 2010/11 and 2012/13.
- As at October 2013, there has been an increase of 4.8% in the total number of type 1 A&E attendances compared with the same period last year.
- A 3.1% increase in non-elective admissions[1] for the Halton population across the 2 local acute trusts between 2010/11 and 2012/13.
- An average of 4,000 monthly attendances since April this year at the Widnes Walk in Centre.
- On average monthly, between April – September 2013, there have been approximately 1,500 monthly calls to the Out of Hours GP Service.
- The number of Category A calls received by the Ambulance Service resulting in an

[1] Non-Elective Admission : A patient not admitted from a waiting list e.g. admitted as an emergency, via A&E etc.

emergency response arriving at the scheme of an accident is averaging approximately 600 per month.

Current Performance

3.10 There are a range of performance and benchmarking measures that help us to monitor the urgent care system both on a daily basis and over time to establish trends. This range of data includes the NHS and Local Government Quality and Efficiency Scorecards which are produced by the Advancing Quality Alliance (AQuA)

3.11 Comparisons have been undertaken between the data AQuA produced between March 2013 and December 2013; these comparisons are attached at ***Appendix 2.*** It should be noted that September and December's information does not include Cumbria and as such this needs to be taken into account when considering Halton's position against other Northwest (NW) areas and in terms of its direction of travel.

3.12 The latest data provided by AQuA does demonstrate **excellent** performance in the following areas:

- permanent admissions to residential/nursing care – Although it should be noted that there has been an increase in admissions between September and December 2013; this is currently subject to investigation and a working group has been established to examine the reasons behind the increase;
- proportion of Local Authority Adult Social Care spend on residential/nursing care - It should be noted that Halton has previously been ranked the best in the NW in relation to this area, however according to December's information Halton has now been ranked 2nd and are being out-performed by Bolton – this links to the increase in permanent admissions outlined above; and
- delayed transfers of Care – This is an area which significantly improved between March and September 2013. Although there has been a dip in performance between September and December we have improved on our NW ranking over the last 12 months. In March 2013, based on January 2013 bed days we were ranked 21st, in December 2013 based on October 2013 bed days Halton is now ranked 17th. However this is still subject to the inclusion of Cumbria's information, but even taking account of the fact that Cumbria might well be performing better than Halton in this area there has been an overall improvement. Changes to the Integrated Discharge Team at Warrington have enabled the development of a more proactive approach to managing length of stay and has positively impacted on this area. Work has also been taking place with the Discharge Team at Whiston Hospital to ensure that this proactive approach is reflected across the system.

3.13 Areas that are improving but still present significant challenges include:

- non elective bed days – Between March and December 2013 although we have seen a reduction in the numbers of non-elective bed days, from 3119 in March to 2802 in December 2013, we are still only ranked 18th out of the NW Local Authority areas. As outlined in the paragraph above, changes to the Integrated Discharge Team at Warrington and work with the Team at Whiston has enabled the development of a more proactive approach to managing length of stay and therefore on associated bed days.

3.14 Areas that remain as significant challenges include:-

- non elective admissions and non-elective re-admission rates within 30 **and** 90 days

(65+) – In terms of non-elective admissions we have seen some improvements in this area; in March 2013 we saw 341 admissions whilst in December 2013 there were 330. Although there was a very slight drop in performance in terms of readmissions at 30 days in December we have improved on our NW ranking. There were improvements at readmissions within 90 days; 29.6 at March and 27.0 in December 2013. A number of initiatives/projects are expected to have a positive impact within this area when they come to full fruition; initiatives include the introduction of the new Urgent Care Model, new GP acute visiting scheme and Community Multi-Disciplinary Teams. Work is also taking place with the acute trusts to examine possible 'coding' issues in relation to re-admissions which may mean that figures have been inflated.

3.15 Areas that remain static include:

- proportion of people discharged direct to residential care; and
- proportion of deaths which occur at home – A recent review of the end of life pathways and services has been undertaken to ensure maximum use of community care planning and preferred place of care processes. Associated reports have been presented to both the Health and Wellbeing Board and Complex Care Board.

3.16 Work has recently been undertaken on the development of an Urgent Care Performance Dashboard, which includes a range of high level indicators such as the numbers of A&E attenders and ambulance turnaround times, which the UCWG use to assess performance within Halton from a 'whole system' perspective. Attached at ***Appendix 3*** is a copy of the Performance Dashboard outlining performance as at November 2013.

Current Local Developments

The following paragraphs outline a number of current local developments currently having an impact on the urgent care system within Halton:-

3.17 **Winter 2013/14**

The delivery of the A&E standard across England throughout winter remains a key priority for NHS England and partners. Since the A&E Improvement Plan was introduced by NHS England in May 2013, UCWGs have been working locally to support the delivery of the delivery of the 4 hour A&E operational standard; Halton included.

Heading into Winter 2013/14, discussions took place at the UCWG to identify a list of schemes/initiatives which had the potential to manage the anticipated increase in activity and support A&E over the winter period. See ***Appendix 4*** for details of these initiatives.

The schemes identified :-

- Support the flow within A&E within Whiston and Warrington Hospitals;
- Support the flow through acute bed base; and
- Deflect admissions from A&E.

These schemes coupled with close operational management of services and work with all providers will be sufficient in managing changes in demand whilst maintaining the high performance and quality of care achieved through the rest of the year.

NOTE: Nationally, some £400m has/will be been injected to help support the NHS over the winter period. The additional resources should/will be used to secure resilient delivery of the services to patients through the winter, and will involve:

- Schemes to minimise A&E attendance and hospital admissions.
- Improvements to system flow through 7 day working across hospital, community, primary and social care with innovative solutions to tackle delayed discharges.
- Specific plans to support high risk groups.

NHS England expects that the use of this money will be fully agreed through UCWGs.

To ensure that Winter pressures are being appropriately managed there are a number of mechanisms/tools that have been introduced in order to do this. In addition to the comprehensive assurance process Halton have gone through with NHS England Merseyside Area Team in respect of our winter plans, Halton are also active participants in the teleconferences introduced by the Area Team (3 per week) where issues within the system are discussed and solutions agreed; these are in addition to the operational teleconferences that take place. The UCWG have also developed a system wide Winter Risk Register which outlines all the major risks, from a whole system perspective, in addition to the measures introduced to help mitigate these risks; the risk register is reviewed on a monthly basis by the UCWG.

3.18 **Urgent Care Centres (inc. Clinical Decisions Unit)**

Part of NHS HCCG's commissioning intentions 2013/14 included a review of the current urgent care facilities across the borough, development of a preferred model of care and completion of a formal three month public consultation. The new model of care has been designed to reduce pressures on capacity with Accident and Emergency departments and also provide innovate ways of working with partner organisations such as North West Ambulance Service, Acute Hospitals and community NHS trusts.

NHS HCCG completed the public consultation on 31st August 2013 and is in the process of developing the operational model in partnership with Warrington and Halton Hospital NHS Foundation Trust, Urgent Care-24 (GP Out Of Hours), NHS property services, St Helens and Knowsley Teaching Hospitals and Bridgewater Community NHS Trust this will include the development of a business case. The implementation phase is planned for completion in September 2014, taking into account any contingency plans that may need to be actioned.

3.19 **Urgent Care Response Plan**

Halton's Urgent Care Response Plan, first produced in November 2012, has recently been reviewed and updated as many of the work programmes and associated projects that were identified in the first response plan have now been completed/achieved.

In addition to a number of on-going projects, the UCWG, via the development of Halton's Accident and Emergency Recovery and Improvement Plan - May 2013, has identified a number of new projects which will further improve the Urgent and Emergency Care system within Halton. Regular monitoring of the progress of these work programmes is taking place via the UCWG.

3.20 **Community Multi-Disciplinary Team (MDT)**

One of the overall aims of the development of a Community MDT approach to the management of people with Complex Needs is to reduce the number of non-elective admissions and A&E attendances through the use of individualised programmes of care and support.

Each MDT comprises of a core group of staff including a GP, Senior District Nurse, Community Matron, Social Care Practitioner, Medicines Management, Practice Manager, and Community Wellbeing Officer. The core group may call on members of an 'extended

team' and these members would be identified during the initial identification process or subsequent multi-professional meetings. Members of the extended team may include a Social Worker, Mental Health Practitioner or Specialist Nurse etc.

The MDT will meet on a monthly basis to begin with. They combine information from practitioner caseloads, practice nominations and a developing set of data within the portal system to identify a group of patients where cross professional discussion will support a coordinated approach to complex case management.

There are currently 16 out of the 17 GP practices within Halton involved in this project; negotiations are currently taking place to support the final GP practice in Halton to adopt this MDT approach.

3.21 **Care Homes Project**

The care home project in Halton is a 12 month project which was established in July 2013.

The team has one very complex, multifaceted objective which is to investigate unmet need in Halton's care homes from the perspective of health and social services. Although this appears to be quite a tough remit, it was felt that the problems needed to be understood before any attempts were made to remedy them.

The care home project has so far reviewed the residents in 4 care homes; Beechcroft, Widnes Hall, St Patrick and St Lukes and are becoming involved in another 3 homes; Croftwood, Halton View and Ferndale Mews.

On-going work has identified 6 key issues, these include:-

- Communication;
- End of life Care;
- Physical Care;
- Pharmacy;
- Equipment; and
- Primary care utilisation.

A number of recommendations have been made to make improvements in these areas and these are in the process of being implemented.

3.22 **Emergency Care Intensive Support Team (ECIST) Whole System Review (Warrington & Halton)**

ECIST have recently undertaken a whole system review of urgent care across Halton and Warrington.

ECIST focus on improving performance, quality assurance and programme enhancement. Assignments for ECIST typically include working with local health communities jointly to diagnose areas for performance improvement; supporting implementation planning and delivery; and transferring knowledge to produce sustainable and resilient solutions.

As part of the review, ECIST had the opportunity to meet with a number of colleagues from across the health and social care economy within Warrington and Halton who all either directly support the UC system or manage areas of work which impact indirectly within this area.

The whole system review report has been presented to the UCWG.
A number of themes emerged from the review, including :-

- Communication and Language – has improved but could improve further;
- Escalation – does the current escalation policy work?;
- Differences between the UCWGs within Warrington and Halton – possible duplication?
- Need for objective measures; and
- Good integration within Halton – the view being supported by partners such as NWAS and WHHFT.

The review also commented on :-

- Single Point of Access – needs further review;
- Urgent Care Centre development – deemed to be positive by all;
- Care Homes – Further work required;
- Improved dialogue between primary and secondary care clinicians required; and
- Sub-Acute Unit (Ward B1) – well run.

Overall recommendations included the suggestion to run a 'Perfect Week' at Warrington and Halton Hospitals NHS Foundation Trusts in order to 'recalibrate' the system. This has been accepted by the Trust and at the time of writing this report plans are being developed to run the week w/c 3rd March; support from partners will be required.

Additional recommendations included the need to standardised inpatient practice – 'SAFER' flow bundle; again accepted by the Trust, rolling ward rounds, introduction of Internal Professional Standards etc.

Further details can be found in the review report attached.

From ECIST's perspective Halton are 'heading in the right' direction, but we cannot be complacent. We need to be ambitious and brave with our plans and the 'Perfect Week' may be an opportunity to trail new developments.

3.23 It is anticipated that these current local developments will have a positive impact on the urgent care system as a whole in Halton. It is anticipated that we will be able to:-

- Match resources better to expected flow;
- Manage patient's experience, safety and outcomes better;
- Measuring quality, outcomes and performance;
- Work with delivery partners to maintain an integrated 24/7 system;
- Identify and develop alternative patient pathways to A&E; and
- Re-direct resources to enable investment in prevention and early intervention services, including public health improvement/promotion, preventing the exacerbation of Long Term Conditions and thus avoiding unnecessary hospital admissions.

4.0 POLICY IMPLICATIONS

4.1 None identified at this stage.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 In this current economic climate, where both Local Authority and Health Services available resources are contracting, in line with the national agenda, the flow of resources supporting

the urgent care system needs to change to ensure that there is a greater focus on highly responsive, effective and personalised services outside of hospital i.e. within primary, community/voluntary and social care services. These services should deliver care in or as close to people's homes as possible, minimising disruption and inconvenience for patients and their families. Secondly we need to ensure a greater focus on early intervention and prevention work to ensure that people remain healthy for longer, thus reducing the impact on the acute sector and other health and social care services.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

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

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

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

6.4 **A Safer Halton**
None identified.

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

7.0 RISK ANALYSIS

7.1 None identified at this stage.

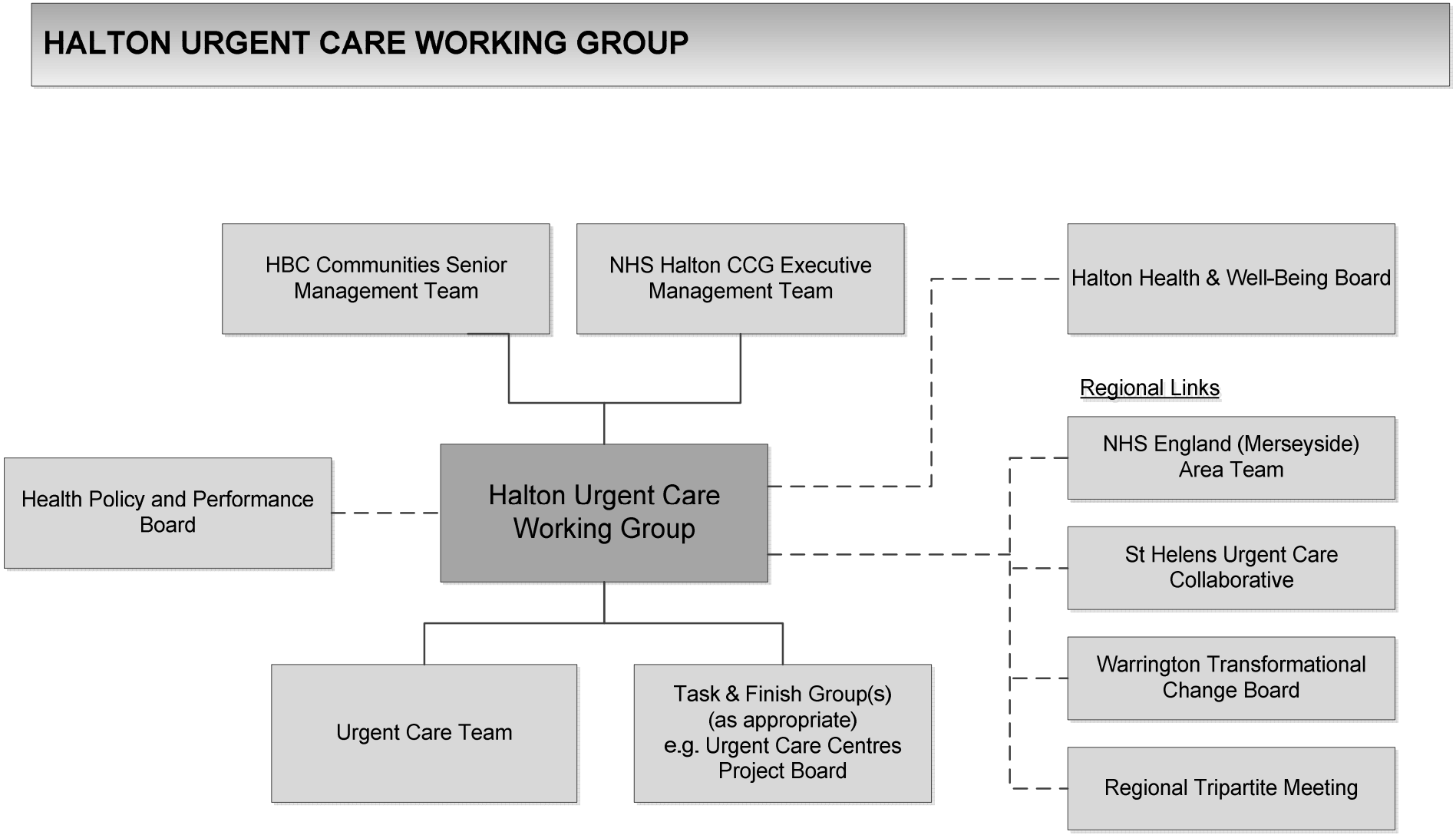
8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None identified.

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

9.1 None under the meaning of the Act.

Halton Urgent Care Governance Structure



AQuA Locality Benchmarking

Indicator	Reporting Date				*Direction of Travel (Between Sept – Dec 2013)
	March 2013	June 2013	*September 2013	*December 2013	
Non elective admissions (65+) - Less is Better	341 (23/23)	322 (21/23)	327 (20/22)	330 (20/22)	There has been a slight increase between September and December; however direction of travel has been assessed as static.
Non elective bed days (65+) – Less is Better	3119 (21/23)	2972 (20/23)	2750 (17/22)	2802 (18/22)	There has been a slight increase in non-elective bed days between September and December, so Halton's NW position has dropped slightly however direction of travel has been assessed as static.
Non-elective re-admission rates within 30 days (65+) – Less is Better	18% (18/23)	18% (17/23)	18.3% (20/22)	18.5% (18/22)	Although there has been a slight drop in terms of overall performance, Halton's overall NW position has improved.
Non-elective re-admission rates within 90 days (65+) – Less is Better	29.6% (17/23)	29.6 % (18/23)	27.9% (19/22)	27.0% (17/22)	There have been continuous improvements during 2013 in relation to non-elective readmissions within 90 days.
Delayed transfers of care (18+) – Less is Better	329 (21/23) – Jan'13 Bed Days	172 (13/23) – April'13 Bed Days	144 (5/22) – July '13 Bed Days	229 (17/22) – Oct'13 Bed Days	There has been a drop in the number of bed days associated with delayed transfers of care.
Proportion of people 65+ discharged direct to residential care – Less is	2.4% (14/23)	2.5% (13/23)	2.5% (12/22)	2.6% (14/22)	Although figures have

Better					remained fairly static we have moved from Green to Amber; however direction of travel has been assessed as static.
Permanent admissions to res/nursing care (65+) – Less is Better	582 (1/23)	440 (1/23)	515 (1/22)	633 (4/22)	There has been an increase in the permanent admissions to res/nursing care, although Halton's performance remains high compared with other NW areas.
Proportion of LA ASC spend on res/nursing care (65+) – Less is Better	44.7%	44.7%	46.9%	49.5%	Linked to an increase in admissions, the proportion of LA ASC spend has also increased; we are still 2nd in the NW only being outperformed by Bolton
Proportion of deaths with occur at home/care homes (65+) – More is Better	40.6% (17/23)	40.6% (17/23)	40.6% (16/22)	40.6% (16/22)	NB. Figures only report Jan-Dec 2012

*September & December 2013 figures did not include Cumbria; as such this needs to be taken into account when considering Halton's position against other NW areas and in terms of its direction of travel between September – December 2013

NB. Figures in () indicate Halton's position against other NW Local Authority areas.

Benchmarking Key

Best 1st – 6th	
7th – 12th	
13th – 17th	
18th – 22nd	

HALTON BOROUGH COUNCIL

Urgent Care Performance Dashboard - November 2013

Halton NHS Clinical Commissioning Group

	Performance Indicators	Operational Standard/Plan	Lower Threshold	Baseline	April	May	June	July	Aug	Sept	Oct	Nov	Direction of Travel	FY target	FY Forecast
Secondary Care															
Accident & Emergency															
	(1) A&E Attendances - Type 1				2628	2749	2699	2775	2647	2634	2541	2505	↓		
Narrative	Overall the number of A&E attendances has reduced for the fourth month in a row, Novembers figure of 2505 is 3% lower than the same month last year but this is within the natural variability of these figures.														
	(4) Percentage of patients who spent 4 hours or less in A&E	>95%			n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a		95%	
Narrative	The data quality issues with regards to the 4 hours figure for Halton registered patients has still not been resolved, however at Trust level (including type 3 units the figures are; Warrington & Halton YTD (to 22nd December) - 95.49%, St Helens & Knowsley 96.75%														
	(6) % of Type 1 A&E attendances where referral source is GP				3.81%	3.02%	3.15%	3.68%	3.25%	4.37%	3.94%	3.91%	↓		
Narrative	This is an expected rate														
	(9) (%) Conversion rate - A&E type 1 attendances admitted to hospital	28%			38.05%	35.43%	35.31%	33.66%	35.81%	34.47%	36.25%	37.13%	↑		
Narrative	The figure above is the combined rate for Halton GP registed patients. When looking at individual trust data for the last week in November Warrington & Halton Type 1 A&E admitted was 26.9%, However the figure for Halton residents at Warrington was 39.2%. St Helens & Knowsley Trust was 37.6%. the figure for Halton residents at St Helens was 35.5%														
Non-Elective Emergency admissions - (based on Admission method 21 - 'Accident and emergency or dental casualty department of the Health care Provider)															
	(23) % of patients discharged following admission from A&E with zero length of stay				32.77%	37.46%	34.06%	29.76%	34.15%	32.33%	32.92%	31.63%	↓		
Narrative	For Halton Registered patients for Q2 (to July-Sept) the percentage of patients admitted from A&E and discharged with zero length of stay was 29.7% at Warrington and 35.4% at St Helens														
	(31) Emergency Re-admissions 30 days				222	267	252	249	242	222	213 (161)	178			
Narrative	There appears to be a trend of reducing numbers of emergency admissions, from 267 in May to 213 in October, However it should be highlihgted that previous months figures can change and Octobers figure has increased from 161 reported lat month to 213 this month. Therefore Novermbers figure of 178 is likely to increase next month and should not be used for decision making.														
Walk in Centre - Provider code RY2 - 'Bridgewater Community Healthcare NHS Trust'															
	(34) All Attendances - Halton walk in centre				3793	4076	3835	4368	4059	3994	2755*	2647*			
Narrative	(Note - * Currently experiencing problems with Bridgewater Community walk in centre data due to transfer over to a new system as of October 2013)														
Out of Hours															
	(52) Total number of Halton calls completed on Adastra				1696	1707	1415	1301	1489	1343	1313	1481	↑		
Narrative	Although overall the number of calls has increased the pattern of responses to those calls is not the same for all outcomes. The number of telephone advice and UCC attendance outcomes has increased. The number of home visits continues to fall. From 306 in April to 186 in November. This is the lowest monthly figure reported.														
Ambulance - NWAS															
	(78&81) The number of category A (red 1& 2) calls resulting in an emergency response arriving at the scene of the incident				610	565	559	577	772	601	582	639	↑		
Narrative	The high figure of 772 in August is due to the additional activity created by Creamfields event.														
	Turnaround times (Average) (mins) Whiston	<15	<30		-	-	-	-		28.3	27.2	26.7	↓		
	Turnaround times (Average) (mins) Warrington	<15	<30		-	-	-	-		25.7	25.2	23.4	↓		
Narrative	The figures are taken from the NWAS Ambulance turnaround figures for November, they relate to attendances at Warrington and Whiston regardless of address of patient. At Whiston 70.4% of cases were longer than 20mins. At Warrington that figure was 58%														
Delayed Discharge Transfers - Halton GP registed patients - Snapshot taken last Thursday of the Month															
	(149 % 150) Number of delayed discharge transfers				8	6	2	5	6	12	5	7	↑		
Narrative	This is the total number of delayed discharges regardless of accountability. There were a total of 7 delayed discharges in November all of which were NHS Accountability - four of the seven delayed patients wer due to further non-acute NHS care, 2 were pateint choice and one was delyaed due to completion of assessment.														
Intermediate Care Services - Halton Borough Council															
	Numbers referred to Intermediate care				140	143	96	131	113	112	95	83	↓		
Narrative	Octobers figure (95)and Novembers (83) are still draft as still waiting for some figures from another team. Of the September figure of 112, 86 were RARS referrals, 26 were reablement, split roughly 50/50 Runcorn, Widnes. 7 referrals from GP's														

Winter Plan 2013/14 : Winter Schemes to Manage Increased Activity and Support A&E Target

Schemes to support flow within A&E (6 month only)

Scheme	Costs (£000's)	Activity	Expected impact and data source	Lead Officer
Funds to Warrington CCG to support winter pressures planning at Warrington & Halton Hospitals NHS Foundation Trust	230	Numerous winter initiatives have been agreed with Warrington CCG and funds will be transferred to Warrington CCG from Halton CCG to support Halton patient pathways.	Business case and data source to be developed across WCCG and WHHFT **Data source**: • Urgent Care Dash Board • Escalation recovery plans	Linda Bennett
Funds to St Helens CCG to support winter pressures planning at St Helens & Knowsley Teaching Hospitals NHS Trust	300	St Helens CCG have worked with providers to develop plans, specifically to support A&E by developing front end primary care provision. Funds will be transferred to St Helens from Halton CCG to support Halton patient pathways.	Business case and data source to be developed across St Helens CCG and STH&K **Data source**: • Urgent Care Dash Board • Escalation recovery plans	Lisa Kieran
Provision of community matrons within A&E departments	41	Deploy community matrons into AED to support patient flows within the department **Timescales:** To commence Monday 16th December 2013 and will run until the end of March 2014.	**Expected impact:** • Reduce hospital admissions; • Facilitate hospital discharges; • Reduce admission to long term care placements; • Support patients to regain or increase level of independence;	Ged Timson

		The matron/nurse will work alongside the existing matron in A&E in diverting patients who do not require emergency admission to community services where possible and appropriate thus avoiding unnecessary admission and pressures on the acute service.	• Support people to return to and remain in their own home for longer; and • Increased ability to manage crisis situations for patients in a community setting • This will increase the flow out of A&E back into community services. **Data source**: • Urgent care Dash Board • Bridgewater Quality performance indicators	
Admission and Alternative Contact Service for Community Services	12	This will support a reduction in GP/RARS admissions by providing a liaison service between community and acute provision for all secondary care providers. The expectation is that patients will be deflected to community provision before being admitted to acute provision. **Timescales :** In place	**Expected impact:** • Reduce hospital admissions; • Support people to return to and remain in their own home for longer; and • Increased ability to manage crisis situations for patients in a community setting **Data source**: • Urgent Care Dash Board • Bridgewater Quality performance indicators • SPA performance dataset to	Steve Holbrook

			be agreed and added to Urgent Care Dashboard	
Development of Merseyside escalation and diversion policy. This Cheshire and Merseyside initiative is being developed across commissioning and provider agencies. Part of the initiative is to review the CMS IT system and its usage and potential impact.	zero	The development of two task and finish groups: CMS group- review CMS system and makes recommendations regarding potential usage in the future and its development (future procurement of the CMS system will also need to be considered within the recommendations). Policy- group lead by Liverpool CCG urgent care lead to review and merge North west escalation policy and NWAS diversion policy with consideration given to command and control arrangements **Timescales :** Policy due to be ratified 19.11.13	**Expected impact:** • This will support the flow through of A&E departments across the health economy • Increase communication across Provider Trusts including community provision • Enable flow to be dealt with, in response to current demand without maintaining delays in the system • Reduce escalation up to command and control **Data Source**: • RUCAT • Provider/Commissioner-system feedback	Leigh Thompson-Greatrex
TOTAL	**583**			

Schemes to support flow through acute bed base (4 months only)

Scheme	Costs (£000's)	Activity	Expected impact and data source	Lead Officer
Increase Intermediate Care bed capacity x 6 beds (Nursing)	63.5	Commission 6 beds from independent sector **Timescales** : To commence Monday 16th December 2013 – to run for 21 weeks	**Expected impact:** • Reduce hospital admissions; • Facilitate hospital discharges; • Reduce admission to long term care placements; • Support patients to regain or increase level of independence; • Support people to return to and remain in their own home for longer; and • Increased ability to manage crisis situations for patients in a community setting **Data source**: • Urgent care Dash Board • SPA performance dataset to be agreed and added to Urgent Care Dashboard	Damian Nolan
Increase capacity in hospital discharge		Review of Integrated discharge	**Expected impact:**	Damian Nolan

teams	45.5	hospitals teams, including the taskforce which will:- • review any duplication across the teams; • support ward staff to identify discharges earlier; • ensure speedy discharge through a single assessment process; and • employment of additional social work capacity. **Timescales** : To commence Monday 16th December 2013 – to run for 21 weeks	• Release acute beds at Warrington and Whiston Hospitals; • Reduces the number of 'non-acute' patients occupying beds; and • Strengthen the ability of Warrington and Whiston Hospitals to continue to meet the 18 week target for Halton patients **Data source**: • Urgent Care Dash Board • SPA performance dataset to be agreed and added to Urgent Care Dashboard • RUCAT	
Increase capacity in MDT Intermediate Care support (community and beds) 1 X OT, 1 x PT, 1 x SW	78	Increased complexity and demand requires additional skilled assessment and intervention work to maintain safe and efficient care. These staff will support additional bed capacity, maintain through put in existing bed bases and support community services	**Expected impact:** • Reduce hospital admissions; • Facilitate hospital discharges; • Reduce admission to long term care placements; • Support patients to regain or increase level of independence; • Support people to return to and remain in their own home	Damian Nolan

		Timescales : To commence Monday 16th December 2013 – to run for 21 weeks	for longer; and • Increased ability to manage crisis situations for patients in a community setting **Data source**: • Urgent Care Dash Board • Bridgewater Quality performance indicators • SPA performance dataset to be agreed and added to Urgent Care Dashboard	
Increase equipment and extend delivery hours	80	Changes in demand during the winter period mean that the type of equipment needed changes with more bed related. Extending delivery hours will support hospital discharges ICES will extend delivery times (16 week period) to 7pm Mon-Friday to support urgent hospital discharges. It will also extend its out of hours support beyond these times for complex equipment i.e. hospital beds, mattresses, hoists. The weekend service will operate	**Expected impact:** • Reduce hospital admissions; • Facilitate hospital discharges; • Reduce admission to long term care placements; • Support patients to regain or increase level of independence; • Support people to return to and remain in their own home for longer; and • Increased ability to manage crisis situations for patients in a community setting **Data source**: • Bridgewater Quality	**Ged Timson**

		from 9-12 noon for all equipment and outside of these hours for complex equipment. **Timescales :** In place	performance indicators	
TOTAL	**267**			

Schemes to deflect admissions from A&E (6 month only)

Scheme	**Costs (£000's)**	**Activity**	**Expected impact and data source**	**Lead Officer**
Development of a MDT within Primary Care	zero	Development of Multi-disciplinary Team approach in Primary Care to the management of high intensity users of health and social care utilising risk stratification. Through the development of a locally enhanced service. The LES will be designed to: • Undertake risk profiling and stratification of registered patients on a monthly basis (LES) following an holistic approach to embracing physical and mental health problems	**Expected impact:** • Reduce hospital admissions; • Facilitate hospital discharges; • Reduce admission to long term care placements; • Support patients to regain or increase level of independence; • Support people to return to and remain in their own home for longer; and • Increased ability to manage crisis situations for patients in a community setting	Damian Nolan

		• Work within a local multidisciplinary approach to identifying those who are seriously ill or at risk of emergency hospital admission • Co-ordinate with other professionals the care management of those patients who would benefit from more active case management **Timescales :** In place	**National Guidance:** • National Service Specification • NHS England 2013/14 DES **Data source:** • LES/DES activity template	
Acute Visiting Scheme (inc.deflection)	195	To develop a Pathfinder Tool which will enable NWAS to work with other services to provide alternatives to hospital transfer. The use of the Pathfinder Tool identifies which patients are safe to be left at home subject to their being another service available to continue appropriate assessment and care of patients in a timely manner, which would include an Acute Visiting Scheme. A dedicated Urgent Care 24 GP would enable NWAS to avoid	**Expected impact:** • Reductions in emergency ambulance activity • Reductions in A&E attendances • Reductions in hospital admissions • Improved ambulance incident times • Improved response to RED ambulance patients *Based on pilot outcomes NWAS gave a deflection rate of 89% of patients seen.*	Jenny Owen

		hospital transfers to A&E, this would include a 2 hour response time. **Timescales:** Scheme to start Monday 2nd December 2013 and run for 5 months.	This scheme will aim to demonstrate QIPP by: • Increasing treatment at home by deploying clinicians to the patient and through access to alternative community services • Reduce unnecessary conveyance by Patient Emergency Services (PES) clinicians/vehicles • Reduce non-elective admissions by helping to avoid unnecessary Emergency Department attendance and subsequent attendance to admission conversion rates • Provide a robust approach to managing clinical risk underpinned by a strategic alliance clinical governance framework • Develop the urgent care workforce knowledge, skills and competencies across the strategic alliance • Maintain public confidence as traditional modes of	

			ambulance response are superseded by more flexible and responsive services tailored to the needs of the patient • Enable further research into clinical decision making tools that facilitate safe closer to home using appropriate providers within an appropriate time scale **National and local Guidance/Evidence:** • Urgent Care options appraisal 2013 • NWAS and UC 24 Acute Visiting Scheme • AED Audit 2013 **Data source**: • Urgent Care Dash Board • Out of Hours Quality performance indicators	
Patient Education - Publicity Campaigns 'Examine your options' an initiative across Merseyside CCGs including Halton and Warrington.	32	Development of campaign across Merseyside to support wider strategic responsibilities around business continuity and	**Expected impact:** • Reduce attendance into AED through the education	Louise Wilson

		emergency preparedness, alongside the requirement to inform and engage communities around the appropriate use of urgent care services. Costs are Halton's contribution to Merseyside scheme. **Timescales** : Campaign commenced 4th November 2013 and will run until w/c 28th April 2014	of the local population • Deliver accurate, timely and consistent advice to the public and health professionals, key stakeholders and the local media • Support improved understanding and navigation of the NHS system to effectively support demand management • Support seasonal flu preparedness and prevention, including staff and public vaccination programmes **National and local Guidance/Evidence:** • Urgent Care options appraisal 2013 • AED Audit 2013 • Urgent Care Public consultation	
1st Stage of implementation of Urgent Care Centre	160	The provision of extended X-ray facilities and extra medical cover	**Expected impact:**	Jenny Owen

		at the Minor Injuries Unit would support the diversion of diagnostic in hours and out of hours linked to Primary Care, Out Hours GP cover - UC 24 etc. **Timescales :** To be in place from Monday 2nd December 2013	• Develop the urgent care workforce knowledge, skills and competencies • Reduce flow into AED in hour and out of hours divert 17% out of A&E departments based on AED Audit **National and local Guidance/Evidence:** • Urgent Care options appraisal 2013 • NWAS and UC 24 Acute Visiting Scheme • AED Audit 2013 **Data source**: • Urgent Care Dash Board • Bridgewater quality and performance dashboard	
TOTAL	**387**			

GRAND TOTAL	**1,237**			

REPORT TO: Health & Wellbeing Board

DATE: 12th March 2014

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health & Wellbeing

SUBJECT: End to End Assessment

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To inform the Health and Wellbeing Board of the End to End Assessment that is being taken forward on behalf of NHS Halton, Knowsley, St Helens and Warrington CCGs and NHS England.

2.0 **RECOMMENDATION: That the Health and Wellbeing Board notes that this work is in progress.**

3.0 **SUPPORTING INFORMATION**

3.1 Using the Government Procurement Service Framework NHS Halton, Knowsley, St Helens and Warrington and NHS England have commissioned an independent provider to an assessment that will deliver:

- A high level retrospective review of health care activity, spend and patient flows by commissioner and by location per quarter in the past three years.
- An analysis of current health care activity, spend and patient flows by commissioner and by location.
- Project activity, spend and patient flows by commissioner and by setting for the next over 3, 5, and 10 years assuming current cost and payment arrangements.

3.2 The scope of the assessment based on the flows of patients from NHS Halton, Knowsley, St Helens and Warrington CCGs into all providers. Analysis will then be required to develop additional granularity in regard to flows into specific providers.

3.3 The assessment will support CCGs and NHS England, working in partnership with local authorities through Health and Well Being Boards, to address the following questions:

- Where do we want to get to? Is this hospital where hospital is needed, more care closer to home and reduced non elective

activity?

- What is the potential impact of our commissioning strategies and plans?
- What are the constraints – what are the barriers to change?
- What is needed for our patients to deliver high quality, sustainable services for the next 10 years and beyond?
- What does this mean for where the money sits? How can we move financial resources to where they are needed to support system change? What bridging activity is needed?
- What would be the impact on commissioners in terms of financial affordability?
- What would be the impact on providers in terms of organisational sustainability?

3.4 The assessment will:

- consider all sectors and providers in regard to activity, spend and patient flows (acute/community/mental health).
- consider interdependencies and flows with other parts of Merseyside.
- take account of and liaise with other similar reviews running concurrently with this project.

The assessment will leave all commissioners with a workable model to support decision making and develop strategic approaches to the challenges for the NHS over the next five years and beyond.

3.5 The work on the assessment is due to commence on 24th February 2014 and will last for 7 weeks. It is overseen by a Steering Group from the constituent CCGs and NHS England. The Project Sponsors are Simon Banks, Chief Officer, NHS Halton CCG and Stephen Sutcliffe, Chief Finance Officer, NHS Warrington CCG.

4.0 POLICY IMPLICATIONS

4.1 The End to End Assessment supports the development of the 5 year strategy required for NHS Halton, Knowsley, St Helens and Warrington CCGs and NHS England under *Everyone Counts: Planning for Patients 2014/15-2018/19*.

5.0 FINANCIAL IMPLICATIONS

5.1 The End to End Assessment will cost £94,824, split equally across the five organisations that are part of the work stream. The End to End Assessment will support these organisations in addressing the financial challenges that they face over the next five years and beyond. It is estimated that NHS Halton CCG alone has to find £45m savings against a £178m budget over the next five years through provider efficiencies; pathway redesign; prevention and reconfiguration.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

The End to End Assessment will cover all ages and will therefore influence commissioning for children and young people.

6.2 Employment, Learning & Skills in Halton

None identified.

6.3 A Healthy Halton

As stated, this work will directly impact on the 5 year strategy that NHS Halton CCG will be developing for June 2014.

6.4 A Safer Halton

None identified.

6.5 Halton's Urban Renewal

None identified.

7.0 RISK ANALYSIS

7.1 The major challenges to the project are associated with timing, availability/accuracy of data, appropriateness and acceptance/consistency of assumptions and engagement of key stakeholders. The impact of these may be felt in terms of the quality of outputs or achievability of the timescale, or both. The project director from the independent contractor and Project Sponsors will be responsible for identifying and managing risks. A risk assessment and risk register have been completed and will be maintained as part of this programme.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 No specific issues

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

There are none within the meaning of the Act.

REPORT TO: Health and Wellbeing Board

DATE: 12th March 2014

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Wellbeing

SUBJECT: Wellbeing Area Awards and Grants.

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

To provide information to the Health and Wellbeing Board on the development of Health and Wellbeing awards and grants for the local community.

2.0 **RECOMMENDATION: That the Board**

1. **note the contents of the report;**
2. **endorse the proposal of Wellbeing Awards and grants; and**
3. **if in agreement, nominate three members of the Board to become members of the judging panel**

3.0 **SUPPORTING INFORMATION**

3.1 In line with the Health and Wellbeing Strategy, and the drive to engage local people in improving health, Wellbeing Areas have been established in Halton. Several health events have now been held in each area and attendance has been good. As part of our on-going commitment to working with local communities it is proposed that the Board endorse the development of a two pronged approach:

- A range of Wellbeing Awards in recognition of outstanding work to improve health.
- A small grant of up to £500 for up to 10 local community projects that support the Health and Wellbeing Boards priorities of improving mental health, reducing falls in older people, reducing harmful drinking, improving child development, preventing cancer and early detection of the signs and symptoms .

3.2 A steering group, terms of reference and a judging panel would be drawn from members of the Health and Wellbeing Board and Wellbeing Areas to take this initiative forward. If in agreement with this proposal it is suggested that three nominations be agreed at this meeting so that the mechanism for judging the applications can be put in place as soon as possible.

3.3 Suggested categories for nominations are invited from Wellbeing Areas and the Health and Wellbeing Board are outlined below:

- **Individual Recognition Award**: Nominations for this category would be drawn from individuals who have made a special contribution to improving health and wellbeing either individually or as part of a particular team or group. This could also include individuals who have significantly improved their own health and wellbeing and have acted as a positive role model to others.

- **Community Group Award**: This award would be aimed at community groups who, through the services or activities they deliver, have improved the health and wellbeing of local people.

- **Healthy Workplace Award**: This award would be aimed at local organisations and businesses who have developed and are actively implementing health and wellbeing initiatives within the workplace.

- **Healthy School Award:** The Healthy Schools initiative already works in Halton to improve the health and wellbeing of local children. The community awards initiative, working alongside Healthy Schools, will request nominations from local schools who feel they have made an outstanding contribution to health and wellbeing.

3.4 A budget of £7000 has been identified to fund the awards and grants and cover publicity, and other materials. Support for the administration of the awards will be provided by the Community Development and Public Health Teams within the Local Authority.

3.5 Assuming the Board is in agreement with this approach details of the scheme will be formally launched at the Health and Wellbeing Community Feedback Event in the spring. Further marketing and promotional materials will then be produced outlining details of the scheme and the application process.

4.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

4.1 Children & Young People in Halton

Whist there are no direct implications as a result of this report, improving the Health of Children and Young People is a key priority in Halton.

4.2 Employment, Learning & Skills in Halton

N/A

4.3 A Healthy Halton

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

4.4 **A Safer Halton**

N/A

4.5 **Halton's Urban Renewal**

N/A

5.0 **RISK ANALYSIS**

N/A

6.0 **EQUALITY AND DIVERSITY ISSUES**

6.1 The Health and Wellbeing Community Awards will be directed at a wide range of residents and community groups in order to ensure equality of opportunity.

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

Halton Health and Wellbeing Strategy 2012

REPORT TO: Health & Wellbeing Board

DATE: 12th March 2014

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Wellbeing

SUBJECT: Dental Health in Halton

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To inform the Board of the progress made in dental public health

2.0 **RECOMMENDATION: That the Board**

1. recognises oral health improvement since 2006; and

2. agrees the dental prevention programme continues.

3.0 **SUPPORTING INFORMATION**

3.1 Dental decay is a preventable disease yet 40% of children in the UK have the condition. Childhood decay rates in the Northwest are the highest in England and historically Halton has always reported highr dental decay rates than the Northwest average.

3.2 This report considers:

1. The dental health of the child population over a 6 year period from 2006-2012 and sets out the impact that local dental preventive measures have had on the dental health of the child population

2. The current position with regard to NHS dental access both for regular and irregularly attending patients in Halton.

3.3 In 2006, child dental health in Halton was poor. In England at that time, 38% of children aged 5 years had experienced tooth decay, the figure in Halton was 51%, with each Halton 5-year-old having, on average 2.01 decayed, missing or filled teeth. There were only 4 Halton electoral wards in which the proportion of 5-year-olds with active tooth decay was lower than the national average (Birchwood, Birchfield, Daresbury, Farnworth). The position was similar amongst the 12-year-old population.

3.4 Against this background in 2008, Halton and St Helens PCT introduced a dental commissioning strategy that aimed to:

- Reduce childhood population prevalence of dental disease
- Reduce inequalities in dental caries prevalence

3.5 A key element of the dental strategy was a programme that distributed fluoride toothpaste (1450 ppm) and a tooth brush, twice yearly, to every child aged 3-11 years, living within the PCT boundary. It was anticipated that the twice yearly distribution would take place for 4 years. Fluoride toothpaste is effective at reducing the prevalence of tooth decay and this initiative was expected to have a significant impact on the dental health of local children.

3.6 Dental epidemiological data allow us to monitor the changes in the dental health amongst Halton 5-year-olds in the period 2006 and 2012 and there have been substantial improvements. In 2006 the average 5-year-old in Halton had 2.01 teeth affected by dental decay and 51% of children were affected. By 2012, decay levels had fallen by 46% to 1.09, with 33.6% of children affected. During the same period there have been improvements nationally in levels of child dental health but these improvements are not as great as those found in Halton.

3.7 It is possible to examine the changes in dental health between 2006 and 2012 at electoral ward level in Halton and these are set out below.

Electoral Ward	**%age of 5-year-olds with active decay 2005**	**%age of 5-year-olds with active decay 2012**	**Change in %age of 5-year-olds with active decay**
Appleton	54.0	40.0	14
Beechwood	36.0	13.0	23
Birchfield	29.0	12.8	16.2
Broadheath	63.0	37.1	25.9
Halton Castle			
Daresbury	26.0	12.8	13.2
Ditton	37.0	38.5	-1.5
Farnworth	32.0	20.5	11.5
Grange	49.0	35.7	11.3
Hale	50.0	NSD	
Halton Brook	48.0	28.0	20
Halton Lea	56.0	45.7	10.3
Halton View	50.0	24.4	25.6
Heath	37.0	30.4	6.6
Hough Green	46.0	34.2	11.8
Kingsway	63.0	40.0	23
Mersey	39.0	32.3	6.7
Norton North	48.0	33.3	14.7

Norton South	61.0	34.7	26.3
Riverside	52.0	36.8	15.2
Windmill Hill	69.0	NSD	

3.9 Over a six year period, the dental health of children in Halton has been transformed. The responsibility for commissioning oral health promotion in Halton now rests with Public Health.

3.10 Access to NHS dental care has been a major priority both nationally and locally. Whilst only 50%-60% of the adult population of England attend a dentist on a regular basis, changes to the primary dental contract in 2006 put pressure on the NHS primary dental care service, with many of those wishing to secure access to an NHS dentist being unable to do so. Central government recognising the problem provided additional funding for PCTs to expand their dental services. Halton and St Helens PCT, as part of its dental commissioning strategy, expanded the number of NHS dentists working locally by the equivalent of 11 whole time equivalents between 2006 and 2012. In Halton, currently there are 14 'High Street' NHS dental practices (7 Runcorn, 7 Widnes. In Autumn 2012, at any one time 70% of Halton dentists were accepting new NHS patients. This suggests that NHS dental access was good and in addition, patients were in a position to choose where they attended for dental care. Following the NHS reorganisation in 2013, the facility to monitor NHS dental access levels was lost, however NHE England Mersey suggest that currently there does not appear to be an access problem in Halton.

3.11 At the same time that the PCT expanded its access to routine dental care, it also redesigned the provision of the emergency 'in hours' dental service which further improved dental access. As a consequence of this latter redesign, those patients who do not wish to avail themselves of regular dental care also have a choice of dentists who, every day, are prepared to offer an urgent care appointment.

3.12 Emergency 'out of hours' dental care is provided by Bridgewater Community NHS Trust. Rotas of dentists provide a service that complies with national standards. Currently 13 of the 14 'High Street' practices are accessible to wheelchair bound patients.

4.0 POLICY IMPLICATIONS

4.1 LA now has responsibility for planning and evaluating oral health promotion [National Health Service, England Social Care Fund, England Public Health, England. The NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012. SI 3094]

5.0 **FINANCIAL IMPLICATIONS**

5.1 Cost of toothpaste distribution which is in the Public Health budget.

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

6.1 **Children & Young People in Halton**

Average level of decay experience in 5-year-olds is a LA PHOF indicator

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

None identified.

6.3 **A Healthy Halton**
Dental health is a prerequisite to general good health.

6.4 **A Safer Halton**

None identified.

6.5 **Halton's Urban Renewal**

None identified.

7.0 **RISK ANALYSIS**

7.1 The Local Authority is maintaining support for an evidence based public health preventive intervention which has been associated with reduced decay levels in the child population. Fluoride toothpaste is a safe and effective way to prevent dental decay. The risks of associated with this programme are purely financial. Because the programme involves the posting of toothpaste and a toothbrush to individual households, the Local Authority retains total control of the spend.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None identified.

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

There are none within the meaning of the Act.

REPORT TO: Health and Wellbeing Board

DATE: 12th March 2014

REPORTING OFFICER: Operational Director Integrated Care Halton CCG

PORTFOLIO: Health and Wellbeing

SUBJECT: Quality Premium

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To provide information to the Board to enable the Board to reach a decision to approve the provider and level of increase in medication error reporting as required by NHS England.

2.0 **RECOMMENDATION: That both the Provider and the specified increase on the level of medication error reporting be approved.**

3.0 **SUPPORTING INFORMATION**

3.1 **Copy of Medication Error Reporting report attached.**

4.0 **POLICY IMPLICATIONS**

4.1 None identified

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 This is an NHS Halton CCG Quality Premium measure. Success in achieving the specified increase equates to 15% of the total value of the quality premium, this is approximately £95,000

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

This is inline with the high level priorities set by the HWBB and evidenced within the Better Care Fund. (BCF) This quality premium will help towards improving the agreed BCF metric of readmissions

6.1 **A Safer Halton**
In increase in the number of medication errors reported, even if they cause low or no harm, show that providers are recognising potential risks and enables learning and action to take place. Thereby reducing the risk of further more serious incidents taking place.

7.0 **RISK ANALYSIS**

7.1 Should the specified increase be achieved NHS Halton CCG will be awarded the proportion of the Quality Premium monies, should the increase not be achieved there will be no financial loss, however further investigation may need to take place to understand the reasons why the increase was not achieved.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 No implications identified.

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

There are none within the meaning of the Act.

NHS
Halton Clinical Commissioning Group

Quality Premium 2014/15

EA5 Medication Error Reporting

As part of the 2014/15 planning round the CCG has 6 quality premium measures, one of these is the Improved reporting of medication-related safety incidents.

This has been chosen by NHS England as contributing to the NHS outcomes framework 5 'Treating and caring for people in a safe environment and protecting them from avoidable harm' and has been selected as a quality premium measure.

This measure will account for 15% of the Quality premium (approximately £95,250)
The quality premium will be awarded if.
A specified increased level of reporting of medication errors is seen between Q4 2013/14 and Q4 2014/15
The increase must be agreed with a local provider, the Health and Wellbeing Board and the NHS England Area team.
The increase can be agreed with more than one CCG with the same provider, but the provider must account for 10% of the CCG's activity.
Primary care can be included as a provider in this measure.
Reporting is via the national Reporting and Learning System.

The four largest providers of CCG activity have been investigated to determine where potential improvement can be found, the four providers are;

- Bridgewater Community NHS Trust
- 5 Boroughs Partnership Mental Health Trust
- Warrington & Halton NHS Foundation Trust
- St Helens & Knowsley NHS Trust

These providers are grouped into clusters, Bridgewater is grouped in 'Community', Warrington & St Helens are grouped into 'medium acute' and 5 Boroughs Partnership is in the group 'Mental Health'

Table 1 shows the percentage of incidents reported that are recorded as 'Medication' alongside cluster averages and the rates of recording all incidents

This data is taken from the NRLS Website on 11/02/2014 and covers the period Q3-Q4 2012/13 (1st October 2012 to 31st March 2013) The actual quality premium is based on the improvement from Q4 2013/14 however this information will not be available until September 2014

http://www.nrls.npsa.nhs.uk/resources/?entryid45=135195

Table 1.

Incidents reported to NRLS for the period 01/10/2012 to 31/03/2013						
	Incidents	Cluster ave Incidents	Severity % moderate or worse	Cluster Ave & moderate or worse	% Incidents 'Medication'	Cluster Ave % incidents 'Medication'
Bridgewater	837	n/a	22.9%	15.7%	3.8%*	9.3%
St Helens & Knowsley	7.9 per 100 admissions	7.6 per 100 admissions	3%	6.3%	8.1%	10.3%
Warrington & Halton	9.1 per 100 admissions	7.6 per 100 admissions	4.5%	6.3%	14.7%	10.3%
5 Boroughs Partnership	52.1 per 1000 bed days	26.8 per 1000 bed days	1.6%	9.1%	29.6%	8.3%

*Note – This data relates to the most accurate data (5 of 6 months) relates to the period to March 2012. A single month of data is available in the period October 2012 to March 2013 however this is not sufficient to base a target on.

Bridgewater Community NHS Trust – Bridgewater only submitted 1 month of data in the 6 month period, no suitable denominator could be calculated so unfortunately no direct comparison could be made. However over for the same six month period to March 2012 Bridgewater submitted a more complete 5 month data set. This more accurate data recorded a medicines error reporting rate of 3.8% against a cluster average of 9.3%. **There appear to be significant data issues with regard to submission, only the most severe incidents appear to be reported. The proposal is for Bridgewater to be chosen as the Quality Premium target provider and for the target to be to increase its rate of medication error reporting over the year 2014/15 as follows**

Baseline -3.8%
Q1 14/15 (target) – 5.2%
Q2 14/15 (Target) – 6.6%
Q3 14/15 (Target) - 7.9%
Q4 14/15 (Quality Premium Target) – 9.3%

St Helens & Knowsley NHS Trust– St Helens & Knowsley report a similar number of incidents as the cluster average. The proportion of these incidents reported as 'medication' is lower than the cluster average, in comparison to the cluster average very few of the incidents are recorded as 'moderate' or 'worse' – **Although not chosen as the Quality Premium target provider, St Helens & Knowsley NHS Trust will have a target set to increase the rate of medication error reporting to 9.9% - The figure of 9.9% has been arrived at by removing The Dudley Group NHS trust as an outlier from the cluster average of 10.3% creating an adjusted cluster average of 9.9%**

Warrington & Halton NHS Foundation Trust – Warrington records significantly more incidents than the cluster average, they also record more 'medication' incidents than the cluster average. **– Not for inclusion, Warrington & Halton reports significantly more incidents than average with a higher proportion of Medication incidents**

5 Boroughs Partnership Mental Health NHS Trust – 5 Boroughs Partnership report twice as many incidents as the cluster average, Many of these are low or no harm incidents and a large proportion are medication errors **– Not for inclusion.**