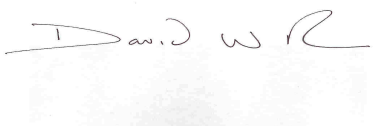
Public Document Pack

Health and Wellbeing Board

Wednesday, 9 July 2014 2.00 p.m.
Karalius Suite, Halton Stadium, Widnes



Chief Executive

COMMITTEE MEMBERSHIP

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, 17 September 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, 7 May 2014 at Karalius Suite, Halton Stadium, Widnes

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

Apologies for Absence: N. Rowe and S. Yeoman

Absence declared on Council business: None

ITEM DEALT WITH UNDER DUTIES EXERCISABLE BY THE BOARD

Action

HWB66 MINUTES OF LAST MEETING

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

HWB67 PRESENTATION - ARE YOU DIFFERENT?

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

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

with actual percentages of those who had;

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

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

RESOLVED: That the presentation be received.

HWB68 PRESENTATION - HEALTH AND WELLBEING PRIORITIES UPDATE

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

- to provide progress on the health and wellbeing priorities;

- agree new actions against the priorities;

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

- launch the Community Health Champions awards.

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

RESOLVED: That the presentation be noted.

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

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

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

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

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

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

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

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

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

RESOLVED: That

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

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

HWB70 HEALTH PROTECTION AND PUBLIC HEALTH GOVERNANCE FUNCTIONS

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

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

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

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

RESOLVED: That

(1) the contents of the report be noted;

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

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

HWB71 CHILD DEVELOPMENT UPDATE

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

identified.

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

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

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

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

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

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

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

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

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

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

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

RESOLVED: That the report and associated appendices be noted.

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

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

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

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

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

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

RESOLVED: That

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

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

Meeting ended at 3.40 p.m.

REPORT TO: Health and Wellbeing Board

DATE: 9 July 2014

REPORTING OFFICER: Simon Banks, Chief Officer

PORTFOLIO: NHS Halton CCG

SUBJECT: End to End Assessment

WARDS: All

1.0 PURPOSE OF THE REPORT

To inform the Health and Wellbeing Board of the outcomes of the End to End Assessment Project, commissioned by NHS Halton CCG with NHS Knowsley, St Helens and Warrington CCGs and NHS England.

2.0 RECOMMENDATION: That the Health and Wellbeing Board note the report.

3.0 SUPPORTING INFORMATION

The Health and Wellbeing Board will be aware that NHS Halton, Knowsley, St Helens and Warrington CCGs and NHS England have commissioned work to deliver:

- A high level retrospective review of health care activity, spend and patient flows by commissioner and by location per quarter in the past three years.
- A review of all current health care activity, spend and patient flows by commissioner and by location.
- Projected activity, spend and patient flows by commissioner and by setting for the next 3, 5 and 10 years assuming current cost and payment arrangements.

The Chief Officer of NHS Halton CCG acted as co-sponsor of this project with David Cooper, Acting Chief Finance Officer - NHS Warrington CCG. They co-chaired a steering group working with Capita, who were selected following a procurement process to deliver this project.

4.0 POLICY IMPLICATIONS

The outcomes of the End to End Assessment work will be factored into the 5 Year Strategy for NHS Halton CCG.

5.0 OTHER IMPLICATIONS

There will be an impact on the provider landscape for Halton as the 5 Year Strategy is progressed. The End to End Assessment work highlights some of the areas in which this will happen.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children and Young People in Halton

NHS Halton CCG's 5 Year Strategy will have areas that will impact on children and young people. The End to End Assessment explored paediatric activity but the outcomes focus mainly on frail and older people.

6.2 Employment, Learning and Skills in Halton

None as a result of this report.

6.3 A Healthy Halton

The End to End Assessment work will help shape the future direction of health and social care commissioning in the borough.

6.4 A Safer Halton

None as a result of this report.

6.5 Halton's Urban Renewal

None as a result of this report.

7.0 RISK ANALYSIS

The End to End Assessment work influences the risk assessment that has been undertaken as part of the development of the 5 Year Strategy by NHS Halton CCG.

8.0 EQUALITY AND DIVERSITY ISSUES

There are no equality and diversity issues arising as a direct result of this work.

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

End to End Assessment .

END TO END ASSESSMENT

Background

The Health and Wellbeing Board will be aware that NHS Halton, Knowsley, St Helens and Warrington CCGs and NHS England commissioned work to deliver:

- A high level retrospective review of health care activity, spend and patient flows by commissioner and by location per quarter in the past three years.
- A review of all current health care activity, spend and patient flows by commissioner and by location.
- Projected activity, spend and patient flows by commissioner and by setting for the next 3, 5 and 10 years assuming current cost and payment arrangements.

The Chief Officer acted as co-sponsor of this project with David Cooper, Acting Chief Finance Officer - NHS Warrington CCG, and co-chaired a steering group working with Capita, who were selected following a procurement process to deliver this project.

Summary

This project has provided a retrospective, current, and future view of health and social care activity, spend and patient flows across the Mid Mersey area. Looking back over the past three years the four CCGs have been relatively consistent in their activity trends. Activity has generally grown in line with underlying population growth, with recent signs of this being offset by schemes put in place to manage demand. The spend over time illustrates a disproportionate increase in spend compared to activity, which may be explained by increasingly more complex case mix or coding changes. Overall the largest growth has been seen in the 65+ age group, which is also the highest spend area, suggesting that continued focus on the frail / elderly will be of particular benefit to the health and social care economy moving forwards.

At present there is a large degree of variation between practices in terms of admission rates, attendance rates and outpatient performance, even after adjusting for population characteristics and weighting for healthcare need. The degree of variation increases the smaller the practice is, which suggests that federated general practice at scale is a factor in reducing variation and spend, which may also result in improved outcomes. Working up analysis alongside local knowledge suggests that practices that have a focus on health and wellbeing and integrated care benefit from a reduced demand for acute services. Lower admission rates were highlighted for particular practices where there has been a recognised long term focus on health improvement and prevention.

Looking forward, a large proportion of commissioning intentions are interventions for the elderly and those with long term conditions – this is consistent with the areas seen to be growing in the retrospective analysis and provides confidence that the right areas are in focus. There appears to be an opportunity to reduce variation by standardising referral thresholds, admission criteria, and pathways for high volume conditions – this would improve the quality of care while managing demand and reducing spend. There is also significant opportunity to reduce variation in length of stay and deal with this demand once in hospital.

Modelled interventions are projected to keep pace with underlying growth over the next 3 years, after which this underlying demand is projected to overtake the reductions in activity that these initiatives are expected to make. This suggests that a more radical approach to meeting the challenge will be needed – current plans could be strengthened by exploring opportunities for more upstream intervention in health and wellbeing, shifting the emphasis from diversion to prevention of demand. In addition, the CCGs could explore more radical approaches to delivery of integrated, proactive care, involving redefining the role and shape of primary, community and social care for the longer term, with the current plans being used to generate headroom to put the necessary investment into non-acute services to enable long-term change.

Retrospective Analysis

The key purpose of the initial high-level analysis was to differentiate between underlying growth and acuity, shifts between providers, re-provision of activity in alternative settings, changes to tariffs, local prices, payment mechanisms, technical coding and counting, contract penalties and incentives, recurrent and non-recurrent changes. Data was assembled and validated for financial years 2010/11, 2011/12, 2012/13 and 2013/14 to January 2014. Capita created a 'standardised' view of the historic data to allow a like-for-like comparison over the three-year period. This work found that:

- The four CCGs have been relatively consistent in their activity trends seen over the past three years.
- With exception of a peak in winter 2012/13, non-elective activity has grown in line with underlying population growth, and has been relatively flat or decelerating in recent months, it appears that population pressure has been offset by schemes put in place to manage demand.
- Elective demand is growing overall but more of this is being carried out in the day case setting.
- The majority outpatient growth over the last year has been in non-GP referred activity
- All CCGs have seen a reduction or slowing of the upward trend in A&E attendances over the past year.
- The largest overall non-elective cost increases in individual specialties has been seen in Respiratory Medicine and General Medicine.
- The spend over time illustrates a disproportionate increase in spend compared to activity, which may be explained by increasingly more

complex case mix, coding changes over time may have impacted on this.
- Overall the largest growth has been seen in the 65+ age group, which is also the highest spend area, suggesting that this is a particular area of opportunity, and that continued focus on frail/elderly patients will be of particular benefit to the health economy.

Current baseline

Capita applied similar principles as to the historic analysis to 2013/14 activity to date to profile current activity, spend and patient flows in order to present a picture of current activity using 2013/14 organisational structure and coding. They provided a statement of the baseline position as well as comparisons of current activity levels between practices and between CCGs to understand variation in the baseline. The main findings were that:

- There is a large scale of variation between practices in terms of admission rates, attendance rates and outpatient performance, even after adjusting for populations an weighting for healthcare need.
- The degree of variation increases the smaller the practice is, which suggests that federated general practice at scale is a factor in reducing variation and spend, which may also result in improved outcomes.
- There is a similar level of overall acute spend per head between the CCGs, combined with larger variation in non-acute spend per head, this may indicate that the level of acute activity is either true patient demand (i.e. there is a level of acute activity that goes into hospital regardless of what is commissioned elsewhere) or that this is led by the providers capacity to accommodate demand (supply led demand).
- With some exceptions the patient flow from practice to provider follows a natural pattern, with limited opportunity for repatriation from Liverpool or Manchester.
- Working up analysis alongside local knowledge suggests that practices that have a focus on health and wellbeing and integrated care benefit from a reduced demand for acute services. Lower admission rates were highlighted for particular practices where there has been a recognised long term focus on health improvement and prevention.

Forecasting the future

Capita worked up a projection of future activity, spend and patient flows. It is made up of the following elements:

• The collation and understanding of commissioning intentions and strategic plans.
• The mapping of intentions to specific patient cohorts impacted by the change.
• The modelling of the impacts on future activity, spend and patient flows.

The main findings are:

- Grouping of commissioning intentions has shown that by far the biggest area of focus for interventions is for the elderly and those with long term conditions – this is consistent with the areas seen to be growing in the retrospective analysis and provides confidence that the right areas are in focus.
- There appears to be an opportunity to reduce variation by standardising referral thresholds, admission criteria, and pathways for high volume conditions – this would improve the quality of care while managing demand and reducing spend. There is also significant opportunity to reduce variation in length of stay and deal with this demand once in hospital.
- Modelled interventions are projected to keep pace with underlying growth over the next 3 years, after which this underlying demand is projected to overtake the reductions in activity that these initiatives are expected to make.
- Working up analysis alongside local knowledge suggests that practices that have a focus on health and wellbeing and integrated care benefit from a reduced demand for acute services. Public health initiatives and preventative schemes may have an impact over the longer term but would need investment now for longer term benefits to be realised.

Implications for commissioners

The purpose of the assignment was to undertake modelling of historic, current and forecast activity, flows and spend. The ultimate aim of this exercise was to support commissioners in their decision making for the longer term. Capita offer a commentary on some of the key points arising from the review, which help address some of the questions CCGs are seeking to answer, and signpost the CCGs to what they might consider next to address remaining gaps in their knowledge. The key issues are summarised below.

Scope of plans	The analysis shows that the current plans will help stem the tide of demand growth from population change but that in the long term, demand will continue to grow. This suggests that a more radical approach to meeting the challenge will be needed – current plans could be strengthened by exploring opportunities for more upstream intervention in health and wellbeing, shifting the emphasis from diversion to prevention of demand. In addition, the CCGs could explore more radical approaches to delivery of integrated, proactive care, involving redefining the role and shape of primary, community and social care for the longer term, with the current plans being used to generate breathing space to put the necessary investment into non-acute services to enable long term change.
Community data	The data provided for community services is not adequate to derive reliable calculations of the impact of commissioning intentions and the information provided in this report should be seen as illustrative. We would recommend that the basis

	for our modelling should be validated in collaboration with providers and further work be undertaken locally to understand the extent to which capacity in community services could be released to support the activity shifts associated with the commissioning intentions, and then the true quantum of additional capacity that will be required to support the long term shift indicated in the first point above.
Impact of social care resource constraints	The modelling suggests that austerity across the system is having an impact on the provision of social care, with a reduction in spend on assessments and shift in provision from institutional to home based care . The impact of this on health status and demand for health services cannot be inferred from the modelling at this point, but it seems logical to assume that there will be an increase in demand, particularly for home-based health care. By investing in more integrated approaches to risk stratification, population segmentation, prevention and proactive care, and by considering further opportunities for pooling resources to achieve this, health and social care commissioners will be better able to avoid this demand emerging in acute services and to deliver the most beneficial outcomes for the population in terms of overall health status. Further work should be undertaken now to understand the nature of social care provision, the client groups impacted and the care pathways / packages needed to address their needs.
Specialised Services / impact of new technologies	Despite the direction of travel to consolidate further the provision of specialist services into larger centres, from the information available, this is unlikely to have a major impact on patient flows within the Mid Mersey geography, as neither of the two local providers delivers significant specialist services (the key exception being burns). The delegation of commissioning of some services to CCGs will impact on local commissioning intentions but is unlikely to impact on patient flows. It is likely that, with technological and pharmaceutical advances, more services and procedures become more amenable to local delivery (as in the case of renal dialysis and chemotherapy) but the need for these to be linked back to specialist expertise suggests the development of outreach from specialist centres of chains of providers, rather than involving a shift of provider.
Aligning wider system changes	The modelling has been built on commissioning intentions and it is suggested that these be compared with the impact of provider supply strategy and business plans, where known. For example, it would be helpful to understand the strategies of local trusts in respect of attracting activity from competitors. The pressure at St Helens and Knowsley Trust to optimise the use of Whiston Hospital may drive it towards a more aggressively competitive approach to practices in Halton, where flows are more varied, which would impact on the viability of the Halton Hospital site. While it is unlikely that the Greater Manchester Healthier Together strategy will impact on flows from mid Mersey, any plans for reconfiguration of services across Liverpool (and in the longer term, the re-build of the Royal Liverpool Hospital)

	may impact on flows from practices on the western edge of the patch. A more likely scenario for CCGs to consider is the impact of their plans for a sustained shift from acute to community services on provider sustainability and consequently, behaviour. To mitigate the impact on income, Trust responses may focus on developing partnerships and alliances with community services, or they may become more overtly competitive, seeking to develop vertically integrated alternatives to current provision. The latter, coupled with potential for establishment of GP Federations, provides a potential threat to Bridgewater Community Trust, which in turn may threaten the implementation of CCGs' plans in the medium term. Further work to understand community services flows would help CCGs develop a clear approach to this area of the market.

Halton specific issues

Capita worked with NHS Halton CCG and Halton Borough Council to produce some findings specific to the borough:

- Including the Better Care Fund there is a governed pooled arrangement worth £42m between NHS Halton CCG and Halton Borough Council for adult services.
- The pooled arrangements delivered savings of £158k in complex care in 2013/14.
- Joint commissioning and funding of intermediate care ensures the reduced need for nursing placements.
- NHS Halton CCG and Halton Borough Council have integrated safeguarding teams, leading to improvements in working arrangements and responsiveness.
- The Integrated Care Home Teams are contributing to a continued reduction in A&E attendances and subsequent admissions.
- Integrated Discharge Teams working with the two main acute providers are ensuring that there are little to no delays for Halton residents. They are contributing to length of stay (LOS) maintenance and improvement.
- Pooled budgets for Continuing Health Care (CHC) result in one assessment and one package of care; this potentially explains the data in the report which shows low assessment levels for Halton.
- The pooled arrangements and Better Care Fund place Halton in a good position to meet the challenges of Social Care Act.
- The Better Care Fund and NHS Halton CCG investment to provide 2 Urgent Care Centres will further reduce A&E activity and non-elective admissions (NELs).

i5 Work

In addition to the work with Capita, NHS Halton CCG commissioned i5, who are health economists, to review the potential benefits of the Better Care

Fund, 2 Year Operational Plan and 5 Year Strategy with a specific focus on acute activity.

I5 reviewed actual patient data over a seven month period from April to October 2013 using:

- the actual numbers of patients attending A&E
- what time they attended
- how long they were admitted for (if they were admitted)
- what treatment / diagnostics they received (if any)
- the types and acuity of the conditions they presented
- the costs associated with the attendance and/or admittance

i5 also calculated the actual cost of activity which could have been treated elsewhere. In common with Capita, i5 assumed some growth in elective activity and did not factored in the cost of the schemes needed in the community or elsewhere to achieve the savings required from the acute sector.

NHS Halton CCG has compared the i5 and Capita work against our plans (Appendix One). Overall both the i5 and Capita assessments give assurance that the commissioning intentions of NHS Halton CCG with Halton Borough Council are focussed in the right areas (acute care and older people). They also provide assurance the level of savings identified in the financial and operational plan are broadly achievable, although at the top end of what is possible.

Conclusion

The Capita End to End Assessment work has shown that the 'Mid Mersey' CCGs all have similar strategic commissioning intentions. The Capita and i5 work suggest that the plans of NHS Halton CCG, in partnership with Halton Borough Council and local providers, are achievable but that there are some significant challenges ahead.

Appendix One Potential savings in acute sector

Savings Identified, (figures in £,000's)						
Financial Plan (2 year)*	Financial Plan (5 year)*	Operational plan (2 year)**	i5 Health***	BCF****	Capita likely savings (5 year)*****	Capita Max savings (5 Year)******
3,708	7,951	3,930	3,638	377	1,665	3,393

* The Financial plan figures reported here are the cumulative recurrent QIPP savings and do not include running cost, tariff and price efficiency savings)

** The Operational plan 2 year savings should match the financial plan 2 year savings, this variation will be amended in the operational plan before submission to NHS-E on the 20th June

*** The sum total of i5 Health's savings is actually £5,978,000 (adjusted for a more realistic A&E attendance cost), however this include schemes in which the savings overlap, when an adjustment is made for this the total amount of savings available in acute care is £4,522,000, This includes some schemes which have not been identified in the operational plan such as 'Roving GP support with Ambulance crews' When these schemes are excluded the total amount of savings for schemes which match in i5 and the operational plan is £3,638,000

**** The savings identified in the BCF are the top level reported in the template, this does not show the breakdown of all savings, as some schemes whilst saving money in the acute sector will cost money elsewhere.

*****The Capita likely savings are based on reductions on acute activity to the best performing 25% of Practices in regards to A&E attendance, Outpatient appointments (first and follow up), Avoidable emergency admissions and early supported discharge.

******The Capita Max savings scenario includes savings identified in the BCF and operational plan, since these plans over cover a two year period the bulk of the £3,393,000 savings identified as 5 year, will in fact be achieved in the first two years, assuming that the Urgent care centre and reduction in variations in general practice activity can be achieved.

CAPITA

End-to-end care assessment

NHS Halton, Knowsley, St Helens & Warrington CCGs

May 2014

Executive summary

This project has provided a retrospective, current, and future view of health and social care activity, spend and patient flows across the Mid Mersey area.

Looking back over the past three years the four CCGs have been relatively consistent in their activity trends. Activity has generally grown in line with underlying population growth, with recent signs of this being offset by schemes put in place to manage demand. The spend over time illustrates a disproportionate increase in spend compared to activity, which may be explained by increasingly more complex case mix or coding changes. Overall the largest growth has been seen in the 65+ age group, which is also the highest spend area, suggesting that continued focus on the frail / elderly will be of particular benefit to the health and social care economy moving forwards.

At present there is a large degree of variation between practices in terms of admission rates, attendance rates and outpatient performance, even after adjusting for population characteristics and weighting for healthcare need. The degree of variation increases the smaller the practice is, which suggests that federated general practice at scale is a factor in reducing variation and spend, which may also result in improved outcomes. Working up analysis alongside local knowledge suggests that practices that have a focus on health and wellbeing and integrated care benefit from a reduced demand for acute services. Lower admission rates were highlighted for particular practices where there has been a recognised long term focus on health improvement and prevention.

Looking forward, a large proportion of commissioning intentions are interventions for the elderly and those with long term conditions – this is consistent with the areas seen to be growing in the retrospective analysis and provides confidence that the right areas are in focus. There appears to be an opportunity to reduce variation by standardising referral thresholds, admission criteria, and pathways for high volume conditions – this would improve the quality of care while managing demand and reducing spend. There is also significant opportunity to reduce variation in length of stay and deal with this demand once in hospital.

Modelled interventions are projected to keep pace with underlying growth over the next 3 years, after which this underlying demand is projected to overtake the reductions in activity that these initiatives are expected to make. This suggests that a more radical approach to meeting the challenge will be needed – current plans could be strengthened by exploring opportunities for more upstream intervention in health and wellbeing, shifting the emphasis from diversion to prevention of demand. In addition, the CCGs could explore more radical approaches to delivery of integrated, proactive care, involving redefining the role and shape of primary, community and social care for the longer term, with the current plans being used to generate headroom to put the necessary investment into non-acute services to enable long-term change.

Local Context

NHS Halton, Knowsley, St Helens and Warrington CCGs were formed on 1 April 2013 and are responsible, together with NHS England and their corresponding Councils for the commissioning of NHS services for a registered population of almost 700,000 people. Together, the CCGs have budgets of just over £910m per annum.

The CCGs operate in a complex health environment – Community and Mental Health services are provided for the four organisations by two main Trusts (Bridgewater Community Healthcare and 5 Boroughs Partnership) – however, while the provision of acute secondary care is dominated by St Helens and Knowsley NHS Trust and Warrington and Halton NHSFT, there is a significant amount of competition from specialist NHS providers on Merseyside as well as local private hospitals.

Sandwiched between the two major conurbations of Merseyside and Greater Manchester, access to specialist care is relatively easy and the two local acute Trusts provide mostly District General Services from three main sites and one community hospital (with some teaching specialties and a specialist burns unit at Whiston Hospital in St Helens).

The health economy has experienced significant financial challenges in recent years, driven by

- demographic growth,
- the health needs of the population in a post-industrial environment, including the need to address health inequalities
- historic funding patterns (notably relative level of underfunding for Warrington, recognised in the latest allocations)
- additional costs associated with acute infrastructure (notably the PFI build at Whiston Hospital and the transfer of the Treatment Centre at Halton Hospital to NHS ownership)
- Increasing spend on high tech and specialised services (now commissioned by NHS England)

These will continue to impact on the health economy, along with new pressures such as the drive towards 7 day working, improving urgent care, extended integration of commissioning and provision with Local Authorities, changes to the NHS funding formula & tariff structure and changes to primary care contracts.

This has contributed to a significant combined financial challenge across the patch, which the CCGs recognise can only be addressed by a fundamental shift in the shape of service delivery, with care delivered in the most appropriate setting to secure the best outcomes for patients and citizens.

The CCGs, together with commissioning partners in NHS England and councils, have accepted the challenges these factors pose and are seeking to address fundamental questions about patient flows and care delivery, which could have far reaching impacts on the balance of care between health and social care, acute and community care and specialist and local care. One illustration of this is the commitment by CCG and LAs to pooling of budgets thus prioritising prevention and early intervention and delivery of care closer to home. The implications of future commissioning decisions on service viability and quality are of critical importance and the CCGs wish to ensure that they are able to base their decisions on the best available evidence.

Purpose of Report

The scope of the project incorporates analysis and modelling of activity and financial flows of patients from NHS Halton, Knowsley, St Helens and Warrington CCGs into all providers, with additional granularity in regard to flows particularly to St Helens and Knowsley NHS Trust, Warrington and Halton NHSFT, Bridgewater Community Healthcare Trust, and 5 Boroughs Partnership NHSFT.

The objectives of this project are to provide:

- Retrospective analysis of healthcare activity, spend and patient flows
- Profile of current activity, spend and patient flows
- Forecast profile of activity, spend and patient flows over 3, 5 and 10 years

This modelling and analysis aims to provide an evidence base help to answer questions such as:

- The potential impact of strategies and plans,
- Constraints and barriers to change,
- Current and potential future resources and care settings,
- The impact on commissioners in terms of affordability and on providers in terms of sustainability

Structure of Report

There are three main parts to this report, after a **Methodology** to describe the approach and the process that we have followed, the report is split into he following areas:

Retrospective analysis

We have created a view of the historic data to allow a like-for-like comparison over the three-year period. This section analyses key trends and drivers of historic change.

Current baseline

We have applied similar principles as to the historic analysis to profile current activity, spend and patient flows in order to present a picture of current activity. We provide a statement of the baseline position as well as comparisons of current activity levels between practices and between CCGs to understand variation in the baseline.

Future Projections

This section provides a projection of future activity, spend and patient flows.

It is made up of the following elements

- The collation and understanding of commissioning intentions and strategic plans.
- The mapping of intentions to specific patient cohorts impacted by the change.
- The modelling of the impacts on future activity, spend and patient flows.

Following these three sections, a final section explores the **Implications for Commissioners**, where we offer a commentary on some of the key points arising from the review, which help address some of the questions CCGs are seeking to answer, and signpost the CCGs to what they might consider next to address remaining gaps in their knowledge.

Contents

Additional material

In addition to this report we have provided data analysis files – for further filtering of outputs (or for a CCG specific view of more general tables) the tableau files hold all tables produced in this document with relevant filters for further drill down of results. The reader application has also been included. Tab names in the file will match the titles on graphs and tables in this document.

Glossary

Phrase	Definition
NURHA	Emergency admissions for acute conditions that should not usually require hospital admission (NHS Outcomes Framework indicator)
ACS	Ambulatory care-sensitive conditions
DC	Daycase activity
EL	Elective activity
NE	Non-Elective activity
TFC	Treatment Function Code
MSC	Main Specialty Code

CAPITA

Methodology

Methodology

The key purpose of the initial high-level analysis is to differentiate between underlying growth and acuity, shifts between providers, re-provision of activity in alternative settings, changes to tariffs, local prices, payment mechanisms, technical coding and counting, contract penalties and incentives, recurrent and non-recurrent changes.

Data has been assembled and validated for financial years 2010/11, 2011/12, 2012/13 and 2013/14 to January 2014. We have created a 'standardised' view of the historic data to allow a like-for-like comparison over the three-year period.

Retrospective analysis	Current activity, spend & patient flows	Collation of commissioning intentions	Forecast of activity, spend and patient flows
• Applyi2013/14 tariffs and payment arrangements to all previous years. • Map coding classifications between years, for example changes in diagnosis coding between 11/12 and 12/13. • Standardise specialty coding across all years using consistent rules. • Group specialist activity across previous years using the 2013/14 prescribed services grouper. • Map to CCGs on the basis of practice codes across all years for a consistent view of activity.	• Coded activity data has been available to early February (end of February for outpatient and emergency data), the remaining few weeks of 2013/14 have therefore been projected on the basis of equivalent days in January and early February. • This methodology has allowed us to present a picture of current activity using 2013/14 organisational structure and coding	• The collation and understanding of commissioning intentions and strategic plans. • The mapping of intentions to specific patient cohorts impacted by the change. • As would be expected, these intentions and plans have originated from a number of sources*, been described in different way at various levels of granularity and overlap in their intended impact. We have translated each into a standard template and mapped individual lines to areas and types of impact	• Modelling of the impacts of commissioning intentions on future activity, spend and patient flows.

Testing understanding & validation

Our approach to this assignment has been based on full engagement to ensure that the data and modelling outputs are validated at key points in the process, and that assumptions are verified and scenarios co-designed. The majority of engagement has been conducted through regular steering group meetings with key stakeholders, with additional sessions with NHS England as well as the wider area to understand specialist activity as well as potential impacts resulting from the Healthier Together programme.

*** Sources used are listed in Appendix 1**

Methodology – Key assumptions and caveats

It is important to recognise some key caveats and assumptions that have been made as part of the analysis and this document in regard to data availability or methodological considerations.

Data provided for community services and mental health has only been available as an overall spend figure for each CCG, either based on forecast outturn or current budgets. Historic data or more detailed data of the current baseline has not been available, so representation of historic activity or future impact on commissioning intentions on community services should be seen as illustrative.

Acute spend figures are based on national tariff prices only, and will not include local pricing or costs for PbR excluded activity.

Assumptions on streaming of patients to other settings have been based on high level assumptions about the impact of avoiding acute admissions and reducing length of stay on non-acute services. The model does not make any assumptions about the efficacy of current non-acute bed use and makes no assumptions about community service productivity and capacity. Further work would be necessary to map current flows and understand current patterns of community provision to validate the findings.

Social Care data has also only been available as a high level spend per year, sourced from national data returns (PSS expenditure and unit costs, England) . The exact nature of the impact of changing social care funding and provision on health status and demand for health services cannot be inferred from the modelling at this point, further work would be required to understand the full impact.

In the modelling of future impacts of commissioning intentions, we have not assumed a reduction in daycase and elective admissions. This is to ensure that there is enough activity commissioned to deliver 18 weeks. It is also worth noting that baseline activity has been included ‘as-is’. This has not been adjusted for the impact of any over performance or explicit waiting list initiatives within the baseline period.

Assumptions relating to specialised commissioning have been based on high level shifts at specialty level only as the national “derogation list” was not available.

No specific assumptions have been made about the impact of public health interventions / prevention as it was not possible to derive clear assumptions from the information provided by Public Health England.

CAPITA

Retrospective analysis

Healthcare activity, spend and patient flows

Key Findings - retrospective analysis

Purpose of this section

The key purpose of the initial high-level analysis is to differentiate between underlying growth and acuity, shifts between providers, re-provision of activity in alternative settings, changes to tariffs, local prices, payment mechanisms, technical coding and counting, contract penalties and incentives, recurrent and non-recurrent changes.
Data has been assembled and validated for financial years 2010/11, 2011/12, 2012/13 and 2013/14 to January 2014. We have created a 'standardised' view of the historic data to allow a like-for-like comparison over the three-year period.

Main Findings

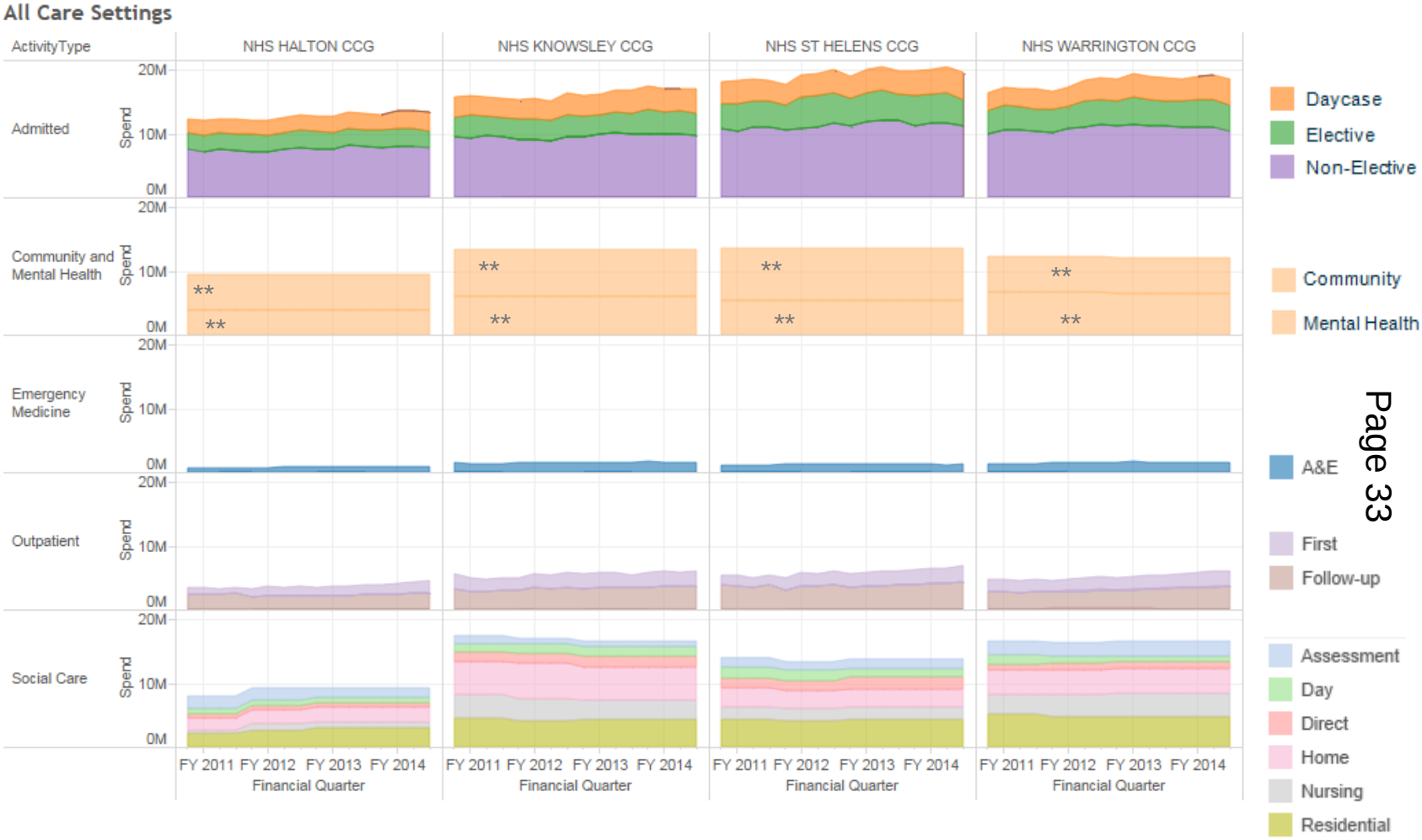
- The four CCGs have been relatively consistent in their activity trends seen over the past three years.
- With exception of a peak in winter 2012/13, non-elective activity has grown in line with underlying population growth, and has been relatively flat or decelerating in recent months, it appears that population pressure has been offset by schemes put in place to manage demand.
- Elective demand is growing overall but more of this is being carried out in the day case setting.
- The majority outpatient growth over the last year has been in non-GP referred activity
- All CCGs have seen a reduction or slowing of the upward trend in A&E attendances over the past year.
- The largest overall non-elective cost increases in individual specialties has been seen in Respiratory Medicine and General Medicine.
- The spend over time illustrates a disproportionate increase in spend compared to activity, which may be explained by increasingly more complex case mix, coding changes over time may have impacted on this.
- Overall the largest growth has been seen in the 65+ age group, which is also the highest spend area, suggesting that this is a particular area of opportunity, and that continued focus on frail/elderly patients will be of particular benefit to the health economy.

Overview - Spend by setting

Overall acute spend has increased across all care settings and CCGs over the last three years. The overall increase has been 9% between 2010/11 and 2013/14, with the largest increases at NHS Warrington CCG (12%).

Social care spend has been flat at an aggregate level with variations between CCGs, highlighted in more detail in following slides.

Data provided for community services and mental health is an overall spend figure for each CCG. Historic data has not been available so trends are not shown graphically.



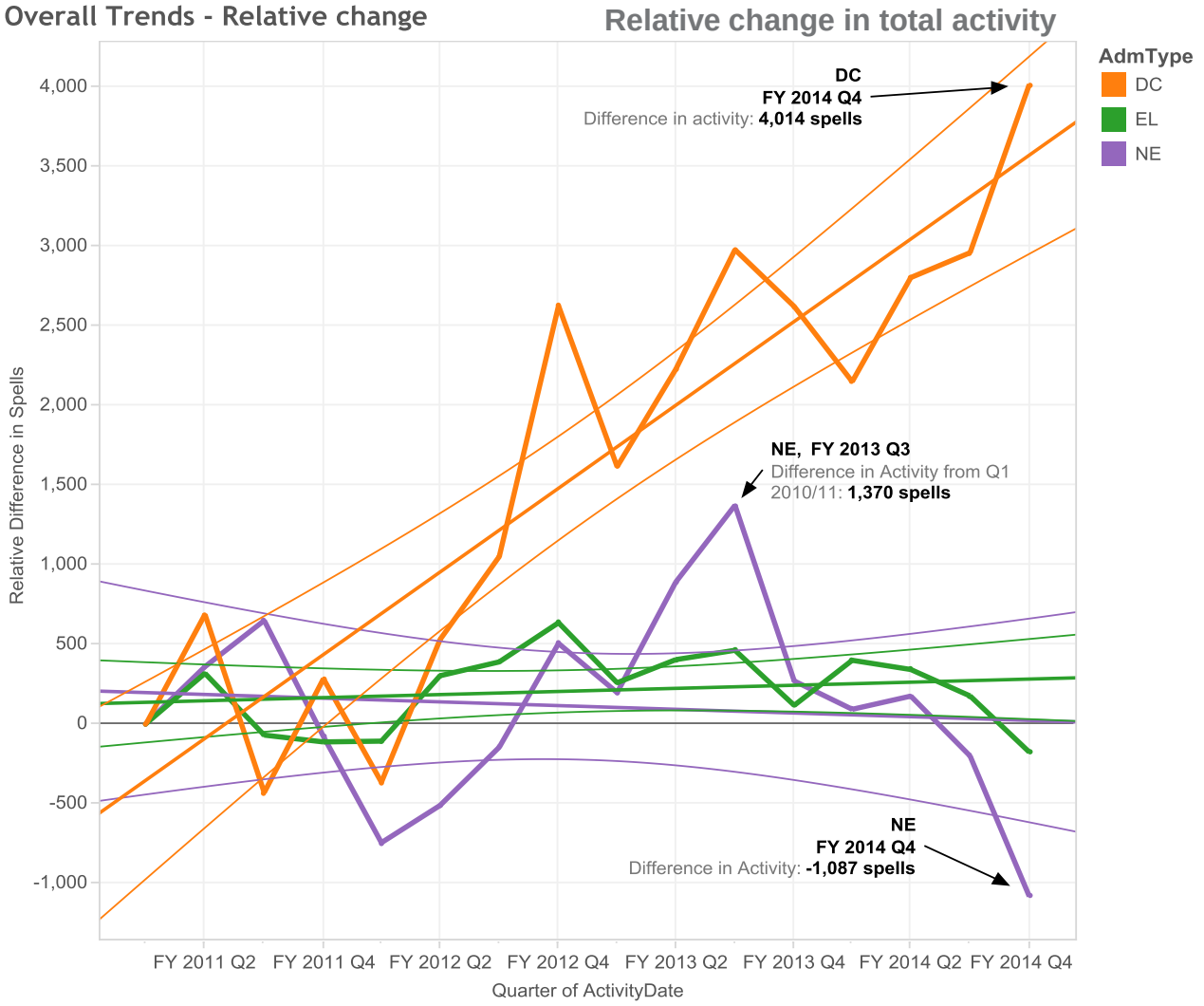
Change over time in admitted activity

Retrospective analysis of the relative change (to the start of 2010/11) in admitted patient activity over time shows that there is:

•Overall a relatively flat to reducing trend in Non-Elective activity, with a peak in quarter 3 2012/13, likely due to the impact of winter in that period.

• A relatively flat rate in terms of inpatient elective activity, and a significant upward trend in day case activity, showing that elective demand is growing overall but more of this is being carried out in the day case setting.

This pattern is consistent across all CCGs within Mid Mersey, with smaller increases in day case activity for St Helens CCG.



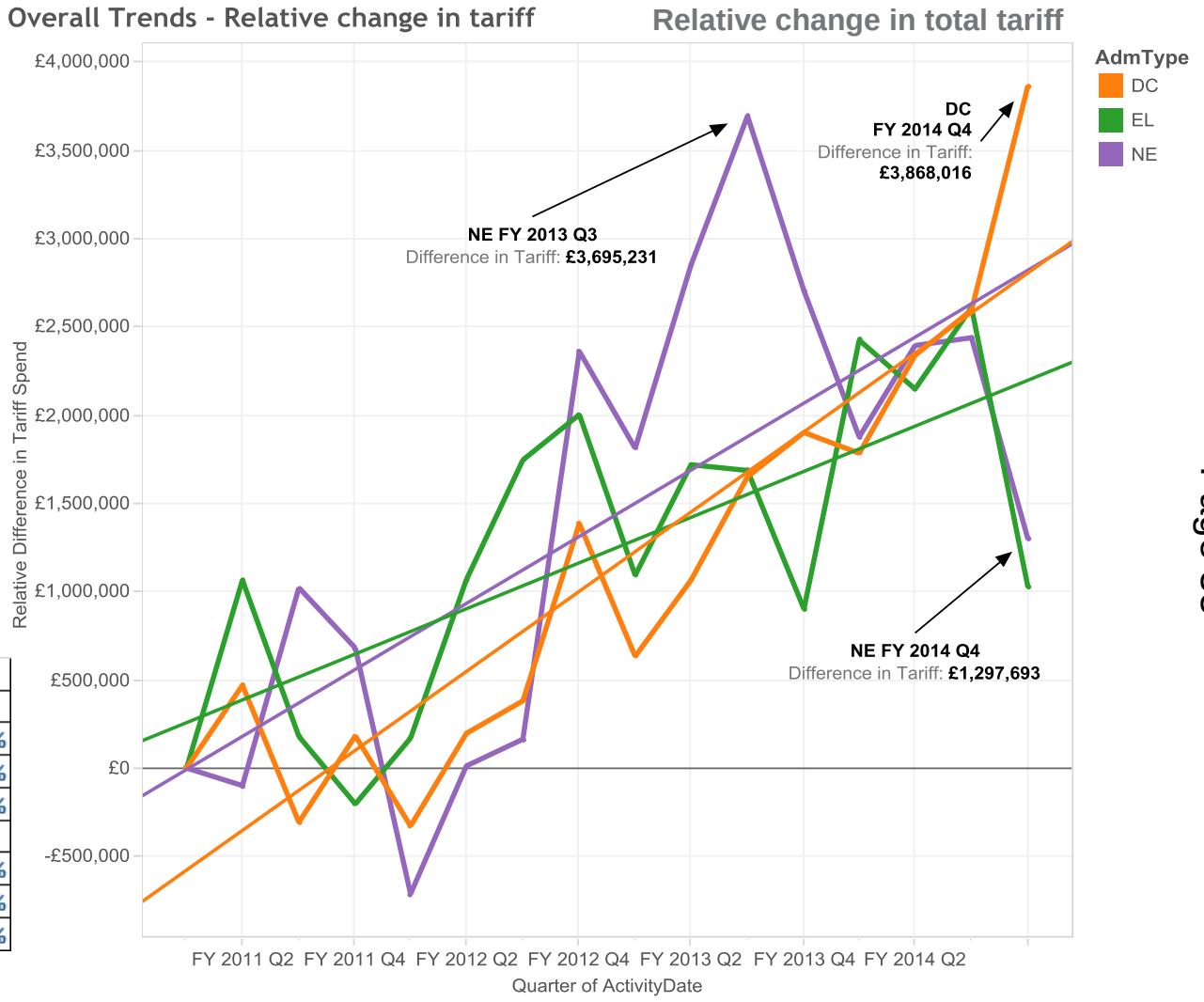
Change over time in admitted spend

The same analysis of spend over time (standardised to 2013/14 tariff rules), illustrates an upward trend across all admitted patient settings.

A possible explanation for an overall increasing inpatient tariff spend against the relatively flat rate of inpatient activity is increasingly more complex case mix, this could also be due to coding changes over time though it is difficult to distinguish between the two.

The table below shows the disproportionate impact of inpatient admitted patient activity on spend.

Rolling 4 months to	FY 2011 Q4	FY 2012 Q4	FY 2013 Q4
% Change in activity			
Daycase	0.6%	4.5%	11.2%
Elective	0.6%	5.6%	5.7%
Non-Elective	0.8%	-0.8%	2.4%
% Change in spend			
Daycase	0.6%	2.8%	9.1%
Elective	1.7%	8.1%	8.8%
Non-Elective	1.0%	1.1%	6.7%

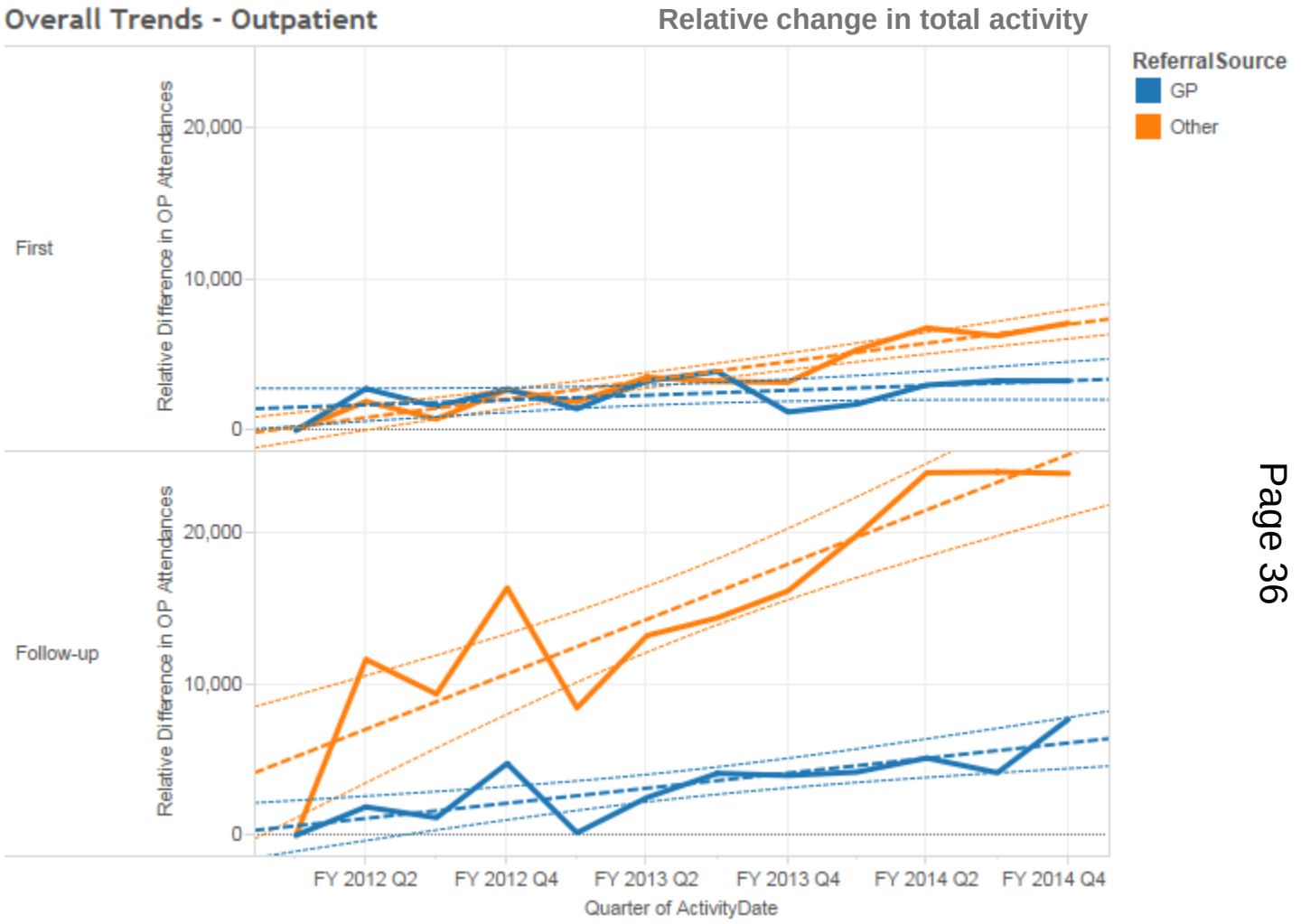


Change over time in outpatient activity

Outpatient activity has also shown an overall upward trend, with a growth of approximately 5% per year. First to Follow up ratios have remained consistent.

The majority of this growth over the last year has been in non-GP referred activity, and of that the major driver of growth has been in consultant referred activity, showing a 22% increase between 2012 and 2013.

These are areas where historic contract provisions may be expected to reduce activity, though this has not been the case. High volume areas where activity has increased include Urology, Orthopaedics, and Respiratory Medicine, although an element of the trend may also be due to increased recording of activity, with increases seen in in therapies and non-consultant led attendances.



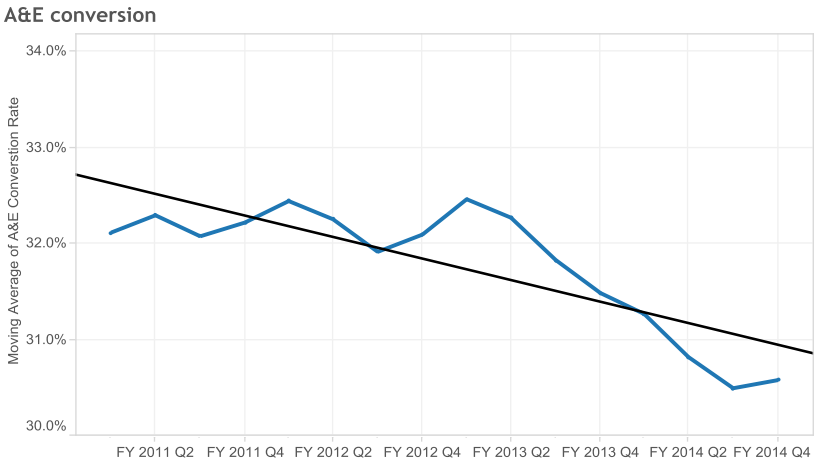
Change over time in emergency activity

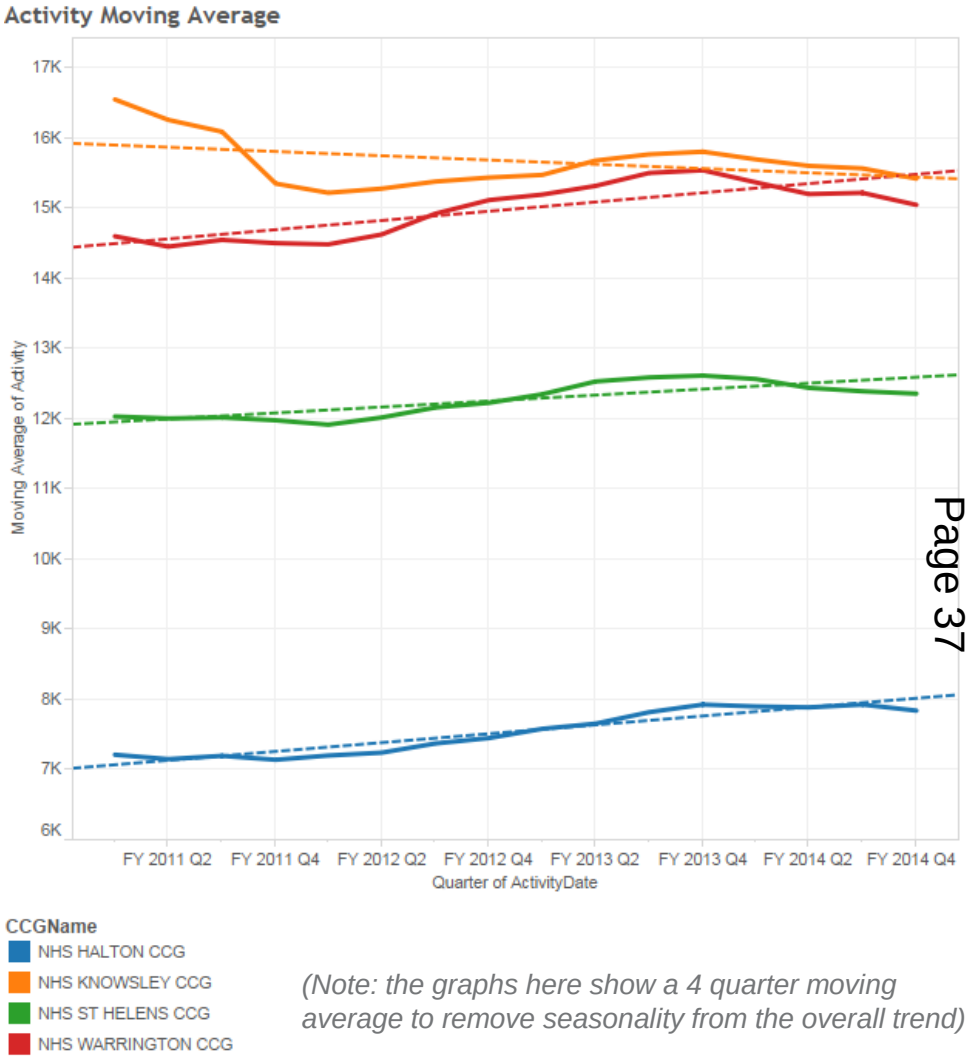
Overall A&E Activity has shown annual increases of between 2% and 4%. NHS Knowsley CCG saw a decrease between 2010/11 and 2011/12 before following a similar pattern to other CCGs.

All CCGs have seen a reduction or slowing of the upward trend in A&E attendances over the past year.

The majority of the growth in A&E attendances has been through self referrals with category 1 or 2 treatment (for example minor dressings, wound closure, tetanus course) , more of these attendances have been discharged without follow up treatment resulting in a decreasing conversion rate.

Note - These figures exclude MIU and WIC activity which would reduce the overall conversion rate.





(Note: the graphs here show a 4 quarter moving average to remove seasonality from the overall trend)

Change over time in specialties

To better understand shifts in specialty level activity and cost, specialties have been re-mapped across all years based on a set of standard rules to minimise the impact of changes in coding practice.

This standardisation includes:

• Initial mapping of treatment function codes (TFC's) to more general specialties (for example Gastroenterology initially mapped to general medicine)

• Standard mapping of children's surgery to paediatric surgical specialties (for example Paediatric ENT rather than ENT where age is under 18)

• Mapping of births to Neonatology and well babies

• Re-mapping of all treatment function codes originally mapped to general medicine based on HRGs (for example re-mapping to gastroenterology specialty for all digestive, hepatobiliary, pancreatic system HRGs)

Change over time in non-elective specialties

The largest overall non-elective cost increases in individual specialties have been seen in Respiratory Medicine and General Medicine, with approximately £3 million growth in spend across the four CCGs between 2011/12 and 2013/14.

Breaking down activity by age, the major components of this growth in activity are seen in the older age bands, particularly amongst the over 65's.

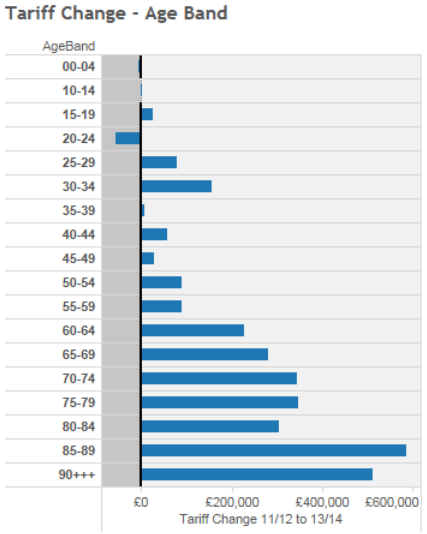
Elective inpatient growth has been seen primarily in the Trauma and Orthopaedics specialty, also driven by older age groups.

Note: growth in Urology activity in the above may be due to re-coding not accounted for in re-mapping of specialties.

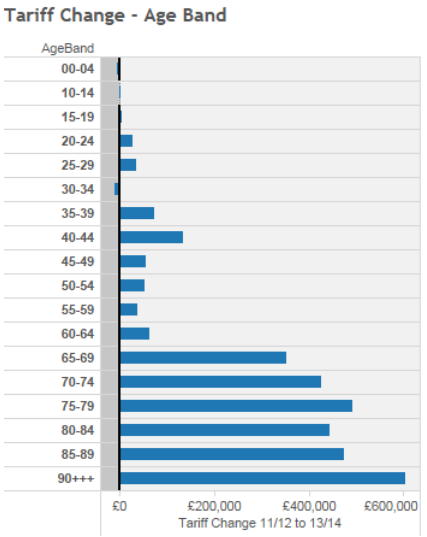
Tariff Change - Specialty

SpecialtyRemapped	Tariff Change 11/12 to 13/14	Percent Change
Respiratory Medicine	£3,267,859	25%
General Medicine	£3,072,840	12%
Urology	£899,347	75%
General Surgery	£703,293	4%
Paediatric Medicine	£597,011	7%
Stroke Medicine	£533,949	15%

General medicine by age



Respiratory medicine by age



Change over time in respiratory medicine

HRG level shifts in non-elective respiratory medicine show the largest increase in pneumonia, which has also seen the largest cost increase across all non-elective activity.

At the other end of the scale there are also corresponding decreases against lower complexity COPD HRGs, which may supports the local observation that changes in coding practice may also be having an impact on shifts between conditions, and that this may not all be natural demand. We can only infer this theory based on the activity data – a case note audit for patients would yield more information on this.

Tariff Change - HRG

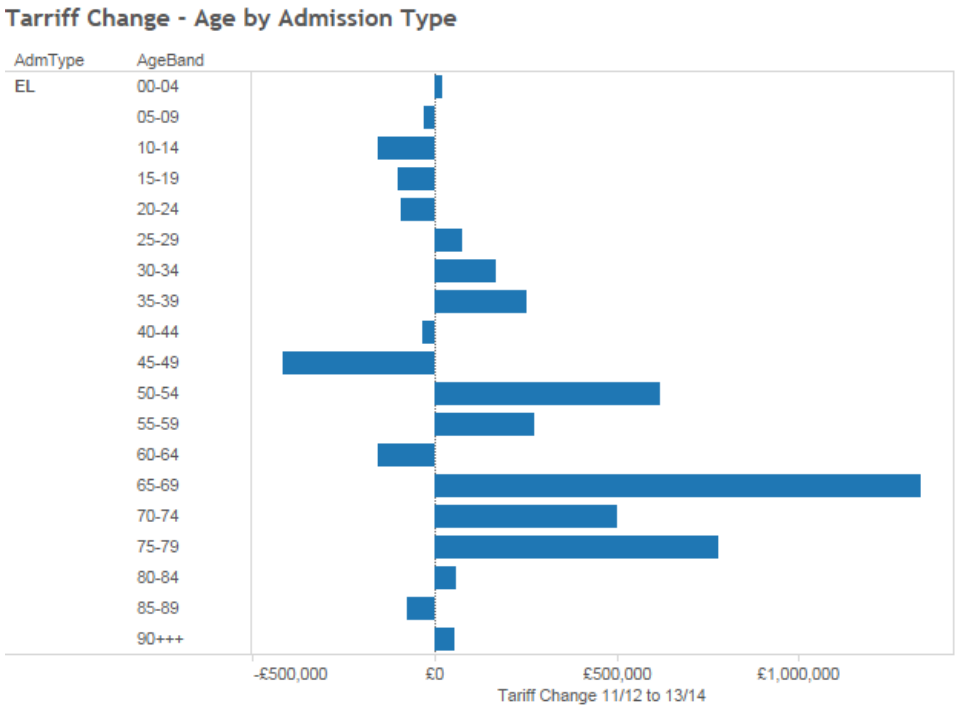
HRG2Description	Tariff Change 11/12 to 13/14	Tariff Percent Change 11/12 to 13/14
DZ11A Lobar, Atypical or Viral Pneumonia with Major CC	£1,831,362	46%
DZ24A Inhalation Lung Injury or Foreign Body with Major CC	£246,496	74%
DZ21H Chronic Obstructive Pulmonary Disease or Bronchitis without..	£185,843	12%
DZ03A Major Thoracic Procedures with CC	£168,359	65%
DZ22A Unspecified Acute Lower Respiratory Infection with Major CC	£148,181	27%
DZ09A Pulmonary Embolus with Major CC	£90,284	37%
DZ11B Lobar, Atypical or Viral Pneumonia with CC	£65,291	9%
DZ07A Fibre optic Bronchoscopy 19 years and over	-£16,869	-7%
LB13A Bladder Major Endoscopic Procedure with CC	-£17,057	-100%
JC03A Major Skin Procedures category 1 with Major CC	-£17,356	-75%
DZ20Z Pulmonary Oedema	-£22,793	-44%
DZ27D Respiratory Failure without Intubation with Major CC	-£22,951	-12%
EB03I Heart Failure or Shock without CC	-£22,999	-49%
DZ21K Chronic Obstructive Pulmonary Disease or Bronchitis without..	-£23,651	-20%
DZ21F Chronic Obstructive Pulmonary Disease or Bronchitis with NI..	-£24,984	-51%
DZ21J Chronic Obstructive Pulmonary Disease or Bronchitis without ..	-£42,029	-4%
DZ23A Bronchopneumonia with Major CC	-£51,969	-46%
DZ16A Pleural Effusion with Major CC	-£61,824	-12%

Change over time in age groups

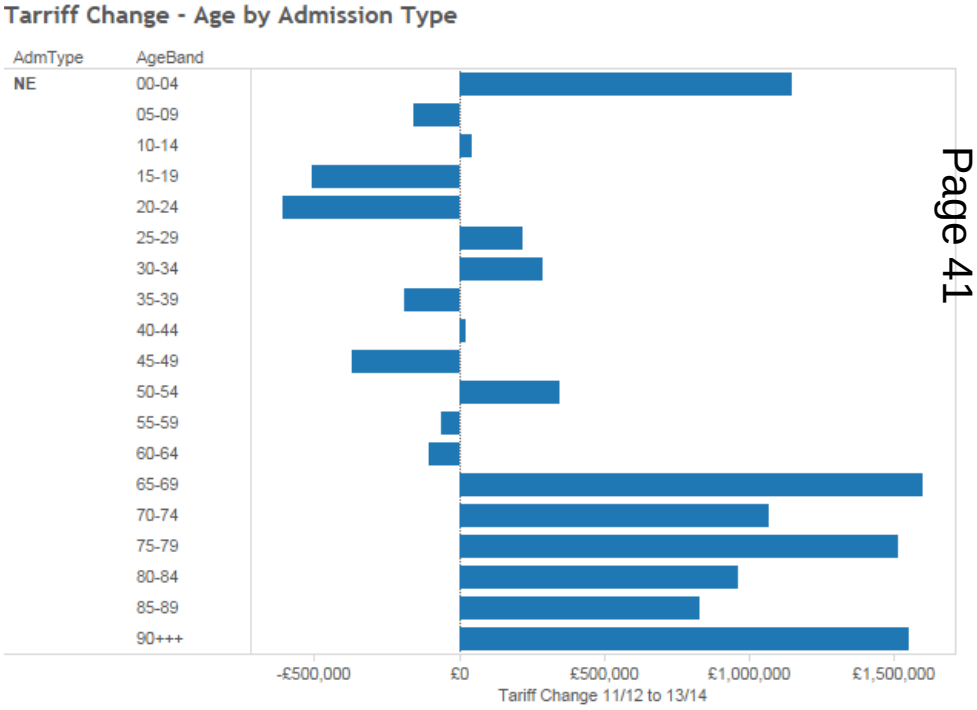
Overall the largest growth has been seen in the over 65 age group as seen in the general and respiratory medicine trends.

There have also been larger increases in neonatal activity, particularly provided by St Helens and Knowsley Hospitals NHS Trust and Alder Hey Children's NHS Foundation Trust, Warrington and Halton Hospitals NHS Foundation Trust does not contribute to this growth. On further investigation the non-elective neonatal spend is not commensurate with activity for these providers, but particularly for Alder Hey where a flat rate of activity has seen a 15% increase in the standardised tariff spend – this may be a result of changes in case mix due to the specialist status of the Trust.

Elective inpatient

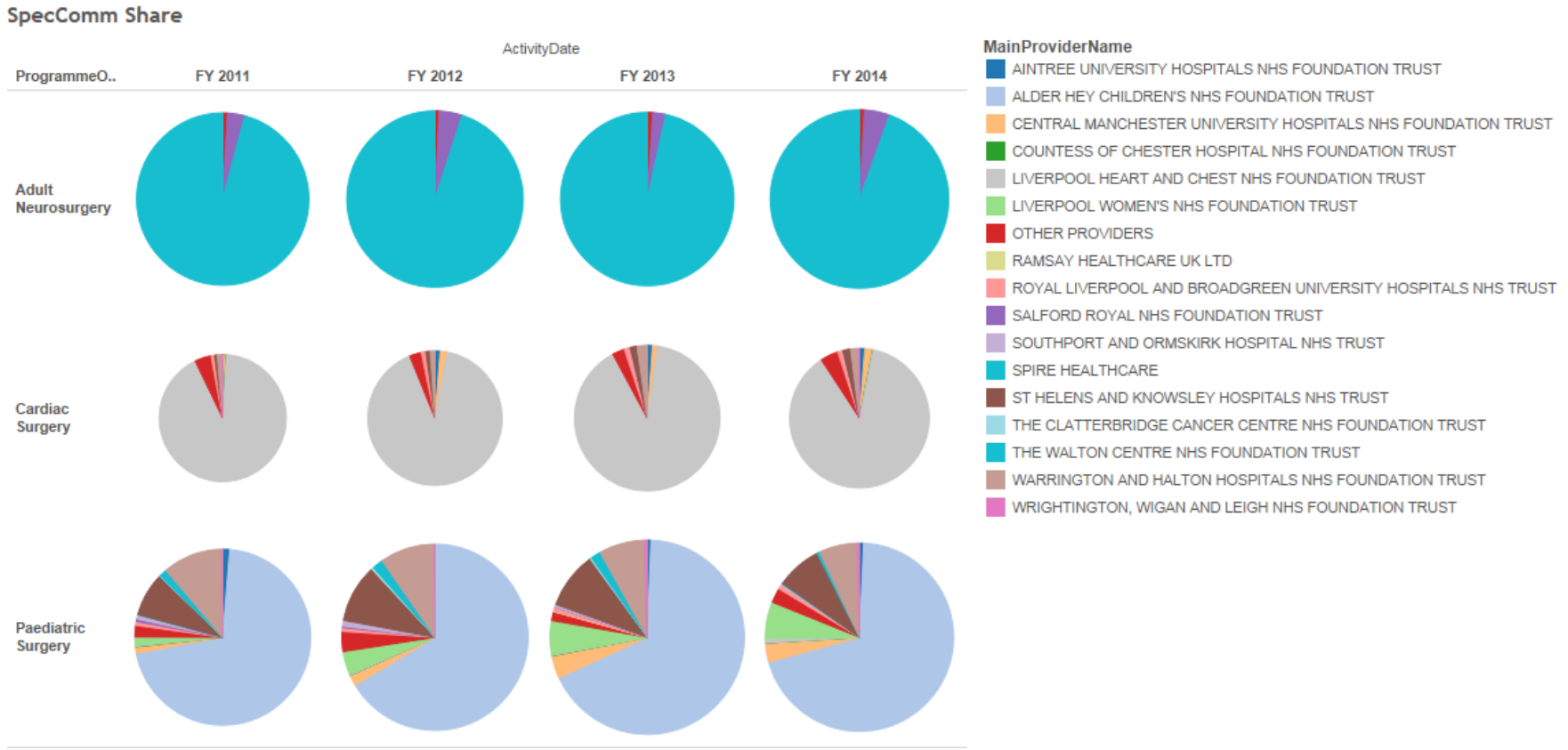


Non-elective inpatient



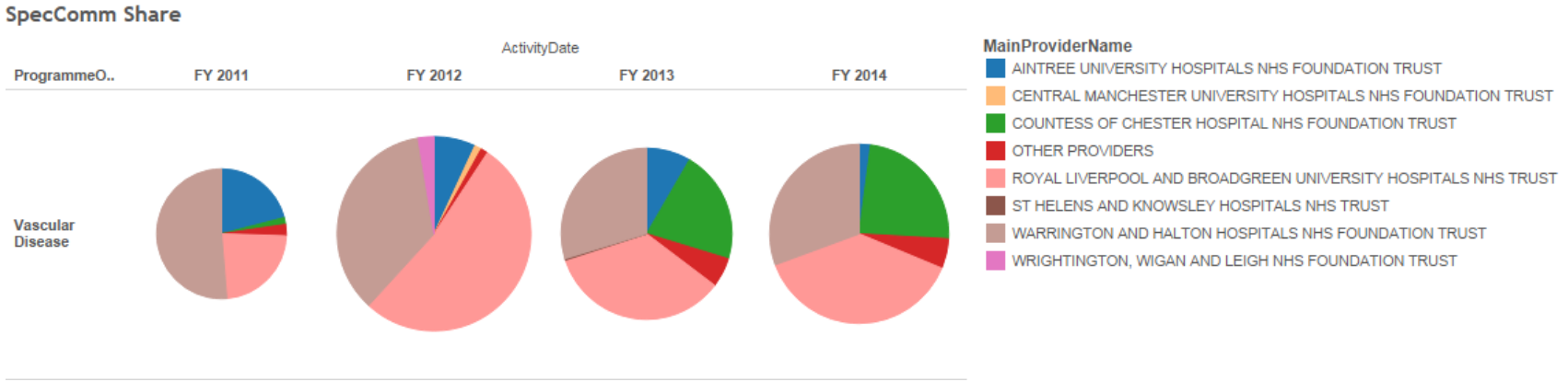
Change over time in specialised commissioning

Historic specialist activity has been grouped to programmes of care using the 2013/14 prescribed services grouper to give a more standardised trend over time. The higher spend areas of Adult Neurosurgery, Cardiac Surgery and Paediatric Surgery are shown below with share of activity by provider – these areas have remained broadly consistent in terms of activity and share over the historic period, demonstrating no major shifts in provider flow.

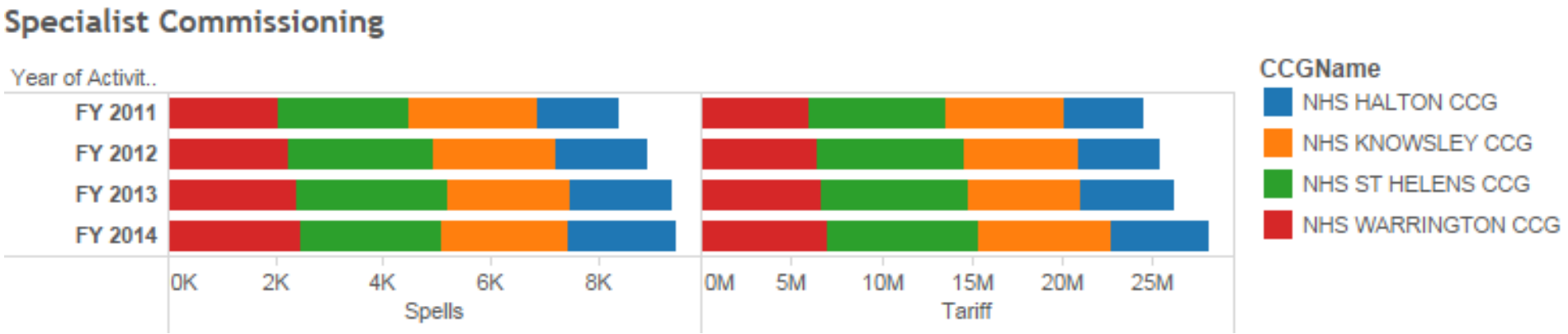


Change over time in specialised commissioning

The only specialty to have seen significant change in activity patterns is vascular surgery, reflecting the reconfiguration of vascular services across Cheshire and Merseyside, where service delivery had been consolidated at the Countess of Chester Hospital and Royal Liverpool and Broadgreen Hospitals.



Taking a standardised view of specialist commissioning (pre-applying current classifications and disregarding organisational changes) the overall spend shows only small growth of approximately 4% per year over the last three years. This is not vastly out of line with other Acute growth.



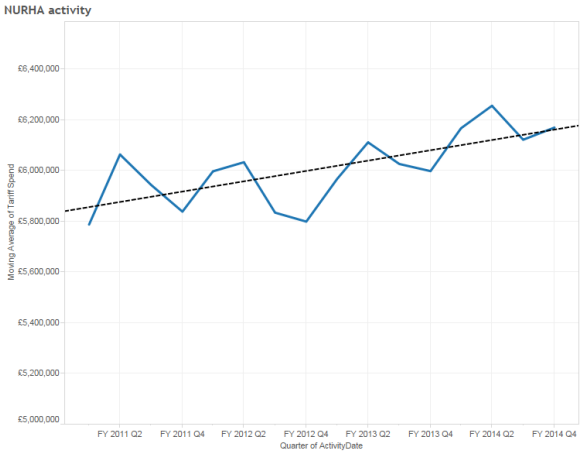
Changes over time in key patient cohorts

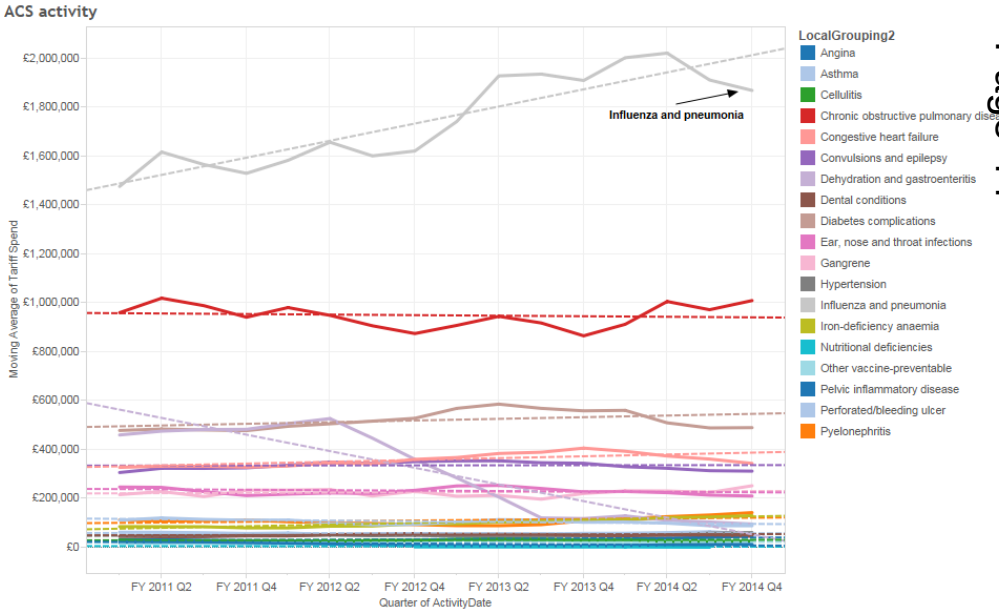
We have investigated the change in activity and bed days in key patient cohorts – these include potentially avoidable emergency admissions (based on NURHA and ACS conditions) as well as bed days for areas where length of stay may be extended, including for elderly patients and those with a secondary diagnosis of dementia.

Emergency admissions for conditions that should not usually require hospital admission have shown an overall increasing trend, essentially growing at a rate comparable with population growth, and being driven by increases in UTI and influenza and pneumonia.

Bed days for the elderly (over 75s) have also shown an increasing trend, with some signs of a flattening trend over recent quarters. The largest increases have been seen in the 90+ age group.

Bed days for those with Dementia have slightly increasing trend overall, with the largest component of this growth driven by increases in St Helens and Warrington CCGs but with decreases in Halton CCG.

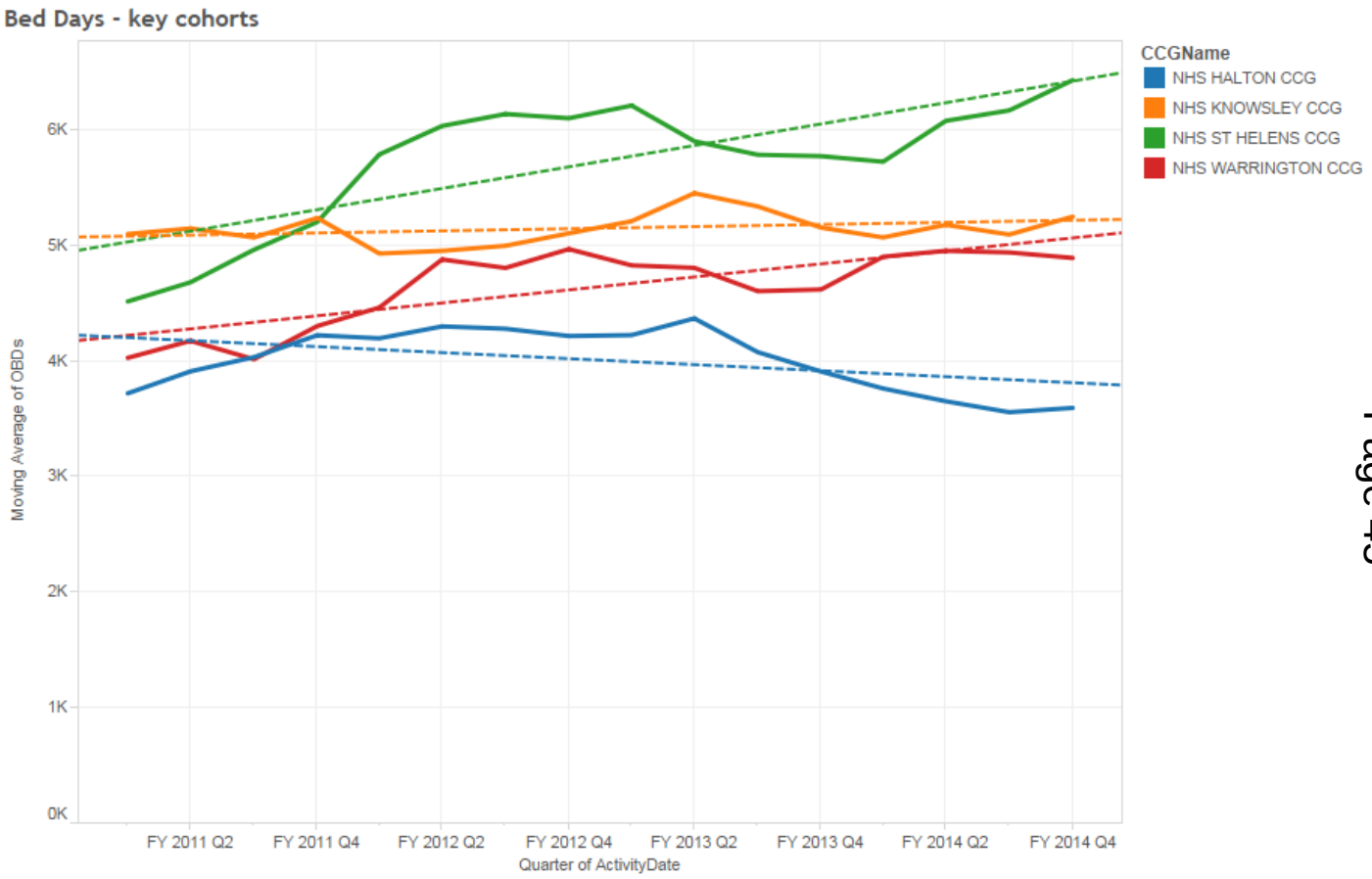




Changes over time in key patient cohorts – dementia bed days

This graph shows a moving average of bed days per quarter for patients with dementia.

Halton CCG exhibit a negative trend in contrast to the growth seen in other CCGs and it would be worth investigating whether there has been any change in approach between CCGs in this area.



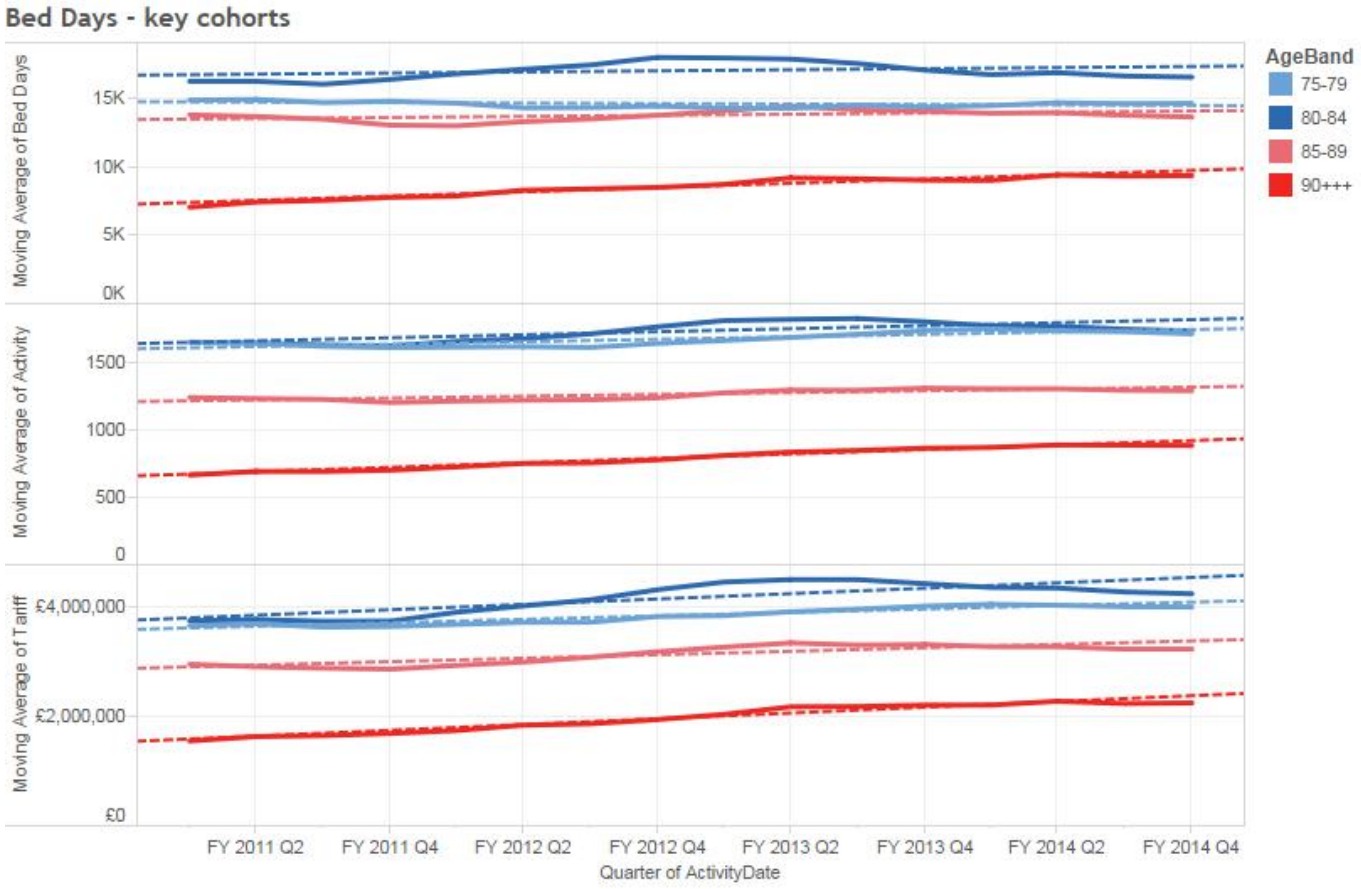
Changes over time in key patient cohorts – over 75's non elective

This chart shows a moving average of the different age bands over the age of 75 against emergency spells, bed days, and tariff.

All show an increasing trend, but potential a slowing over recent quarters.

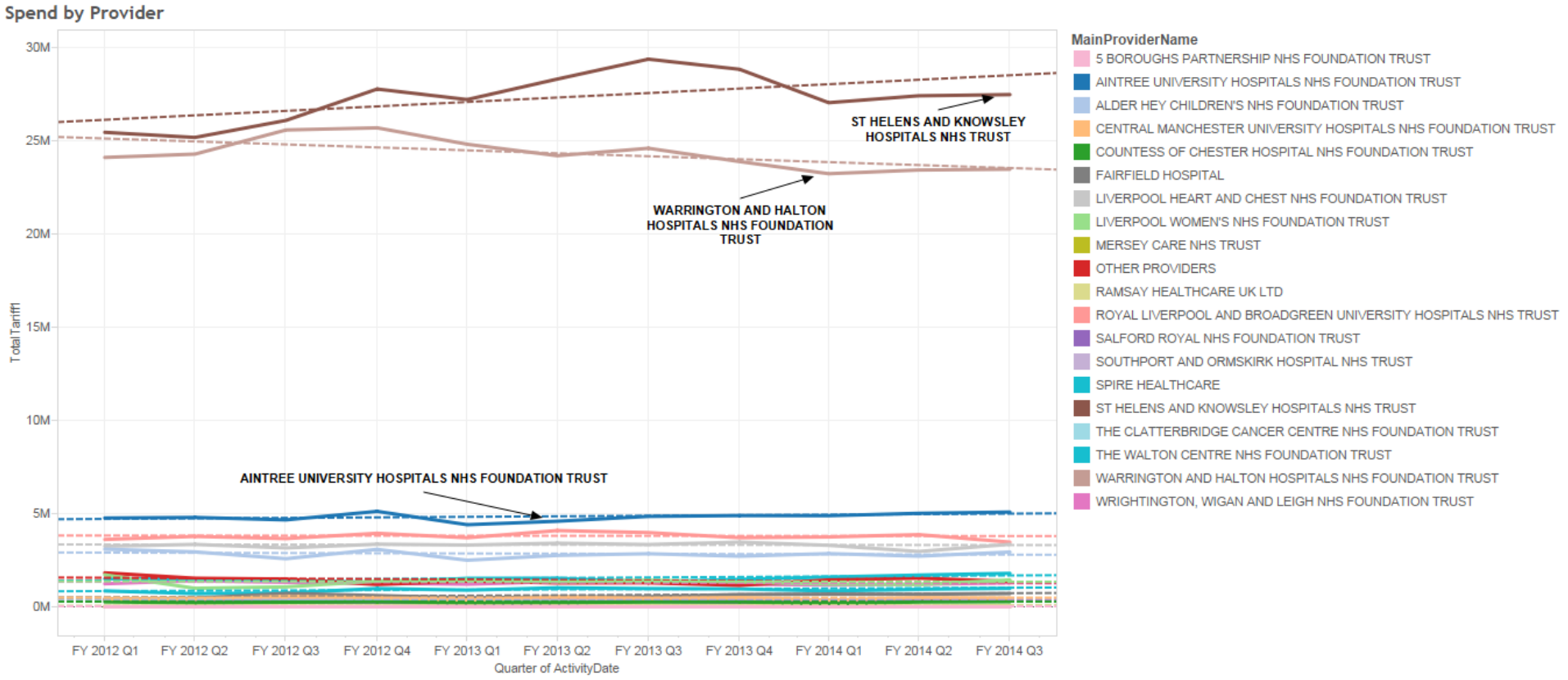
The over 90 age group shows the largest increase over time with around 10% per annum growth in tariff.

There is a higher overall increase in tariff than activity, and a smaller bed day increase. This evidences the increased complexity and decreasing average length of stay for this cohort over time.



Changes over time in provider activity and spend

Looking at a high level trend in provider spend in admitted patient activity shows a difference between St Helens and Knowsley Hospitals Trust and Warrington and Halton Hospitals Foundation Trust in terms of overall admitted patient spend. The high level trend illustrates an increase for St Helens and Knowsley, although a decreasing trend for Warrington and Halton. The increasing trend for St Helens and Knowsley is primarily driven by increases in non-elective spend, approximately 50% of this is driven by increases in activity and the remainder through changes in casemix or coding.



Changes over time in provider activity and spend

The tables here show the change in tariff spend at St Helens and Knowsley NHS Trust and Warrington and Halton NHS Foundation Trust, split by feeding CCG.

At St Helens and Knowsley, both elective and non-elective spend has risen across all CCGs.

Warrington and Halton NHS Foundation Trust has generally shown reductions in non elective spend, with a small increase for Warrington CCG. Elective spend at this provider has increased for both Halton and Warrington CCGs, with a small reduction in spend for Knowsley and St Helens.

Non elective Spend - St Helens and Knowsley NHS Trust

CCG	2010/11	2011/12	2012/13	2013/14	Change 2010/11 to 2013/14	
					Additional Annual Spend	Percent Change
NHS HALTON CCG	£10,599,447	£11,232,789	£13,096,303	£13,096,479	£ 2,497,032	24%
NHS KNOWSLEY CCG	£18,326,237	£17,988,987	£20,909,650	£21,814,252	£ 3,488,015	19%
NHS ST HELENS CCG	£30,527,251	£31,439,711	£34,666,642	£33,642,406	£ 3,115,155	10%
NHS WARRINGTON CCG	£ 508,970	£ 574,121	£ 829,230	£ 864,555	£ 355,585	70%

Elective Spend - St Helens and Knowsley NHS Trust

CCG	2010/11	2011/12	2012/13	2013/14	Change 2010/11 to 2013/14	
					Additional Annual Spend	Percent Change
NHS HALTON CCG	£ 3,623,008	£ 4,174,196	£ 4,469,964	£ 4,767,883	£ 1,144,875	32%
NHS KNOWSLEY CCG	£ 6,748,261	£ 7,356,146	£ 7,691,397	£ 8,257,903	£ 1,509,642	22%
NHS ST HELENS CCG	£15,409,357	£16,986,001	£17,679,406	£19,166,807	£ 3,757,449	24%
NHS WARRINGTON CCG	£ 868,437	£ 794,095	£ 987,812	£ 1,050,724	£ 182,287	21%

Non elective Spend - Warrington and Halton Hospitals NHS Foundation Trust

`	2010/11	2011/12	2012/13	2013/14	Change 2010/11 to 2013/14	
					Additional Annual Spend	Percent Change
NHS HALTON CCG	£14,737,124	£14,401,451	£13,923,709	£13,639,336	-£ 1,097,788	-7%
NHS KNOWSLEY CCG	£ 199,739	£ 278,162	£ 309,541	£ 151,960	-£ 47,779	-24%
NHS ST HELENS CCG	£ 5,407,645	£ 5,461,510	£ 5,214,667	£ 4,799,294	-£ 608,351	-11%
NHS WARRINGTON CCG	£36,313,972	£37,551,694	£39,054,756	£37,250,990	£ 937,018	3%

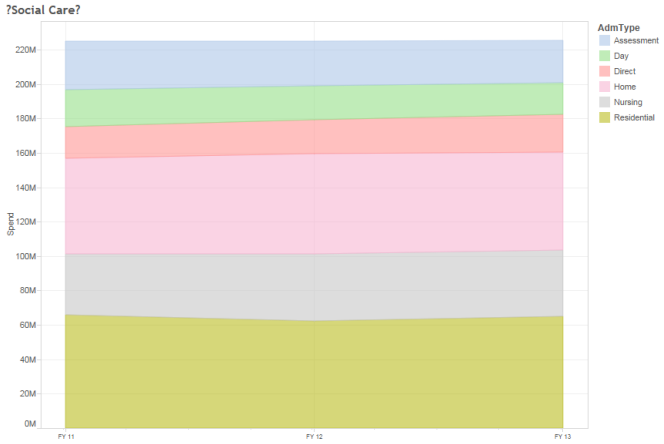
Elective Spend - Warrington and Halton Hospitals NHS Foundation Trust

CCG	2010/11	2011/12	2012/13	2013/14	Change 2010/11 to 2013/14	
					Additional Annual Spend	Percent Change
NHS HALTON CCG	£ 8,157,385	£ 8,866,713	£ 8,934,208	£10,356,601	£ 2,199,216	27%
NHS KNOWSLEY CCG	£ 230,720	£ 230,317	£ 173,739	£ 204,558	-£ 26,162	-11%
NHS ST HELENS CCG	£ 1,895,056	£ 2,115,517	£ 1,798,438	£ 1,591,910	-£ 303,146	-16%
NHS WARRINGTON CCG	£15,173,276	£17,775,089	£19,139,970	£19,473,749	£ 4,300,473	28%

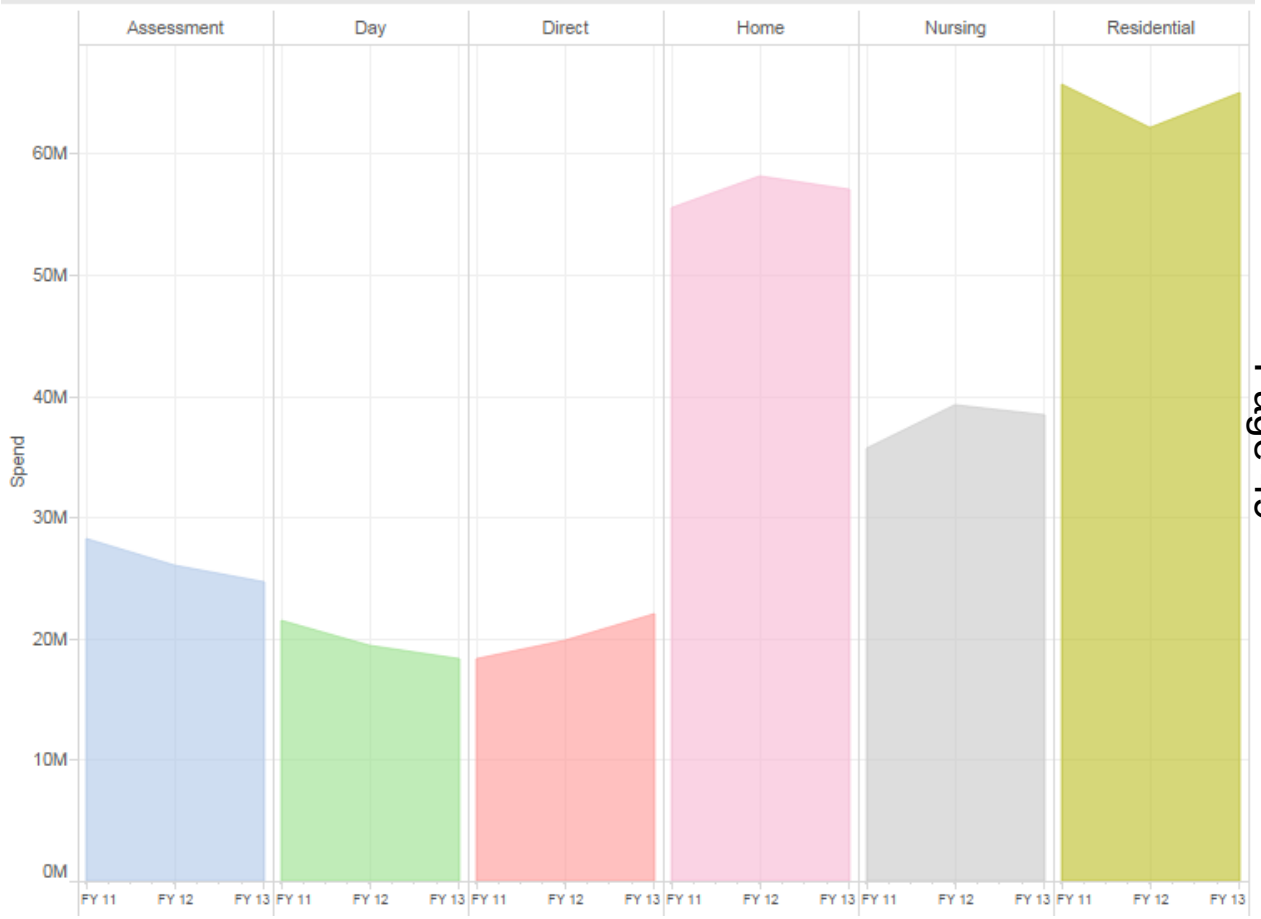
Changes over time in social care spend

Overall total spend on assessments, direct payments, day, home, nursing and residential care has remained consistent between 2010/11 and 2012/13, though there are significant variations between modes of care and within each area. Spend on assessments and day care have reduced overall, with increases in direct payments, home and nursing care. The downward trend in assessments is interesting and warrants further investigation into the cause in order to understand whether this impacts elsewhere in the system.

Social Care Spend by setting



Social Care Spend by setting

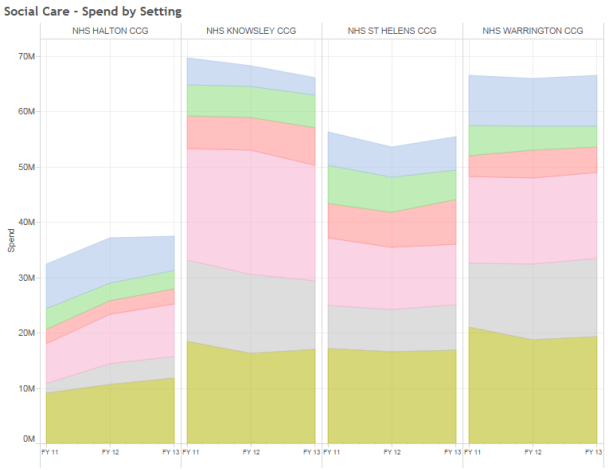


Changes over time in social care spend

Looking at social care spend by area generally shows a decreasing or flat spend, with trends in line with the general policy towards increases in home based and reductions in institutional care.

Conversely, Halton shows an increase in home, residential care, as well as nursing care, although spends a proportionally lower amount on nursing care than the other boroughs.

Knowsley spends a relatively high proportion on home care, but still has higher numbers of permanent admissions to permanent residential care than peer, region and national average (source: Adult Social Care Outcome Framework 2012/13).



CAPITA

Current baseline

Profile of current activity, spend and patient flows

Key Findings - current activity, spend and patient flows

Purpose of this section

We have applied similar principles as to the historic analysis to 2013/14 activity to date to profile current activity, spend and patient flows in order to present a picture of current activity using 2013/14 organisational structure and coding. We provide a statement of the baseline position as well as comparisons of current activity levels between practices and between CCGs to understand variation in the baseline.

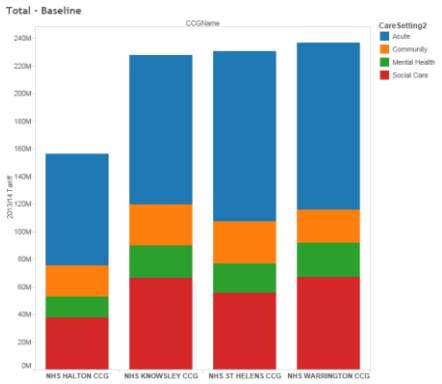
Main Findings

- There is a large scale of variation between practices in terms of admission rates, attendance rates and outpatient performance, even after adjusting for populations an weighting for healthcare need.
- The degree of variation increases the smaller the practice is, which suggests that federated general practice at scale is a factor in reducing variation and spend, which may also result in improved outcomes.
- There is a similar level of overall acute spend per head between the CCGs, combined with larger variation in non-acute spend per head, this may indicate that the level of acute activity is either true patient demand (i.e. there is a level of acute activity that goes into hospital regardless of what is commissioned elsewhere) or that this is led by the providers capacity to accommodate demand (supply led demand).
- With some exceptions the patient flow from practice to provider follows a natural pattern, with limited opportunity for repatriation from Liverpool or Manchester.
- Working up analysis alongside local knowledge suggests that practices that have a focus on health and wellbeing and integrated care benefit from a reduced demand for acute services. Lower admission rates were highlighted for particular practices where there has been a recognised long term focus on health improvement and prevention.

Statement of Baseline position

The baseline position within the scope of this analysis is based on 2013/14 activity (projected – see methodology) and is made up of £404M acute tariff, 193M spend between community and mental health, and £225M spend in key social care areas.

This baseline forms the basis of the forward projections.

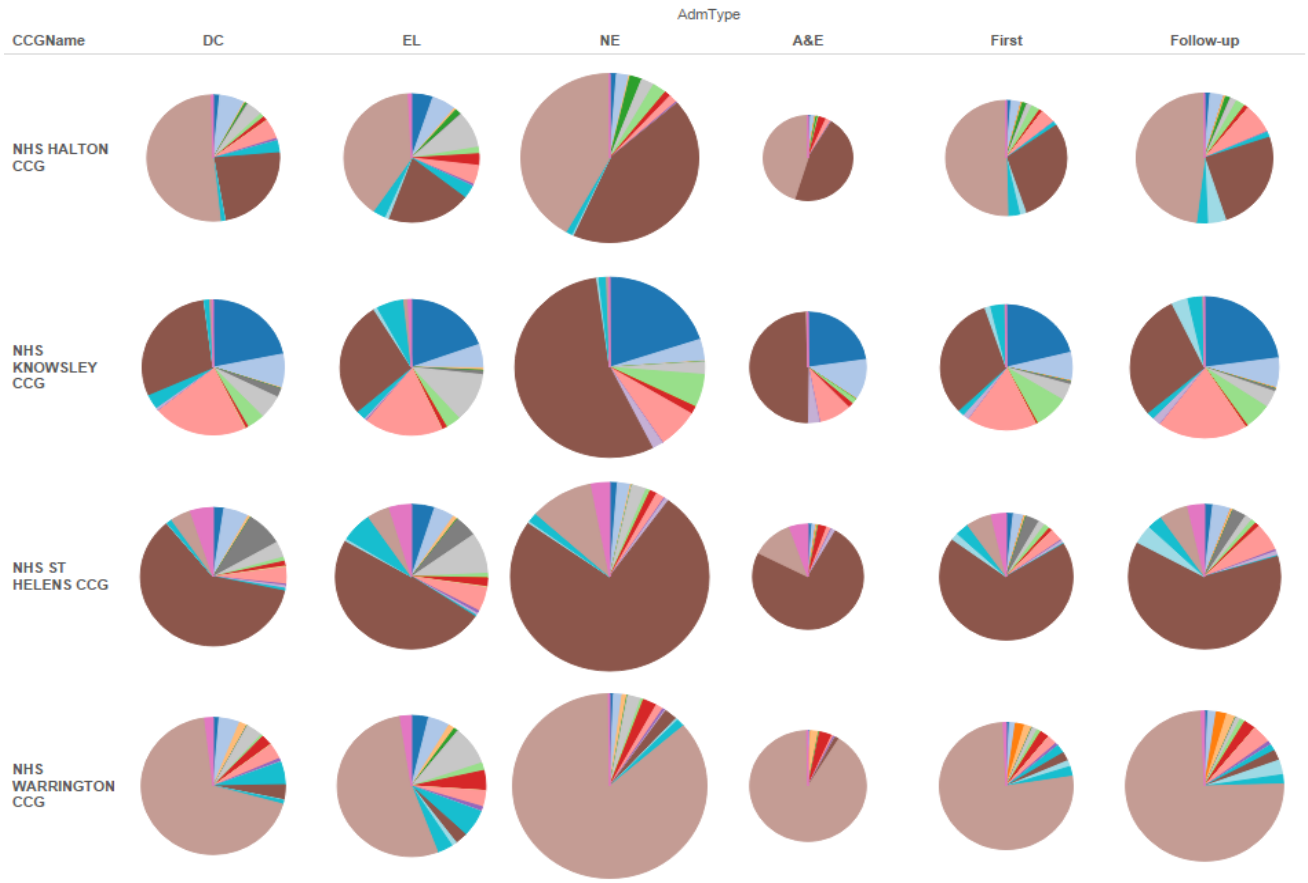


	NHS HALTON CCG	NHS KNOWSLEY CCG	NHS ST HELENS CCG	NHS WARRINGTON CCG	Grand Total
A&E					
Attendances	87,530	117,467	115,990	64,998	**385,985**
Tariff	£ **4,325,324**	£ **6,224,125**	£ **5,422,793**	£ **6,251,392**	£ **22,223,634**
Outpatient					
Attendances	264,755	289,577	319,655	362,077	**1,236,064**
Tariff	£ **17,253,810**	£ **24,388,683**	£ **27,683,107**	£ **23,695,318**	£ **93,020,918**
APC					
Spells	44,800	57,579	62,304	60,523	**225,206**
Bed Days	117,154	149,538	172,196	161,376	**600,264**
Tariff	£ **56,013,713**	£ **71,075,293**	£ **83,453,031**	£ **79,002,541**	£ **289,544,577**
Community					
Spend	£ **22,084,256**	£ **29,128,129**	£ **32,790,430**	£ **22,628,124**	£ **106,630,936**
Mental Health					
Spend	£ **15,609,625**	£ **24,299,852**	£ **21,529,878**	£ **25,609,434**	£ **87,048,789**
Social Care					
Assessment and care management	£ **6,250,000**	£ **3,210,000**	£ **6,031,000**	£ **9,094,000**	£ **24,585,000**
Day Care / Day Services	£ **3,254,000**	£ **5,963,000**	£ **5,262,000**	£ **3,828,000**	£ **18,307,000**
Direct Payments	£ **2,725,000**	£ **6,677,000**	£ **8,069,000**	£ **4,537,000**	£ **22,008,000**
Home care	£ **9,500,000**	£ **20,887,000**	£ **10,962,000**	£ **15,636,000**	£ **56,985,000**
Nursing care placements	£ **3,879,000**	£ **12,397,000**	£ **8,152,000**	£ **13,996,000**	£ **38,424,000**
Residential care placements	£ **11,832,000**	£ **16,996,000**	£ **16,887,000**	£ **19,340,000**	£ **65,055,000**
£ Total	£ **152,726,727**	£ **221,246,082**	£ **226,242,239**	£ **223,617,808**	£ **823,832,857**

Baseline position – Provider share

This chart shows an aggregated view of the share of activity for each provider with each CCG, between day case, elective, non-elective, A&E, outpatient first and follow up. The pattern of provision is as expected given the geographical distribution of practices and illustrates the availability of a range of providers, particularly for Knowsley residents.

Baseline - Provider share by setting and CCG



Current provider landscape

This map illustrates at a high level the flow from each practice to providers in Mid Mersey and the surrounding areas. At a high level the patient flow from practice to provider follows a natural pattern, with limited opportunity for repatriation from the surrounding areas.

It is worth noting that Halton practices north of the Mersey refer 40 / 45% of Elective / Daycase activity to St Helens & Knowsley NHST. An aggressive strategy by either of the two acute trusts to attract this activity for these practices would have a significant impact on the other – for example, if all the activity were to go to Whiston, the impact would be approximately 4000 spells, worth £4m.

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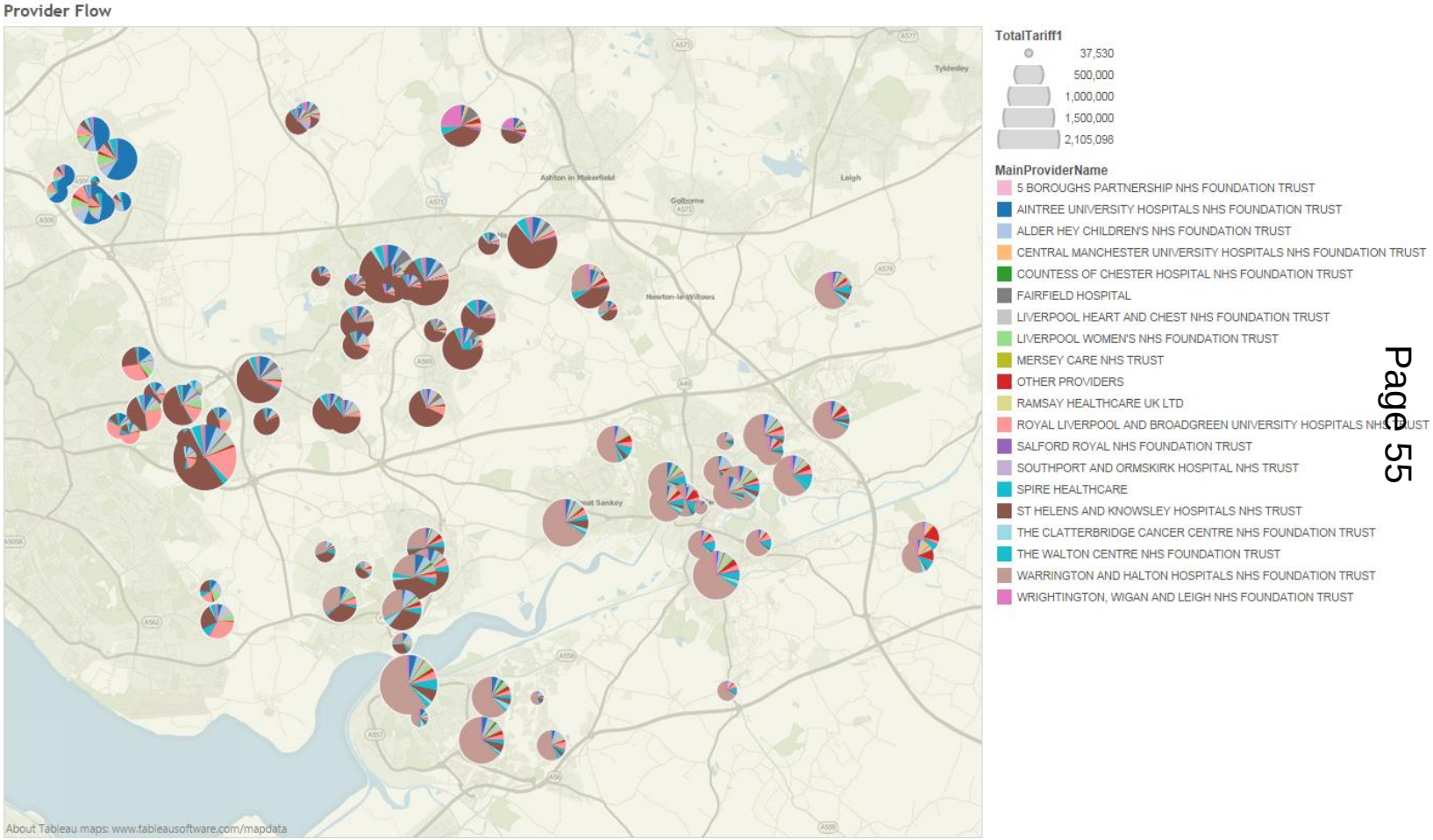
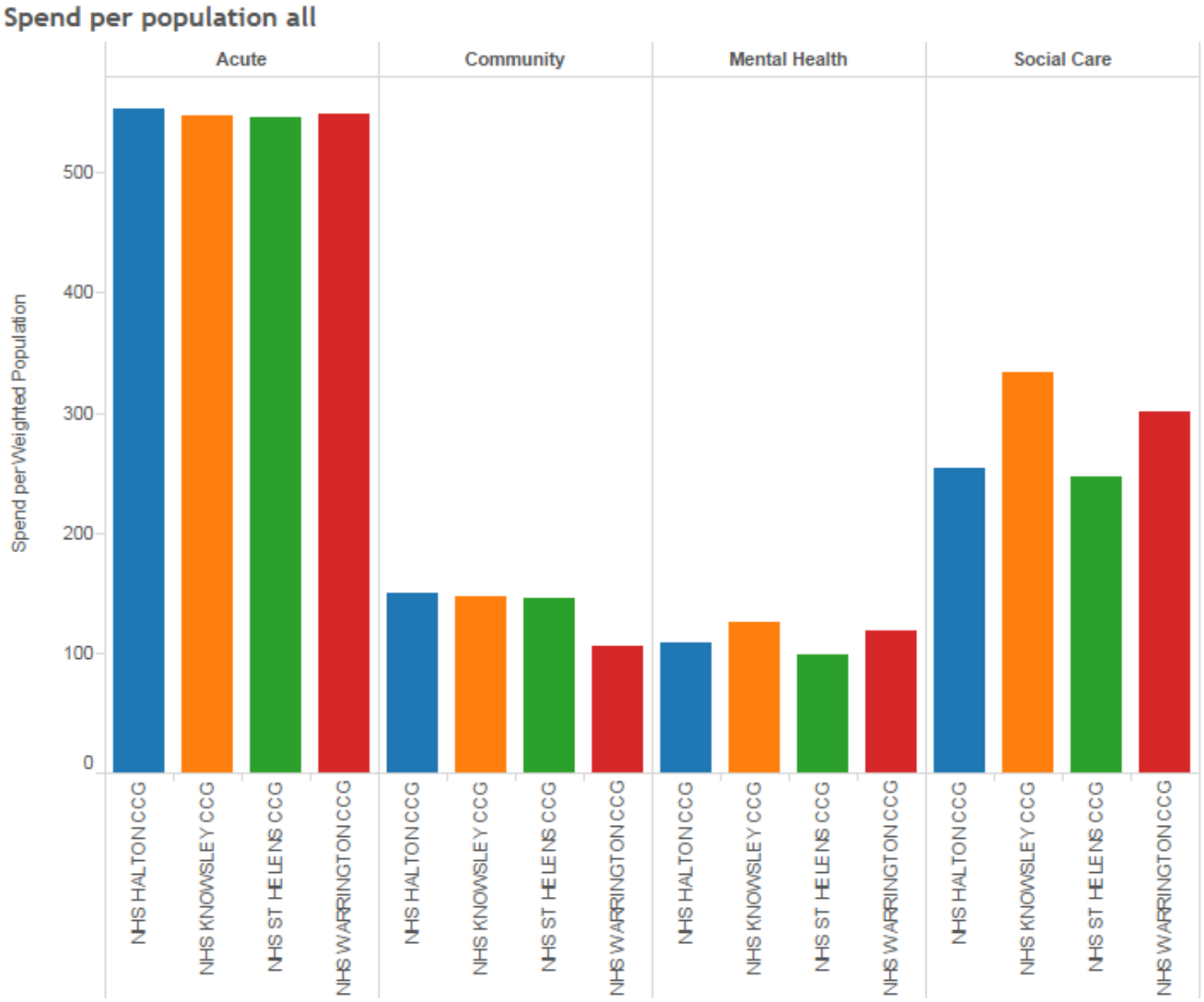


Current cost per head comparisons between CCGs

At an aggregate level the acute spend per population (weighted for age and additional need) is very similar between the four CCGs. There is more variability between the areas in non-acute spend, with a seemingly smaller spend on community health for Warrington CCG, and smaller social care spend for Halton and St Helens boroughs. For Halton this may reflect the priority placed on prevention, with the aim of resulting in lower demand for social care. It would be worth testing this in comparison with the other boroughs.

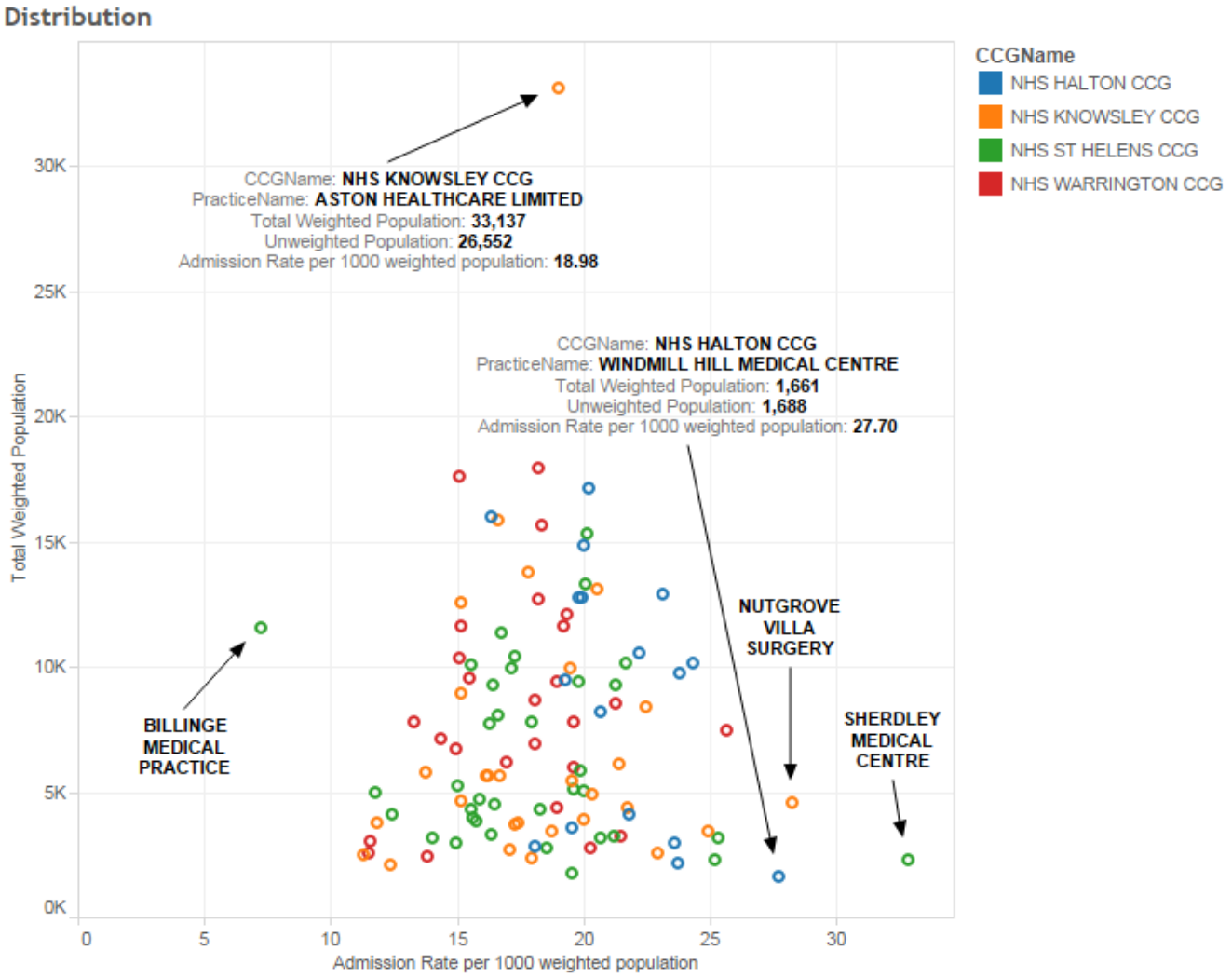
This may indicate that the level of acute activity is either true patient demand (i.e. there is a level of acute activity that goes into hospital regardless of what is commissioned elsewhere) or that this is led by the providers capacity to accommodate demand (supply led demand).



Practice admission rates – avoidable emergency admissions

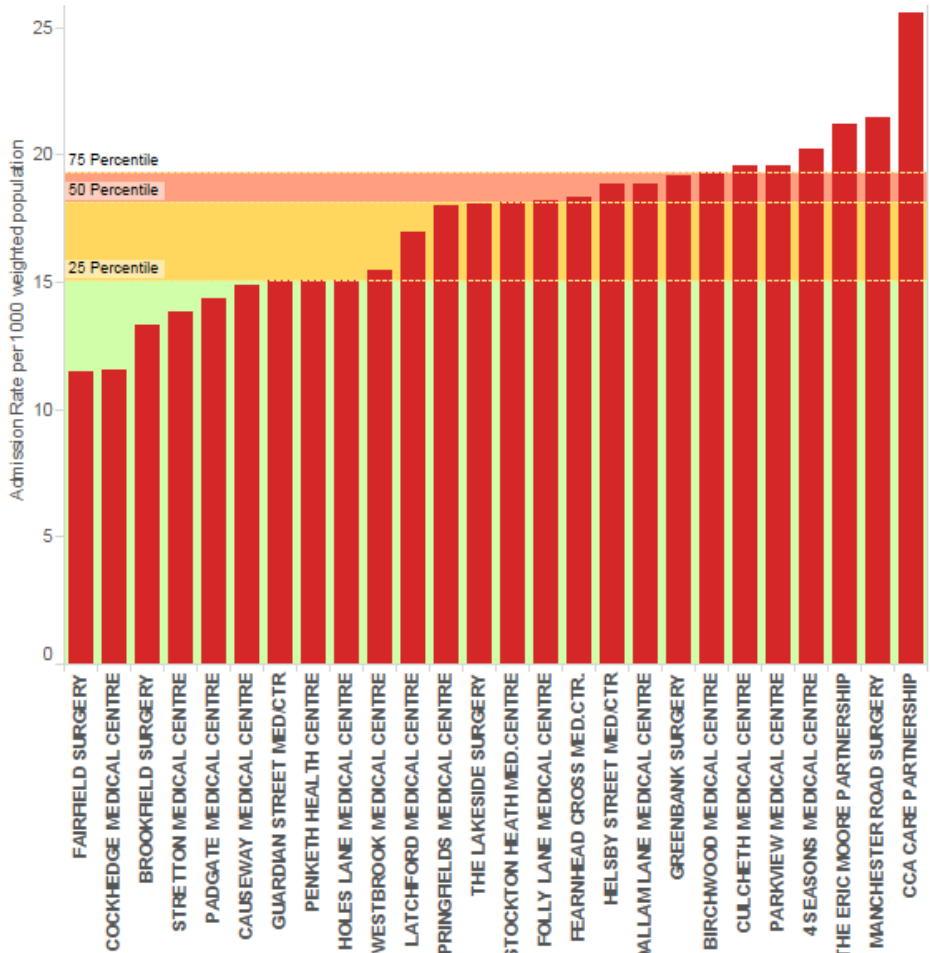
There is more variance between practices and within specific cohorts. This chart shows the distribution of rates of admission for conditions not usually requiring hospital admission (ACS and NURHA). There is more variation in smaller practices, suggesting that scale is a factor in reducing variation.

Specific practice outliers are highlighted, and the next two slides show individual rates for each practice. By CCG.

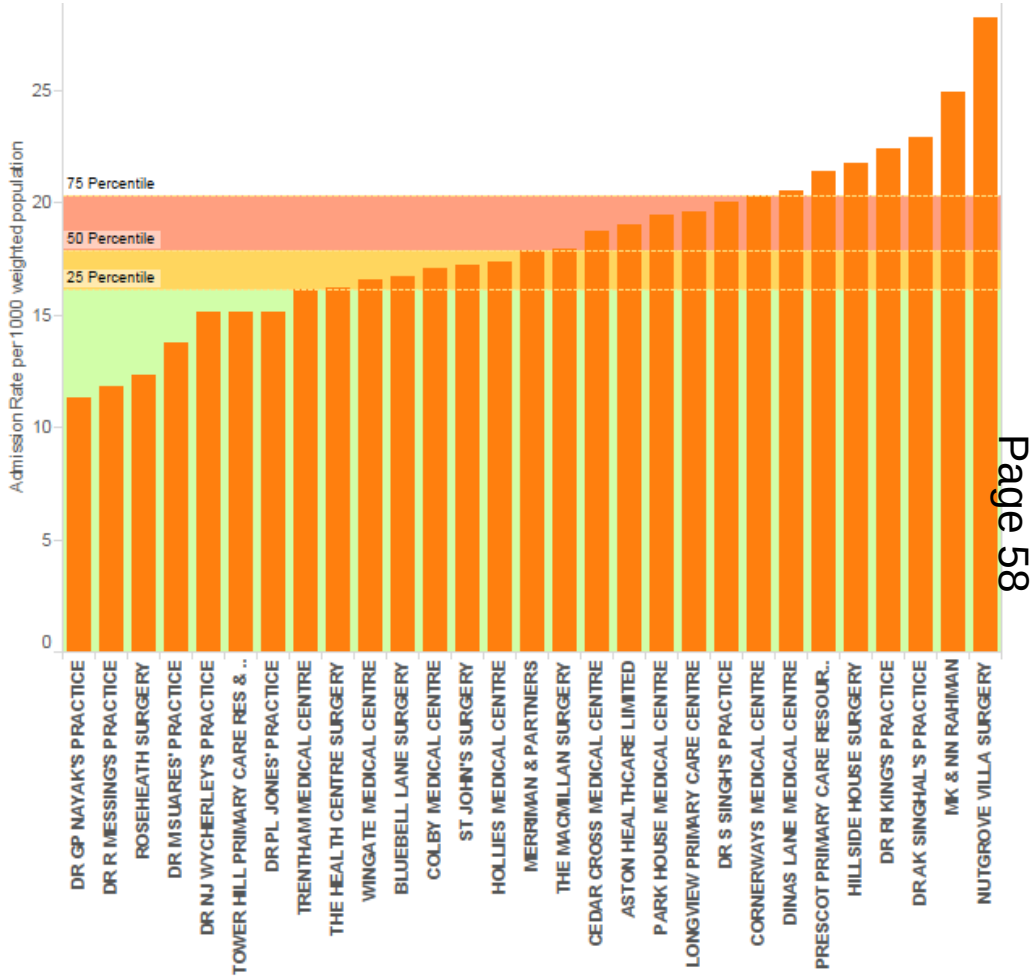


Practice admission rates – avoidable emergency admissions

Warrington CCG

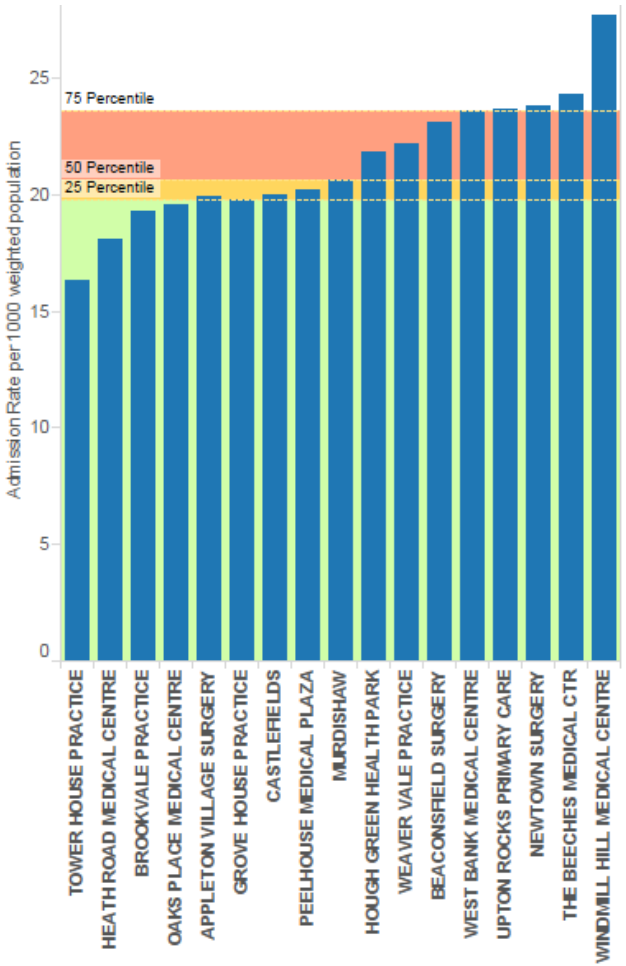


Knowsley CCG

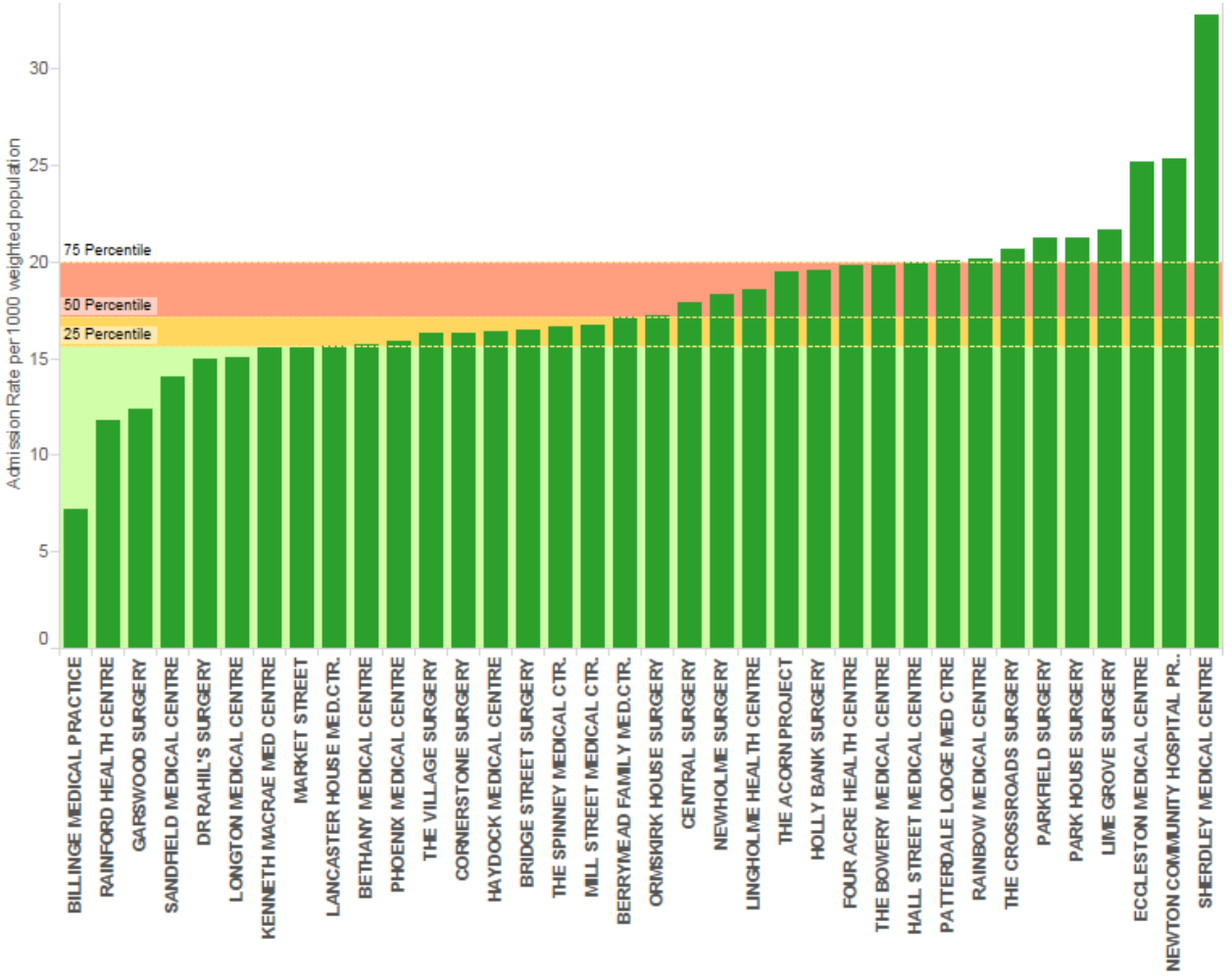


Practice admission rates – avoidable emergency admissions

Halton CCG



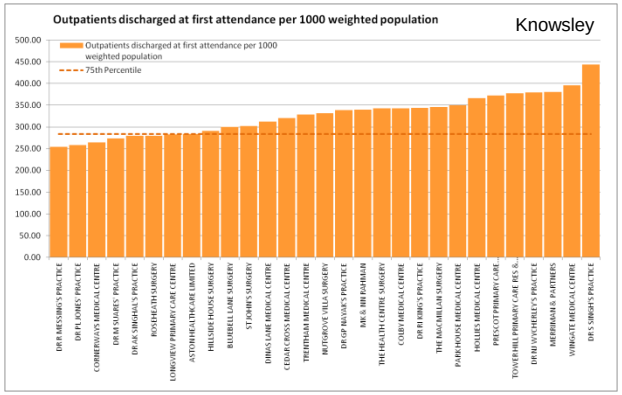
St Helens CCG

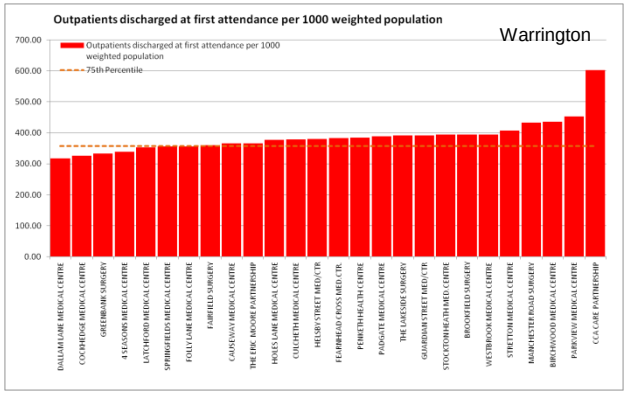


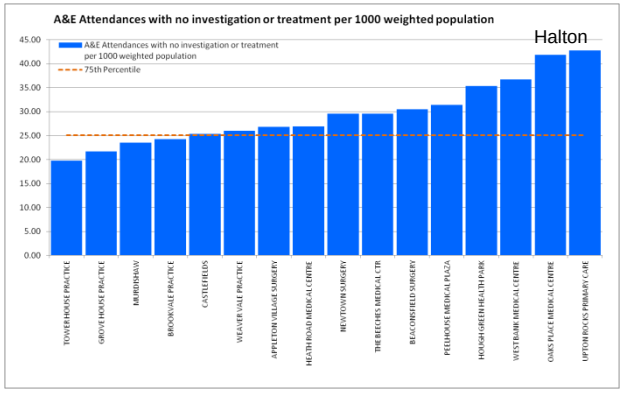
Baseline – Practice variation

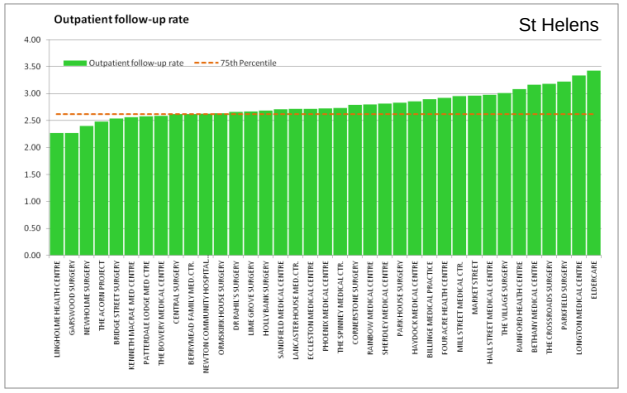
Variation is also apparent in other performance and activity levels across Mid Mersey - understanding this at a practice level has helped to recognise outliers. The challenge is in reducing the bad variation, while preserving the good variation that makes care patient centred. Some specific activity measures we have highlighted where variation between the CCGs may contribute to increased spend and worse outcomes for patients include:

- 50% variance in the average outpatient follow-up rate within a CCG (St Helens Practices)
- Over 90% difference in the rate of outpatients discharged at first attendance (Warrington Practices) - age and additional need weighted.
- 115% difference between the lowest and highest rate of A&E Attendances with no investigation or treatment within a CCG (Halton Practices).









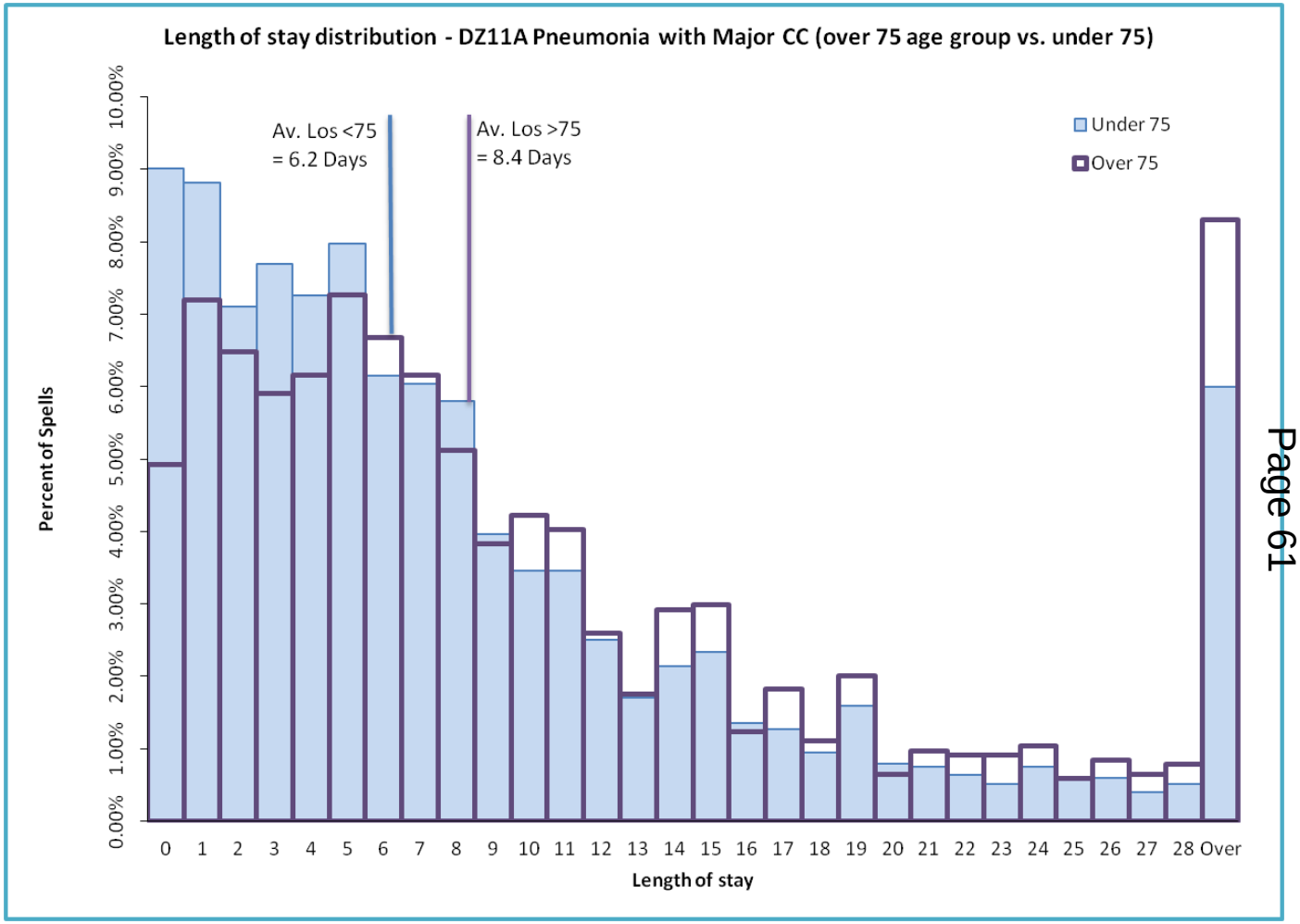
Variation in Length of stay

We have identified variations between the length of stay in acute care for patients with the same medical conditions but with non-medical reasons for an extended length of stay.

This is particularly the case for the elderly. As an example the average length of stay for HRG 'DZ11A Pneumonia with major complications' is 7.4 days. For the over 75's this is 8.4 days compared with 6.2 days for patients under the age of 75.

Similarly, for patients with a secondary diagnosis of dementia the average length of stay is extended. For this HRG, the average length of stay is extended to 8.5 days, compared with 7.3 days for those with no Dementia in any age group.

This variance is also seen when outliers are excluded – a median length of stay shows 6.8 vs. 4.5 days for over and under 75's, and 7.6 vs. 5.7 days when looking at the impact of dementia co morbidities.



CAPITA

Future activity

Forecast profile of activity, spend and patient flows

Key Findings – forecast of activity, spend and patient flows

Purpose of this section

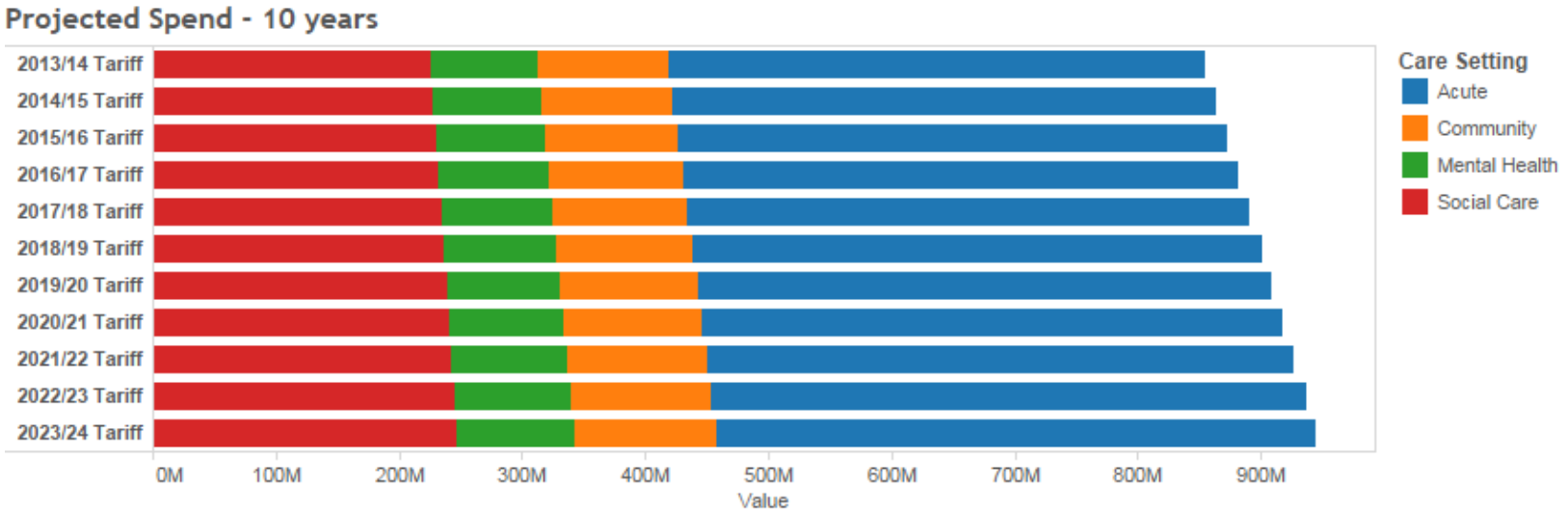
This section provides a projection of future activity, spend and patient flows.
It is made up of the following elements
- The collation and understanding of commissioning intentions and strategic plans.
- The mapping of intentions to specific patient cohorts impacted by the change.
- The modelling of the impacts on future activity, spend and patient flows.

Main Findings

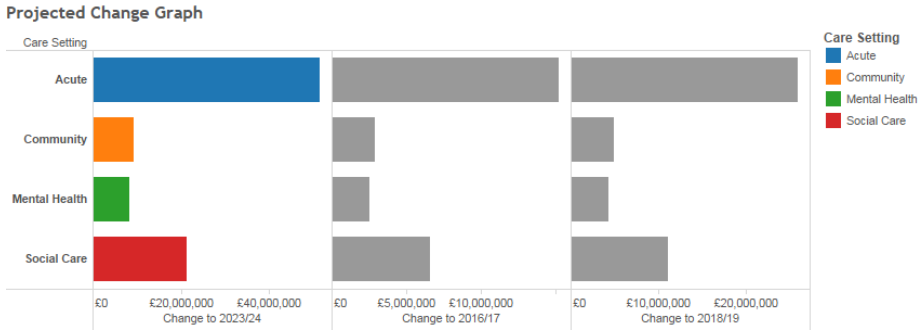
- Grouping of commissioning intentions has shown that by far the biggest area of focus for interventions is for the elderly and those with long term conditions – this is consistent with the areas seen to be growing in the retrospective analysis and provides confidence that the right areas are in focus.
- There appears to be an opportunity to reduce variation by standardising referral thresholds, admission criteria, and pathways for high volume conditions – this would improve the quality of care while managing demand and reducing spend. There is also significant opportunity to reduce variation in length of stay and deal with this demand once in hospital.
- Modelled interventions are projected to keep pace with underlying growth over the next 3 years, after which this underlying demand is projected to overtake the reductions in activity that these initiatives are expected to make.
- Working up analysis alongside local knowledge suggests that practices that have a focus on health and wellbeing and integrated care benefit from a reduced demand for acute services. Public health initiatives and preventative schemes may have an impact over the longer term but would need investment now for longer term benefits to be realised.

‘Do nothing’ scenario – overview

Before understanding the impact of interventions it is important to understand the impact of ‘do nothing’. The projections below illustrates the overall impact on each care setting based on population growth only.



Over 10 years the greatest anticipated increase in spend is seen in the acute care setting, approximately £50M across Mid Mersey CCGs (£15M over three years).



‘Do nothing’ scenario – by CCG and setting

The projected future impact of population growth on Warrington CCG is higher than the other areas, this is seen as the ‘new town’ impact with increases in activity driven by large demographic growth in the older population.

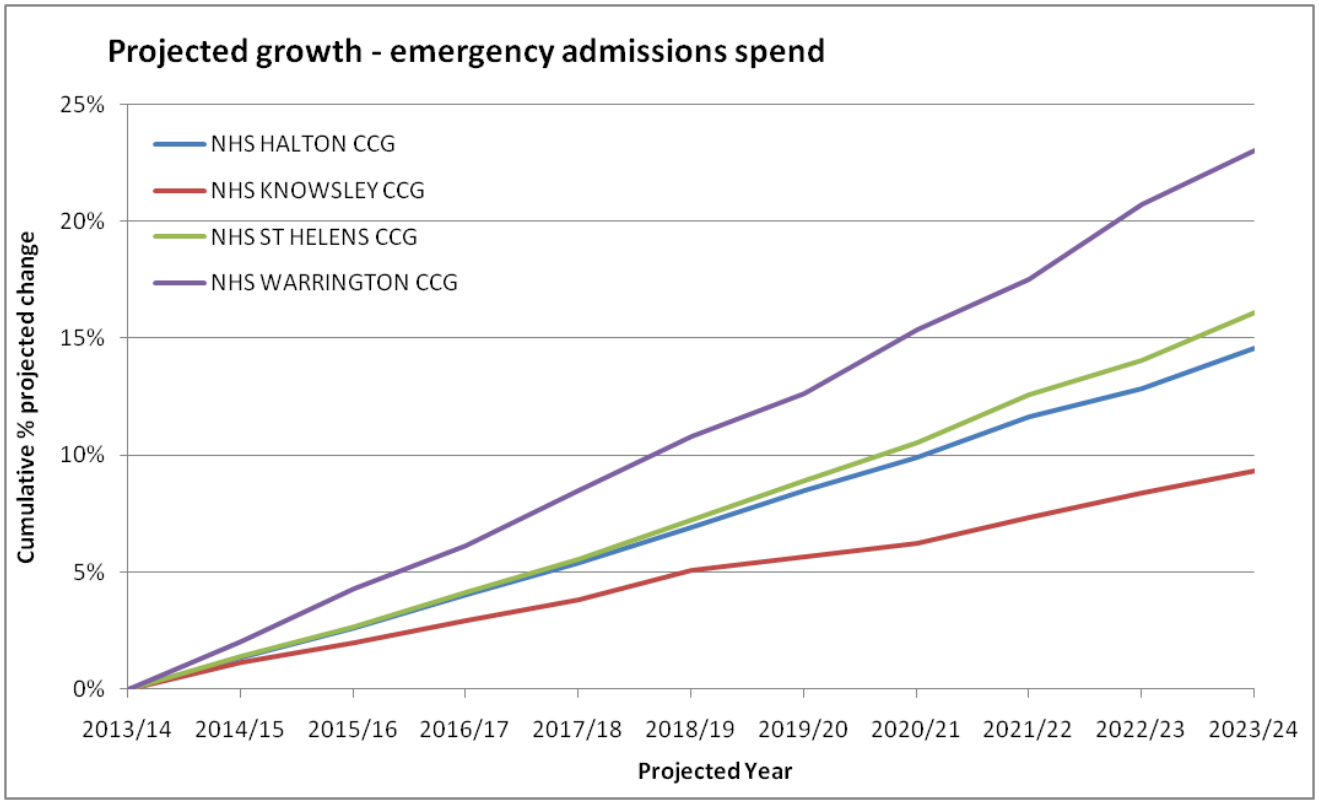
Projected Change

CCGName	Care Setting	Change to 2016/17	Change to 2018/19	Change to 2023/24	Percent Change to 2016/17	Percent Change to 2018/19	Percent change to 2023/24
NHS HALTON CCG	Acute	£2,599,874	£4,234,313	£8,390,681	3.2%	5.2%	10.2%
	Community	£552,733	£885,720	£1,698,086	2.5%	4.0%	7.7%
	Mental Health	£390,670	£625,999	£1,199,833	2.5%	4.0%	7.7%
	Social Care	£937,029	£1,501,472	£2,877,825	2.5%	4.0%	7.7%
NHS KNOWSLEY CCG	Acute	£2,250,291	£4,067,080	£7,297,085	2.1%	3.7%	6.7%
	Community	£432,928	£789,537	£1,379,668	1.5%	2.7%	4.7%
	Mental Health	£361,199	£658,716	£1,151,053	1.5%	2.7%	4.7%
	Social Care	£982,974	£1,792,640	£3,132,494	1.5%	2.7%	4.7%
NHS ST HELENS CCG	Acute	£4,059,763	£6,839,723	£14,128,676	3.3%	5.5%	11.4%
	Community	£815,341	£1,329,879	£2,631,975	2.7%	4.3%	8.6%
	Mental Health	£574,306	£936,721	£1,853,822	2.7%	4.4%	8.6%
	Social Care	£1,479,676	£2,413,425	£4,776,300	2.7%	4.4%	8.6%
NHS WARRINGTON CCG	Acute	£6,354,043	£10,889,935	£21,803,575	5.2%	9.0%	17.9%
	Community	£1,115,576	£1,892,089	£3,727,667	4.8%	8.1%	15.9%
	Mental Health	£1,231,489	£2,087,101	£4,108,997	4.8%	8.1%	15.9%
	Social Care	£3,183,016	£5,394,488	£10,620,848	4.8%	8.1%	15.9%
Grand Total		£27,320,906	£46,338,837	£90,778,585	3.2%	5.4%	10.6%

‘Do nothing’ scenario – projected impact on emergency admissions

The projected future impact of population growth on emergency admissions is shown in the graph below. The highest projected growth is seen at Warrington CCG with a projected increase of 23% over 10 years.

	HALTON	KNOWSLEY	ST HELENS	WARRINGTON
2013/14	0%	0%	0%	0%
2014/15	1%	1%	1%	2%
2015/16	3%	2%	3%	4%
2016/17	4%	3%	4%	6%
2017/18	5%	4%	6%	8%
2018/19	7%	5%	7%	11%
2019/20	9%	6%	9%	13%
2020/21	10%	6%	11%	15%
2021/22	12%	7%	13%	18%
2022/23	13%	8%	14%	21%
2023/24	15%	9%	16%	23%



Summary of interventions

The word cloud below is a summary of all commissioning intentions, interventions and initiatives reviewed as part of the document collection process. In total around 220 different intentions have been collated from a number of different sources across the four CCGs.

Grouping of interventions

As would be expected, these intentions and plans have originated from a number of sources (see appendix), been described in different way at various levels of granularity and overlap in their intended impact. We have translated each into a standard template and mapped individual lines to areas and types of impact

The 220 collated interventions have been filtered based on their likely impact on activity and spend. Interventions have also been grouped to common cohorts, intervention type, and their core impact type. Full details can also be seen in supporting analysis.

CCG
- Halton CCG
- Knowsley CCG
- St Helens CG
- Warrington CCG
- NHS England

Grouping of interventions

A key patient cohort is the elderly and those with long term conditions, this is where the highest number of documented interventions have been mapped to. ‘Case management and coordinated care’ is the most common category of intervention approach.

Interventions by Cohort

Modelling of interventions

Interventions have been received from a number of sources and at different levels of detail – by incorporating these into a consistent template and mapping to key areas and impacts it is clear that the majority of the documented interventions that impact on activity are based on achieving out of hospital care in the appropriate setting for a number of cohorts, either through avoiding an attendance or admission, or through early supported discharge and a reduced length of stay in acute care. These interventions that impact on avoidable admissions and bed days follow the principle of the hospital only where the hospital is needed.

The key areas highlighted include:

Reduced unplanned admissions for long term conditions and areas that should not usually require acute care

- ACS – Emergency admissions for ambulatory care sensitive conditions
- NURHA – Emergency admissions for acute conditions that should not usually require hospital admission

Reduction in the length of hospital stay for those who do not require acute care (early supported discharge)

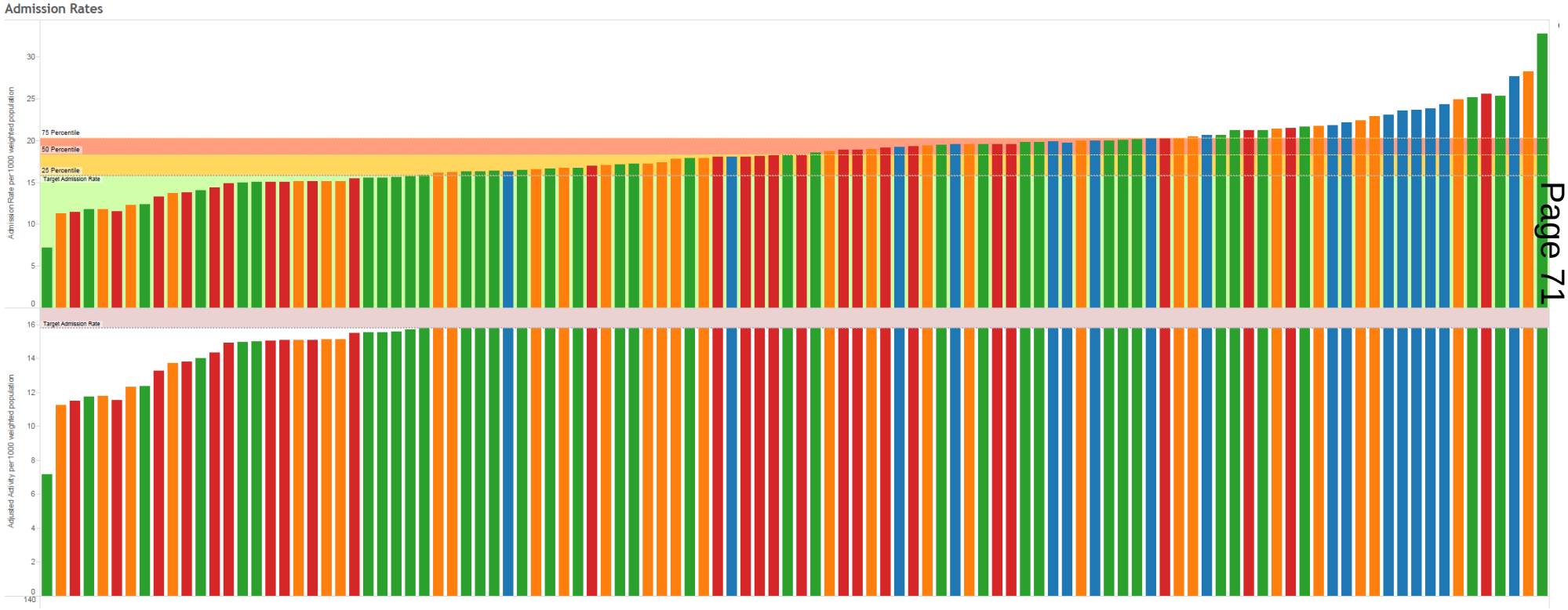
- Patients with dementia
- Elderly patients
- Patients receiving end of life care

We have not assumed a reduction in daycase and elective admissions, this is to ensure that there is enough activity commissioned to deliver 18 weeks. It is worth noting that there is a risk that the baseline is overstated due to overperformance or explicit waiting list initiatives but this has not been possible to quantify.

Emergency admission reductions

To quantify the potential reduction in admissions, internal benchmarking has been used to make comparisons of weighted practice admission rates for the key areas for reduced emergency admissions. The intention of this analysis is to identify achievable levels of admissions based on rates already seen in practices in the region.

The planned BCF reductions in ACS and NURHA areas actually go further than 75th percentile, the reductions are the equivalent of the 95th percentile of current performance, which highlights the level of ambition and change in approach envisaged by the CCGs.



Emergency admission reductions

Activity reductions in these scenarios assume all GP practices reach current 75th percentile activity rates.

NURHA

	NHS HALTON CCG	NHS KNOWSLEY CCG	NHS ST HELENS CCG	NHS WARRINGTON CCG	Overall
Activity Reduction	653	398	319	275	1,645
% Activity Reduction	3.80%	1.90%	1.40%	1.20%	1.90%
Percentage of Cohort Activity	22.60%	11.70%	8.60%	7.80%	12.20%
Tariff Reduction	£ 1,121,692	£ 720,971	£ 549,073	£ 500,346	£2,909,486
% Tariff Reduction	4.00%	2.00%	1.40%	1.30%	2.00%

ACS

	NHS HALTON CCG	NHS KNOWSLEY CCG	NHS ST HELENS CCG	NHS WARRINGTON CCG	Overall
Activity Reduction	433	413	254	213	1,313
% Activity Reduction	2.50%	2.00%	1.10%	0.90%	1.50%
Percentage of Cohort Activity	21.10%	16.00%	9.50%	8.30%	13.30%
Tariff Reduction	871,463	864,128	504,011	448,525	2,691,561
% Tariff Reduction	3.10%	2.40%	1.30%	1.20%	1.90%

Combined ACS/NURHA Cohort

	NHS HALTON CCG	NHS KNOWSLEY CCG	NHS ST HELENS CCG	NHS WARRINGTON CCG	Overall
Activity Reduction	758	507	414	391	2,070
% Activity Reduction	4.40%	2.40%	1.80%	1.70%	2.40%
Percentage of Cohort Activity	24.00%	13.60%	10.30%	10.10%	14.00%
Tariff Reduction	1,423,526	986,547	774,020	769,867	3,968,242
% Tariff Reduction	5.00%	2.80%	2.00%	2.00%	2.80%

Early Supported Discharge / reductions in length of stay

Based on the interventions received from CCGs, the key patient cohorts where a reduction in acute length of stay is intended include:

- Patients with dementia
- Elderly patients
- Patients receiving end of life care

To quantify the potential reduction in bed days, lengths of stay for patients with a secondary diagnoses of dementia have been compared against patients with the same primary medical condition but no mental health co-morbidities. Similarly, lengths of stay for patients aged 75+ have been compared against younger patients with the same primary medical condition and similar levels of complication and co-morbidity.

The intention of these analyses is to identify where acute hospital stays appear to be extended for non-medical reasons and to estimate the associated volume of bed days that could potentially be avoided.

Early Supported Discharge / reductions in length of stay

At a high level the modelling shows similar potential between both Warrington and Whiston sites, with comparable length of stay reductions for each cohort.

Patients with dementia

Comparing lengths of stay for patients with a secondary diagnoses of dementia against patients with the same primary medical condition but no mental health co-morbidities shows a potential reduction of approximately 5,000 bed days (16 beds) at each of Warrington and Whiston.

Elderly patients (over 75's)

Modelling shows a potential reduction of up to 24,000 bed days (circa 73 beds) at both Warrington and Whiston hospitals. This is on the assumption that non-elective length of stays for elderly patients could be reduced to the same as younger patients with the same primary medical condition and similar levels of complication and co-morbidity.

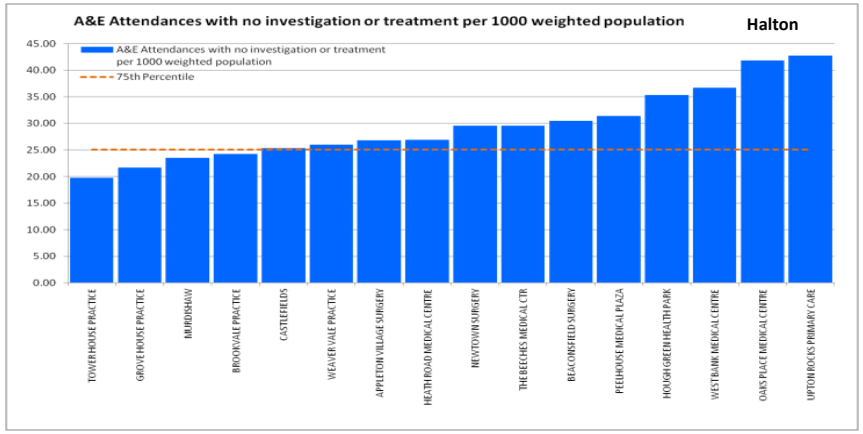
Patients receiving end of life care

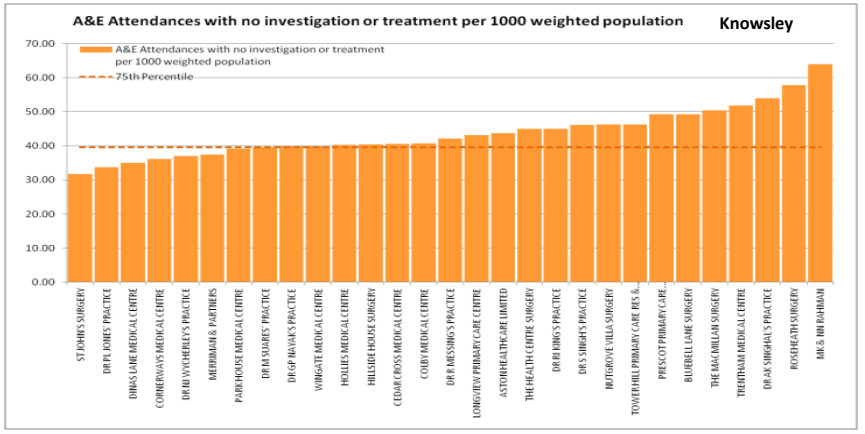
Comparing the length of stay of patients with and without palliative care for the same primary medical condition and similar complexity shows a potential shift of approximately 500 bed days (1.6 beds) at each of Warrington and Whiston.

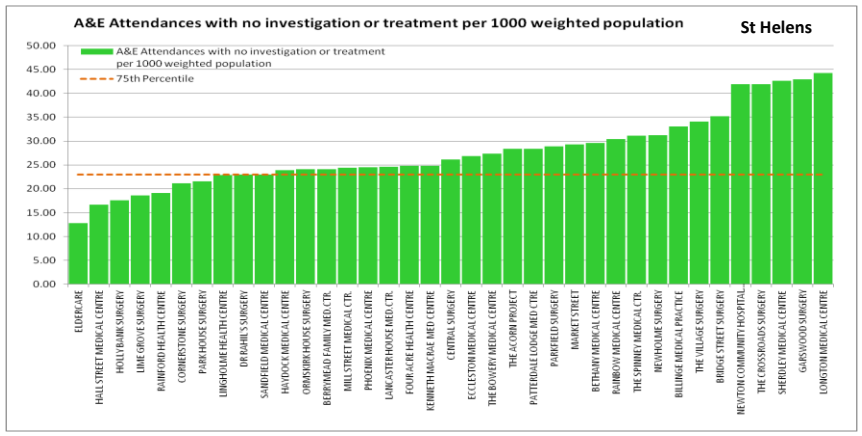
All of the above are mutually exclusive, and in total represent potential reductions of around 20% in non-elective bed days for St Helens and Knowsley and Warrington and Halton Trusts.

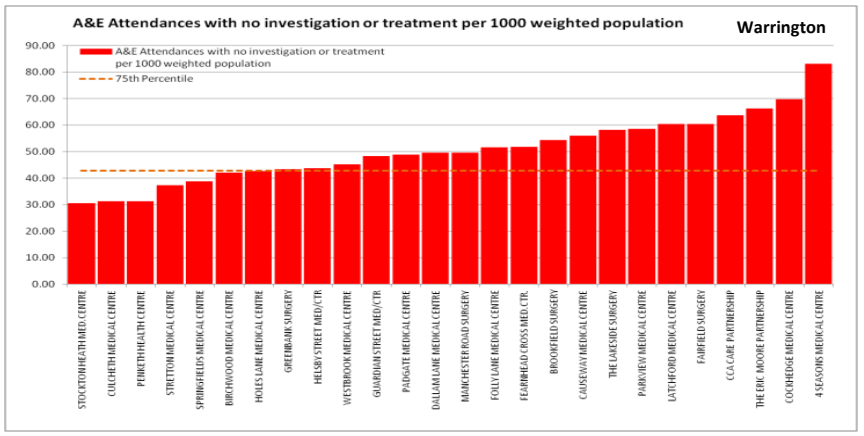
Reduction in A&E Attendances

As a measure of increased standardisation, reducing the rate of simple A&E Attendances (those not requiring investigation or treatment) to the 75th percentile level would reduce the number of attendances by approximately 4,000 per year. This would equate to £229,000 of tariff spend. It is important to note that this figure only includes those A&E attendances with no investigation or treatment.



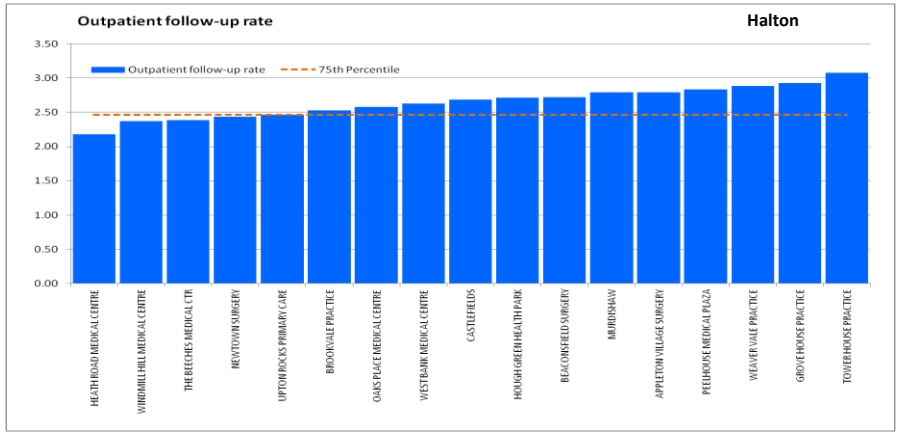


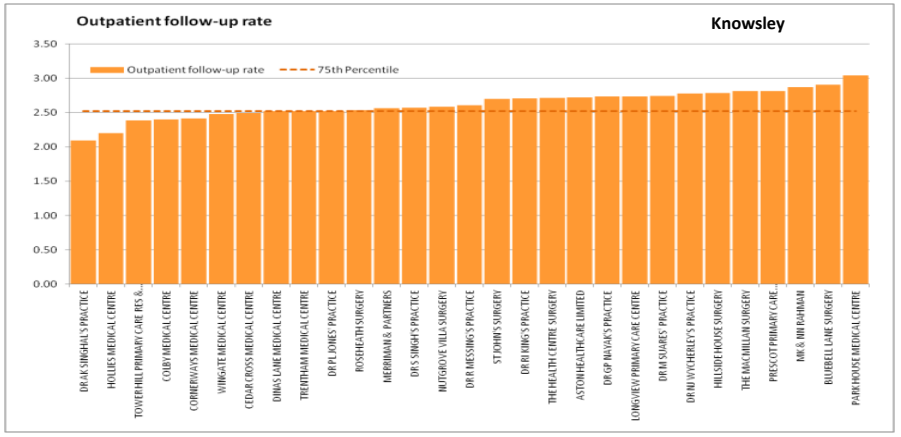


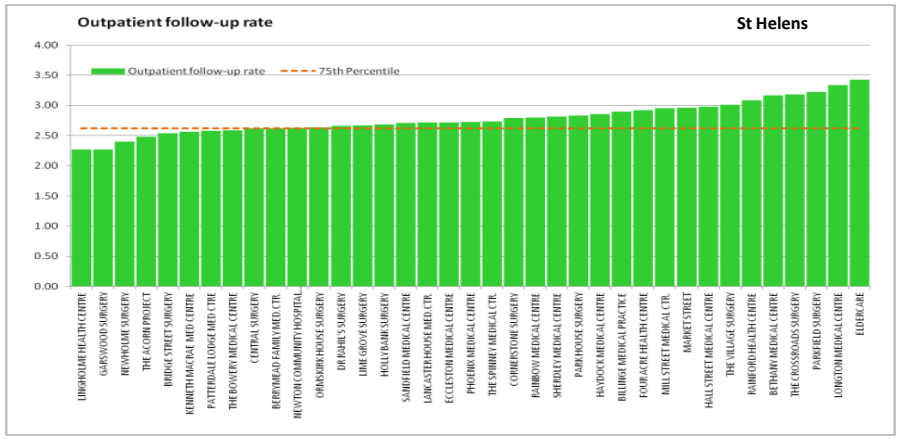


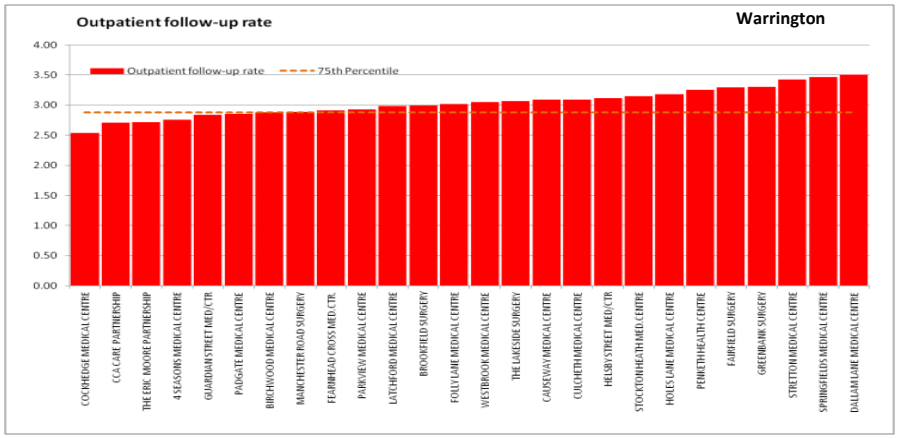
Outpatient Follow-up Rates

Standardising outpatient follow-up rates at the 75th percentile would mean a reduction of approximately 50,000 follow up attendances across the four CCGs, and a reduction in spend of £2.5M.



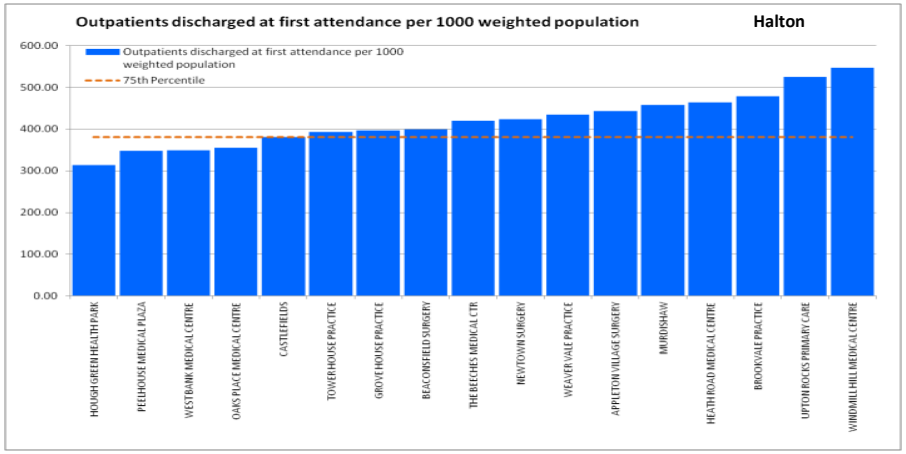


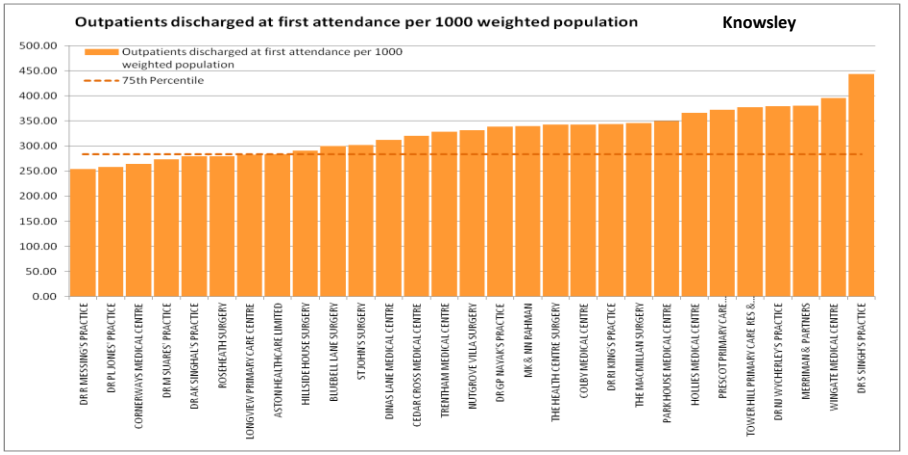


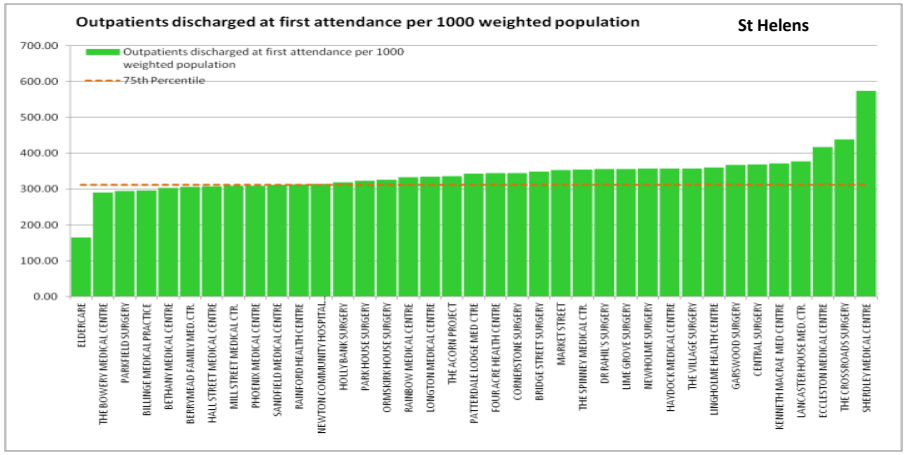


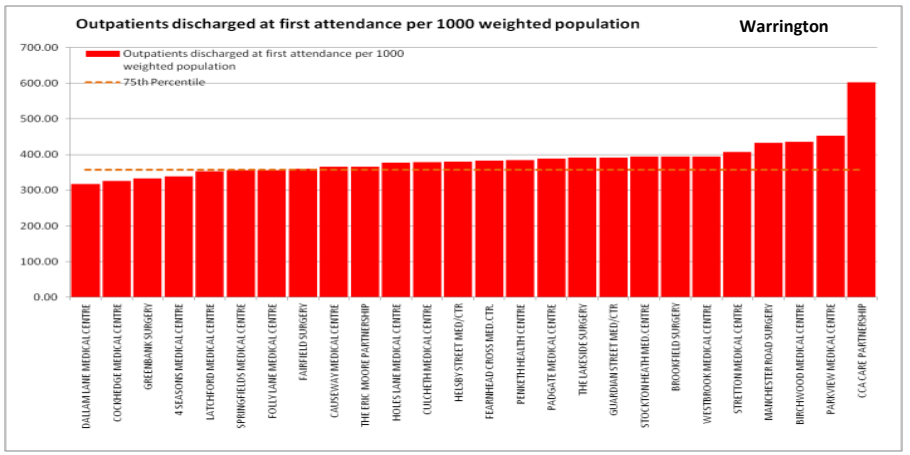
Outpatients discharged at first attendance

Outpatient first appointments that are discharged at the first appointment account for £21M of spend across the four CCGs. Standardising the rate of these attendances at the 75th percentile would equate to 28,000 attendances and £2.2M in spend across Mid Mersey.









Scenarios for three, five and ten year projections

In addition to the 'do nothing' scenario we have also modelled two further scenarios that include the impact of interventions on acute activity and spend:

Likely Scenario

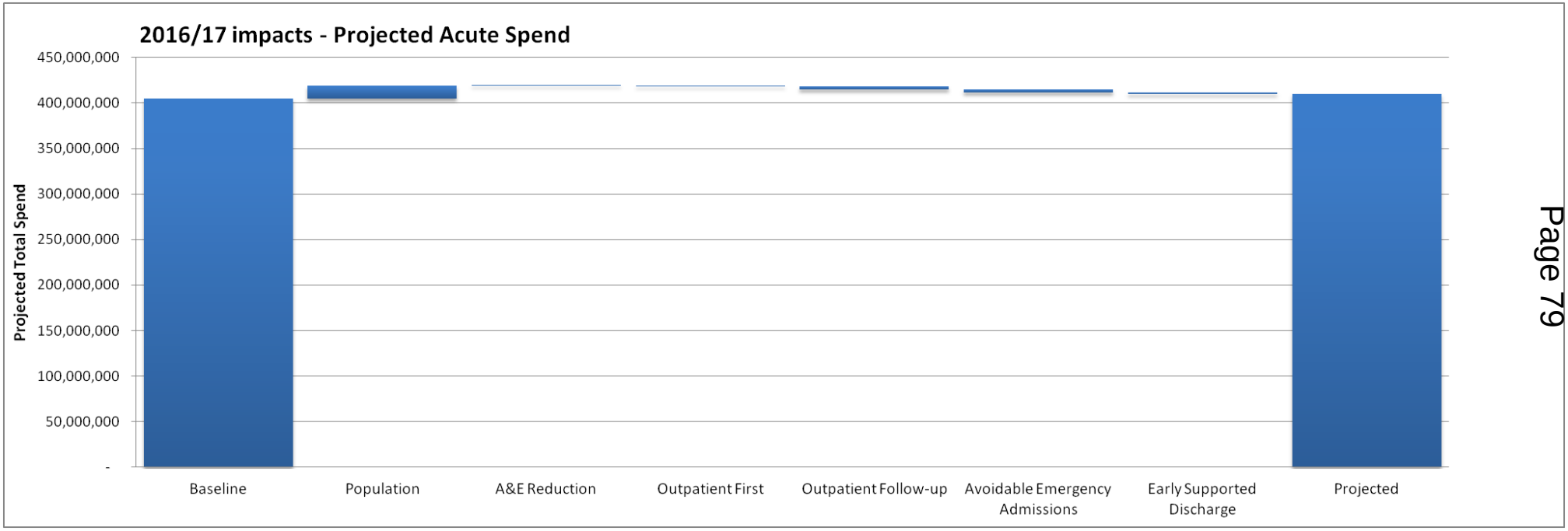
- Admission rates to the 75th percentile based on GP internal benchmarking for each CCG
- 75% of modelled early supported discharge achieved
- Outpatient Follow up and First Discharge reductions to the 75th percentile based on GP internal benchmarking for each CCG
- A&E simple attendances reductions to 75th percentile based on GP internal benchmarking for each CCG

Maximum Scenario

- Reductions in avoidable admissions as seen in BCF plans (CCG specific rates, overall approx 20% reduction in this cohort over 5 years)
- All modelled early supported discharge achieved
- Outpatient Follow up and First Discharge reductions to the 75th percentile based on GP internal benchmarking for each CCG
- Reductions in overall A&E attendance as seen in BCF plans (CCG specific rates, overall approx 7% reduction over 5 years)

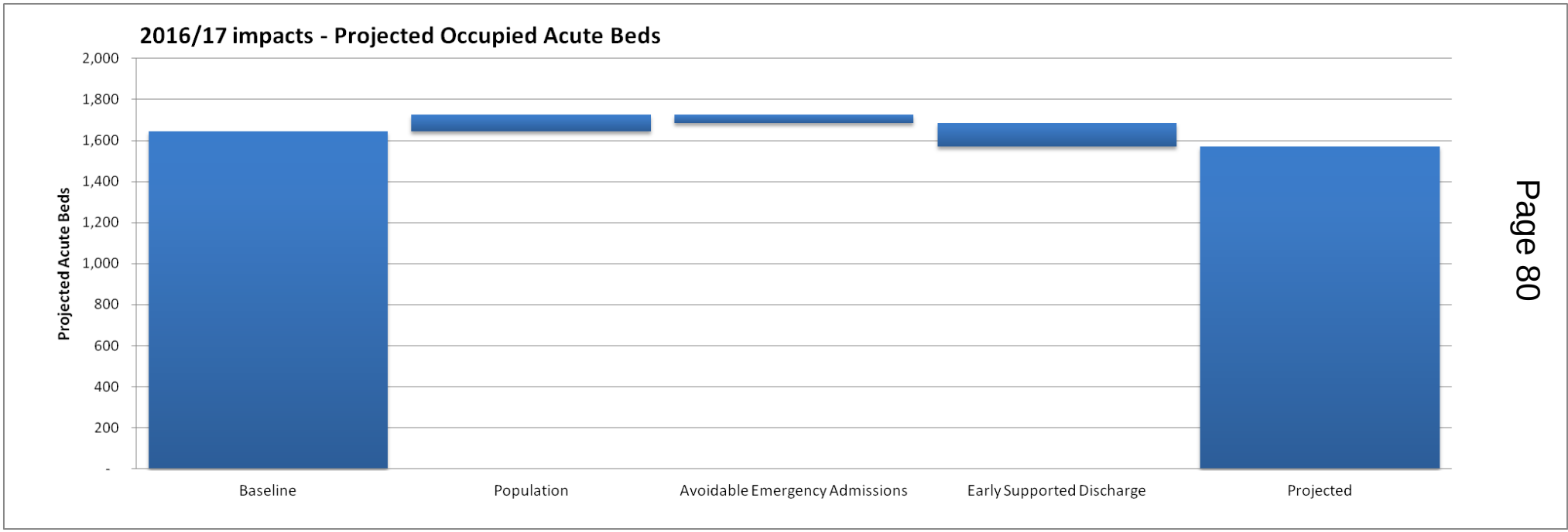
2016/17 Projected Acute Spend (Likely Scenario)

The chart below shows the projected impact of each area on total acute spend in three years. Population growth is projected to impact by adding an additional £14M pressure to the total acute spend across Mid Mersey in this time frame. The modelled interventions neutralise the majority of this underlying growth.



2016/17 Projected Acute Occupied Beds (Likely Scenario)

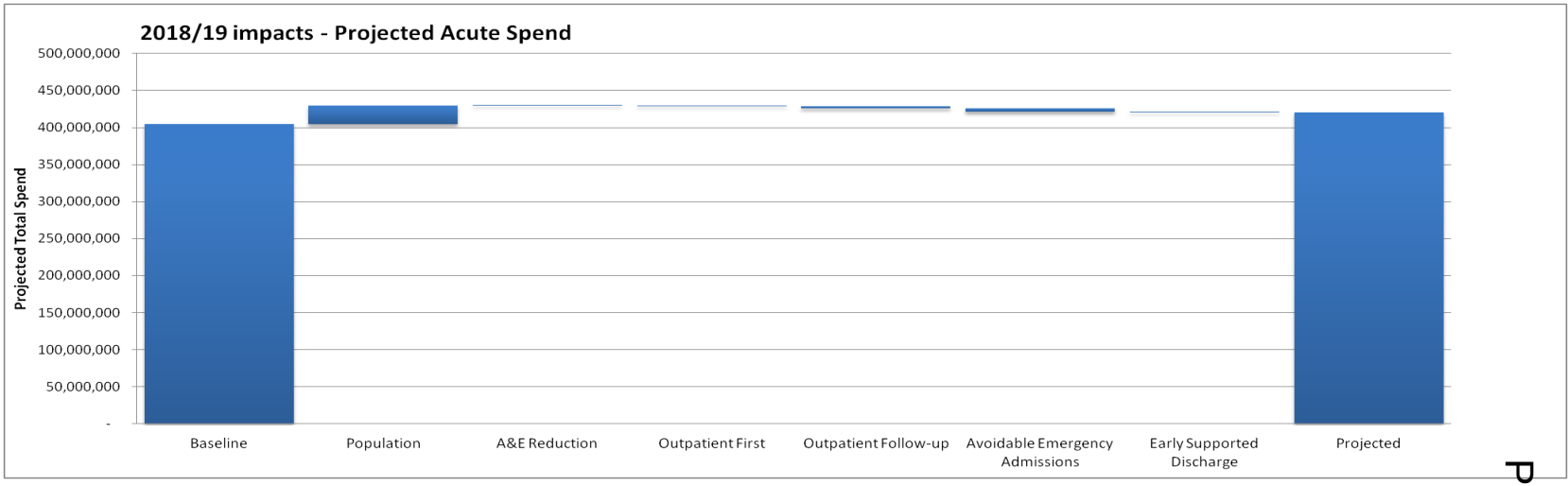
The overall impact on Acute bed days of the modelled interventions is for a reduction from the current baseline position. The reductions resulting from earlier supported discharge and reduced acute admissions more than counteract the impact of underlying growth.

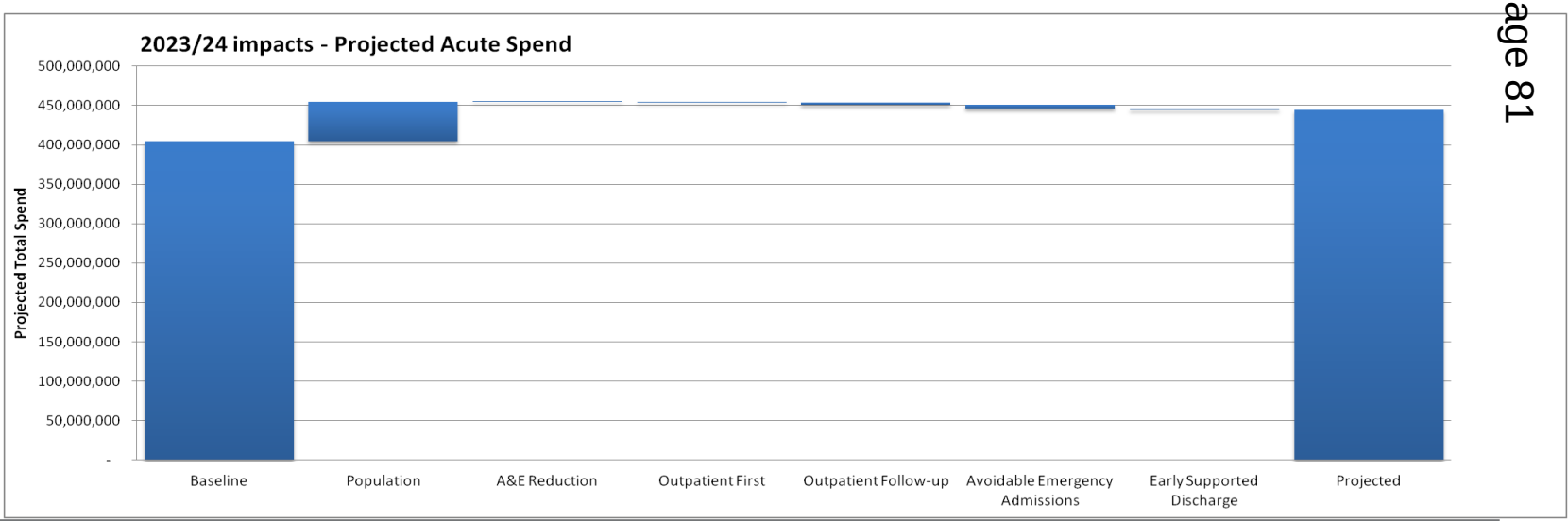


2018/19 and 2023/24 Acute Spend (Likely Scenario)

Looking further ahead to five and ten year projections, the underlying demand is projected to overtake the reductions in activity that initiatives are expected to make.

This highlights that in the longer term, there is a need to look at more radical changes in which health services are delivered that look beyond diversion and to prevention, health and wellbeing and integrated care which may also impact on the structure of the care delivery system.





Five year scenario output (Likely scenario)

The table below shows the modelled impact to 2018/19 on each CCG on tariff and bed days. The most obvious difference between CCGs is the difference in impact of underlying growth, with more of a challenge seen for Warrington CCG.

Tariff	NHS HALTON CCG	NHS KNOWSLEY CCG	NHS ST HELENS CCG	NHS WARRINGTON CCG	Grand Total
Baseline	£77,592,846	£101,688,101	£116,558,931	£108,949,251	£404,789,129
Population	£3,862,838	£3,632,768	£6,235,892	£9,217,817	£22,949,315
A&E Reduction	-£47,024	-£46,007	-£87,570	-£101,448	-£282,049
Outpatient First	-£202,398	-£383,859	-£225,887	-£320,661	-£1,132,805
Outpatient Follow-up	-£760,098	-£511,449	-£740,214	-£681,817	-£2,693,578
Avoidable Emergency Admissions	-£427,532	-£1,110,263	-£1,217,722	-£1,350,766	-£4,106,284
Early Supported Discharge	-£227,774	-£279,627	-£486,599	-£459,394	-£1,453,3[illegible]
Projected	£79,790,858	£102,989,665	£120,036,831	£115,252,981	£418,070,3[illegible]

Acute Occupied Beds	NHS HALTON CCG	NHS KNOWSLEY CCG	NHS ST HELENS CCG	NHS WARRINGTON CCG	Grand Total
Baseline	321	410	472	442	1,645
Population	24	25	38	53	140
Avoidable Emergency Admissions	-4	-12	-12	-14	-43
Early Supported Discharge	-23	-21	-37	-40	-121
Projected	318	402	461	441	1,621

Five year scenario output (Max Scenario)

The ‘maximum’ scenario – including better care fund assumptions, shows reductions in activity and spend keeping pace with underlying growth for longer, with only a small projected difference across all CCGs.

Tariff	NHS HALTON CCG	NHS KNOWSLEY CCG	NHS ST HELENS CCG	NHS WARRINGTON CCG	Grand Total
Baseline	£77,592,846	£101,688,101	£116,558,931	£108,949,251	£404,789,129
Population	£3,862,838	£3,632,768	£6,235,892	£9,217,817	£22,949,315
A&E Reduction	-£680,178	-£210,822	-£413,747	-£1,189,689	-£2,494,435
Outpatient First	-£202,398	-£383,859	-£225,887	-£320,661	-£1,132,805
Outpatient Follow-up	-£760,098	-£511,449	-£740,214	-£681,817	-£2,693,578
Avoidable Emergency Admissions	-£1,441,430	-£2,300,256	-£1,957,952	-£2,144,800	-£7,844,438
Early Supported Discharge	-£308,401	-£383,111	-£658,690	-£633,205	-£1,983,407
Projected	£78,063,179	£101,531,374	£118,798,333	£113,196,896	£411,589,768

Acute Occupied Beds	NHS HALTON CCG	NHS KNOWSLEY CCG	NHS ST HELENS CCG	NHS WARRINGTON CCG	Grand Total
Baseline	321	410	472	442	1,645
Population	24	25	38	53	140
Avoidable Emergency Admissions	-17	-28	-23	-26	-94
Early Supported Discharge	-28	-27	-47	-51	-152
Projected	300	380	440	418	1,538

Impact on the provider market

The table below shows the impact of the modelled reduction in emergency admissions and emergency length of stay on St Helens and Knowsley Hospitals NHS Trust and Warrington and Halton Hospitals NHS Foundation Trust. While recognising that the CCGs commission services and not providers, this provides reassurance that the potential impact on main providers would not have a destabilising effect.

Without accounting for population growth (which would in itself offset reduction in income), the impact in these areas would be a reduction in income for these Trusts of £2.9M and £2.25M respectively.

Assuming that costs can be recovered from the bed shift associated with early supported discharge this would offset the income reduction through a saving of 3.1M and 2.6M respectively.

ST HELENS AND KNOWSLEY HOSPITALS NHS TRUST	Avoidabe Emergency Admissions	Early Supported Discharge
Sum of Projected Spells	- 1,069	-
Sum of Projected Bed Days	- 8,069	- 23,716
Sum of Projected Total Tariff	-£ 2,117,226	-£ 810,118

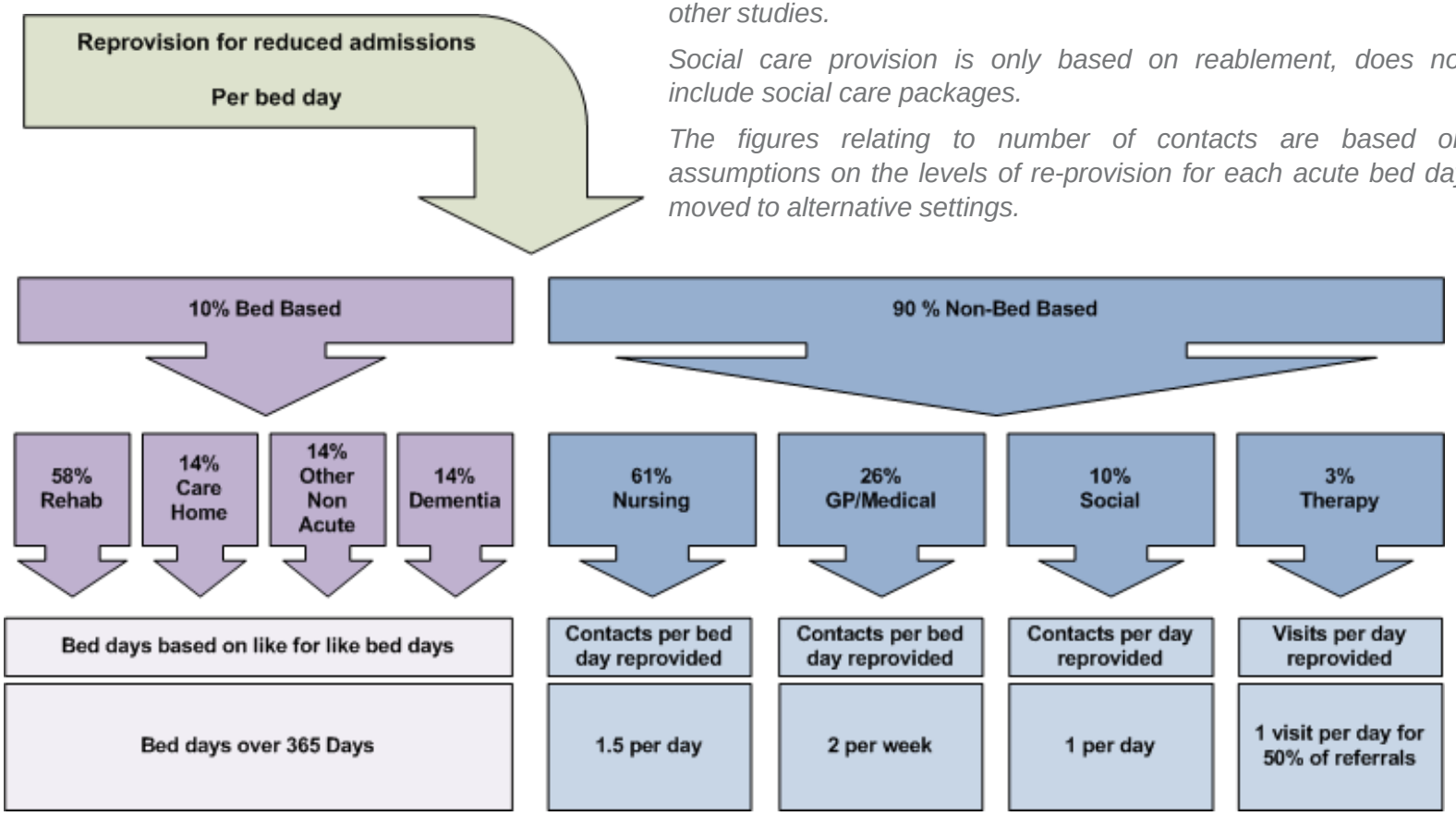
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	Avoidabe Emergency Admissions	Early Supported Discharge
Sum of Projected Spells	- 783	-
Sum of Projected Bed Days	- 5,984	- 20,479
Sum of Projected Total Tariff	-£ 1,612,606	-£ 643,277

Re-provision assumptions for avoided admissions

Using our experience in other parts of the country we have been able to develop some assumptions about the impact of avoiding acute admissions and reducing length of stay on non-acute services.

The assumptions are based on streaming of patients to alternative settings for each acute bed day avoided and are based on acuity assessments and observations of the appropriate alternative placements for patients who do not require acute admission / continued stay.

These are indicative figures only and further work would be necessary to map current flows, understand current patterns of community provision to validate these assumptions.



Comments

Percentages relating to care location are based on CAPA, acute evidence is based on small samples but is in line with findings in other studies.

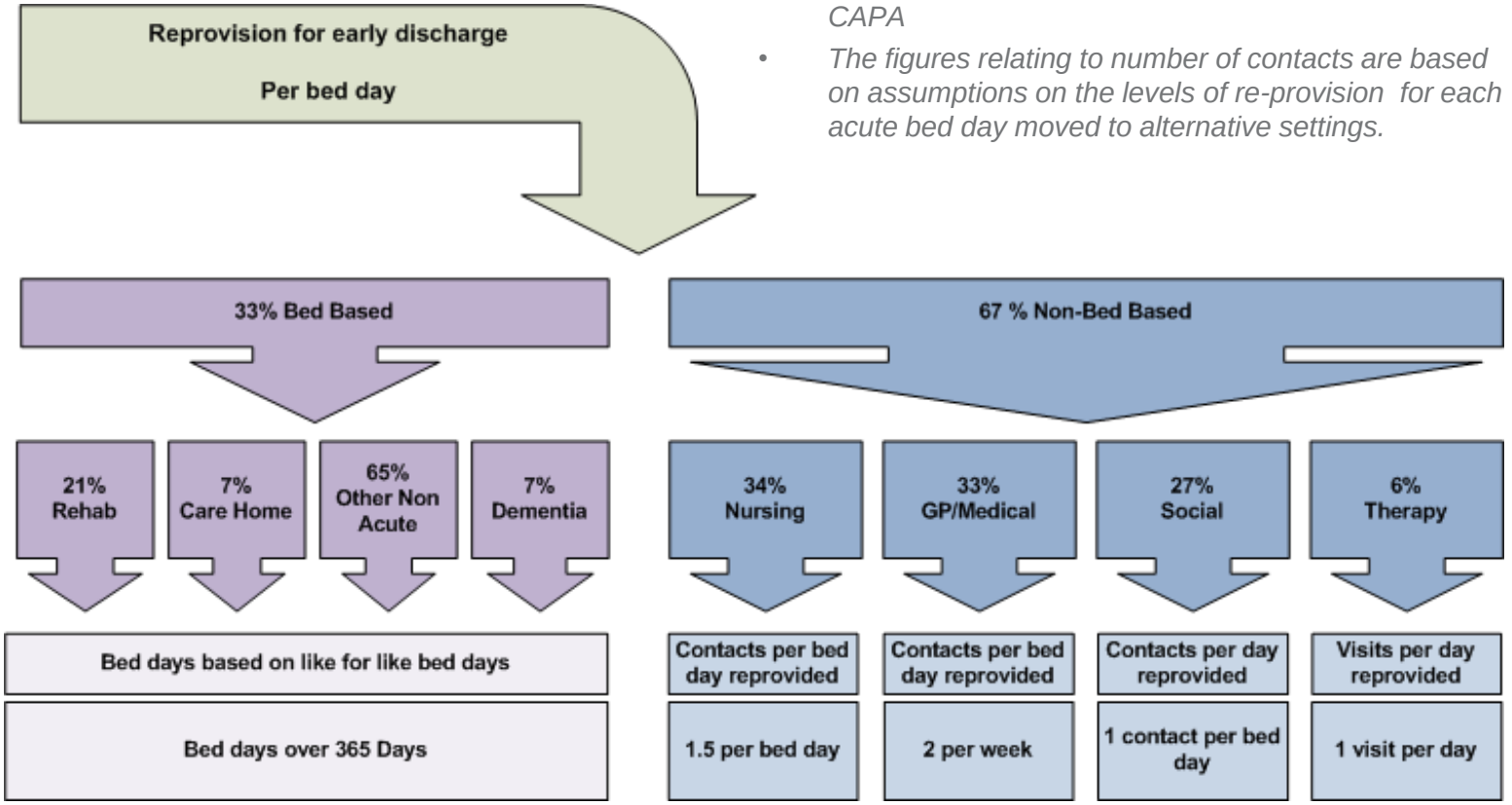
Social care provision is only based on reablement, does not include social care packages.

The figures relating to number of contacts are based on assumptions on the levels of re-provision for each acute bed day moved to alternative settings.

Re-provision assumptions for early supported discharge

The indicative level of reprovision for early discharge has been modelled in the a similar way, estimating the alternative reprovision necessary to support early discharge and avoid acute bed days.

Again these are indicative figures only and further work would be necessary to map current flows, understand current patterns of community provision to validate these assumptions.



Comments:

- *Percentages relating to care location are based on CAPA*
- *The figures relating to number of contacts are based on assumptions on the levels of re-provision for each acute bed day moved to alternative settings.*

Re-provision in alternative settings

Using these re-provision assumptions for the levels of reduced acute activity and bed days in the likely scenario for 2016/17 gives these results.

The largest diversion can be seen in the number of nursing contacts for reduced admissions.

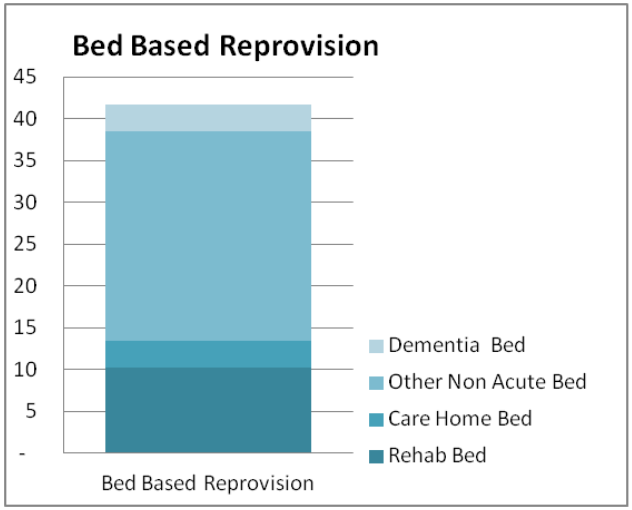
For reduced length of stays, clearly there would be an increased requirement for additional non-acute beds to support the earlier discharge.

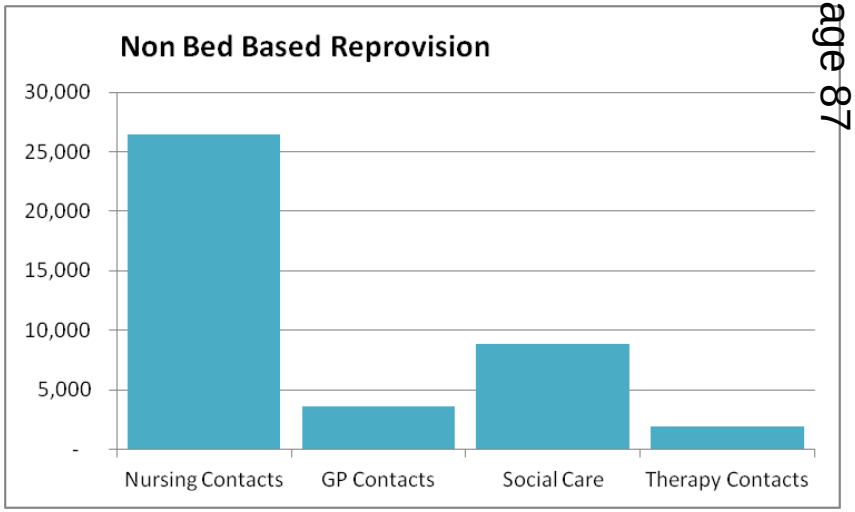
The model does not make any assumptions about the efficacy of current non-acute bed use (typically, we find that around half of patients in non-acute beds could be discharged earlier to home based care). The model also makes no assumptions about community service productivity and capacity.

Further work would be necessary to map current flows and understand current patterns of community provision to validate the findings.

Bed Based Reprovision	Reprovision for Early supported Discharge	Reprovision for Admission Reduction
Rehab Bed Days	2,885	859
Care Home Bed Days	962	207
Other Non Acute Bed Days	8,929	207
Dementia Bed Days	962	207
Indicative Non-Acute Beds	**38**	**4**

Non Bed Based Reprovision	Reprovision for Early supported Discharge	Reprovision for Admission Reduction
Nursing Contacts	14,224	12,194
GP Contacts	2,630	990
Social Care	7,530	1,333
Therapy Contacts	1,673	200





CAPITA

Implications for Commissioners

Commentary on key issues

Implications for Commissioners

While the purpose of the assignment was to undertake modelling of historic, current and forecast activity, flows and spend, the ultimate aim of this exercise is to support commissioners in their decision making for the longer term. In this section, we offer a commentary on some of the key points arising from the review, which help address some of the questions CCGs are seeking to answer, and signpost the CCGs to what they might consider next to address remaining gaps in their knowledge. The key issues are summarised below.

Scope of plans	The analysis shows that the current plans will help stem the tide of demand growth from population change but that in the long term, demand will continue to grow. This suggests that a more radical approach to meeting the challenge will be needed – current plans could be strengthened by exploring opportunities for more upstream intervention in health and wellbeing, shifting the emphasis from diversion to prevention of demand. In addition, the CCGs could explore more radical approaches to delivery of integrated, proactive care, involving redefining the role and shape of primary, community and social care for the longer term, with the current plans being used to generate breathing space to put the necessary investment into non-acute services to enable long term change.
Community data	The data provided for community services is not adequate to derive reliable calculations of the impact of commissioning intentions and the information provided in this report should be seen as illustrative. We would recommend that the basis for our modelling should be validated in collaboration with providers and further work be undertaken locally to understand the extent to which capacity in community services could be released to support the activity shifts associated with the commissioning intentions, and then the true quantum of additional capacity that will be required to support the long term shift indicated in the first point above.
Impact of social care resource constraints	The modelling suggests that austerity across the system is having an impact on the provision of social care, with a reduction in spend on assessments and shift in provision from institutional to home based care . The impact of this on health status and demand for health services cannot be inferred from the modelling at this point, but it seems logical to assume that there will be an increase in demand, particularly for home-based health care. By investing in more integrated approaches to risk stratification, population segmentation, prevention and proactive care, and by considering further opportunities for pooling resources to achieve this, health and social care commissioners will be better able to avoid this demand emerging in acute services and to deliver the most beneficial outcomes for the population in terms of overall health status. Further work should be undertaken now to understand the nature of social care provision, the client groups impacted and the care pathways / packages needed to address their needs.

Implications for Commissioners

Specialised Services / impact of new technologies	Despite the direction of travel to consolidate further the provision of specialist services into larger centres, from the information available, this is unlikely to have a major impact on patient flows within the mid Mersey geography, as neither of the two local providers delivers significant specialist services (the key exception being burns). The delegation of commissioning of some services to CCGs will impact on local commissioning intentions but is unlikely to impact on patient flows. It is likely that, with technological and pharmaceutical advances, more services and procedures become more amenable to local delivery (as in the case of renal dialysis and chemotherapy) but the need for these to be linked back to specialist expertise suggests the development of outreach from specialist centres of chains of providers, rather than involving a shift of provider.
Aligning wider system changes	The modelling has been built on commissioning intentions and it is suggested that these be compared with the impact of provider supply strategy and business plans, where known. For example, it would be helpful to understand the strategies of local trusts in respect of attracting activity from competitors. The pressure at St Helens and Knowsley Trust to optimise the use of Whiston Hospital may drive it towards a more aggressively competitive approach to practices in Halton, where flows are more varied, which would impact on the viability of the Halton Hospital site. While it is unlikely that the Greater Manchester Healthier Together strategy will impact on flows from mid Mersey, any plans for reconfiguration of services across Liverpool (and in the longer term, the re-build of the Royal Liverpool Hospital) may impact on flows from practices on the western edge of the patch. A more likely scenario for CCGs to consider is the impact of their plans for a sustained sift from acute to community services on provider sustainability and consequently, behaviour. To mitigate the impact on income, Trust responses may focus on developing partnerships and alliances with community services, or they may become more overtly competitive, seeking to develop vertically integrated alternatives to current provision. The latter, coupled with potential for establishment of GP Federations, provides a potential threat to Bridgewater Community Trust, which in turn may threaten the implementation of CCGs' plans in the medium term. Further work to understand community services flows would help CCGs develop a clear approach to this area of the market.

CAPITA

Appendices

Appendix 1 - Summary of data sources used

Collection of interventions and assumptions

Commissioning interventions have been imported from a number of sources and filtered into areas for modelling – the list of documents is shown here.

Document	Source	Type	Received From	Date
5 year plan meeting notes	Halton CCG	doc	Mike.Shaw@haltonccg.nhs.uk	27/02/2014
5 year plan on a page V2	Halton CCG	doc	Mike.Shaw@haltonccg.nhs.uk	27/02/2014
5 year strategic plan 2014_19 V1 6SB	Halton CCG	doc	Mike.Shaw@haltonccg.nhs.uk	27/02/2014
5 year strategic plan presentation	Halton CCG	ppt	Mike.Shaw@haltonccg.nhs.uk	27/02/2014
140205 Plan Assurance - 3x3 matrix	Halton CCG	ppt	Mike.Shaw@haltonccg.nhs.uk	27/02/2014
Anytown Tool - Halton CCG Mapping exercise	Halton CCG	doc	Mike.Shaw@haltonccg.nhs.uk	27/02/2014
CCG_Com_Planning_Template_(Functional)_V5 0 (1) SUBMITTED	Halton CCG	xls	Mike.Shaw@haltonccg.nhs.uk	27/02/2014
Copy of Operational workplan figures 2014-16	Halton CCG	xls	Mike.Shaw@haltonccg.nhs.uk	27/02/2014
Medication Error Reporting -Proposal for plan BRIDGEWATER as QP provider	Halton CCG	doc	Mike.Shaw@haltonccg.nhs.uk	27/02/2014
operational plan 2014-16 V2.3.6 FINAL	Halton CCG	doc	Mike.Shaw@haltonccg.nhs.uk	27/02/2014
ProvCom_Planning_Template_(functional)_V7 0 SUBMITTED	Halton CCG	xls	Mike.Shaw@haltonccg.nhs.uk	27/02/2014
stra-op-stat-temps	Halton CCG	doc	Mike.Shaw@haltonccg.nhs.uk	27/02/2014
Summary Doc 5 year and 2 year plans	Halton CCG	doc	Mike.Shaw@haltonccg.nhs.uk	27/02/2014
Link to JSNA	Halton CCG	pdf	Mike.Shaw@haltonccg.nhs.uk	11/03/2014
Copy of V7 DRAFT - Better Care Fund Template Part 2 14 2 14 Submission to NHSE	St Helens CCG	xls	Ian.Campbell@sthelensccg.nhs.uk	26/02/2014
V7 DRAFT Better Care Fund planning template part 1 - 14 2 14 Submission to NHSE	St Helens CCG	doc	Ian.Campbell@sthelensccg.nhs.uk	26/02/2014
v7.0 ProvComm Planning Template 2014-15 for UNIFY Submission.xls	St Helens CCG	xls	Jason.Taylor@sthelensccg.nhs.uk / Kerry.In	05/03/2014
v5.0 CCG Planning Template for Unify (functional)	St Helens CCG	xls	Jason.Taylor@sthelensccg.nhs.uk / Kerry.In	05/03/2014
Internal data collection CCG Com Plans 2014-15	St Helens CCG	xls	Jason.Taylor@sthelensccg.nhs.uk / Kerry.In	05/03/2014
v8.0 ProvComm Planning Template 2014-15 for UNIFY Submission.xls	St Helens CCG	xls	Jason.Taylor@sthelensccg.nhs.uk	12/03/2014
PROVCOMM MATRIX OF CHANGE	St Helens CCG	doc	Jason.Taylor@sthelensccg.nhs.uk	12/03/2014
St Helens CIs 1415 contract round v5	St Helens CCG	xls	Jason.Taylor@sthelensccg.nhs.uk	12/03/2014
Project Information Collation Table V0.2	St Helens CCG	xls	Jason.Taylor@sthelensccg.nhs.uk	12/03/2014
link to WCCG refreshed commissioning intentions	Warrington CCG	ppt	Linda.Bennett@warringtonccg.nhs.uk	03/03/2014
link to ISOP 2012/13-13/14	Warrington CCG	ppt	Linda.Bennett@warringtonccg.nhs.uk	03/03/2014
Financial Plan Template 1415 to 1819 CCG (14Feb14 1014 - v4.7 updated) Text	Warrington CCG	xls	David.Cooper@warringtonccg.nhs.uk	06/03/2014
Warrington BCF Plan - Part 1 (2)	Warrington CCG	doc	David.Cooper@warringtonccg.nhs.uk	06/03/2014
Warrington BCF Planning Template - Part 2	Warrington CCG	xls	David.Cooper@warringtonccg.nhs.uk	06/03/2014
2014_02_Urgent_Care_GP_Specification v1 1 - final for inclusion	Warrington CCG	doc	David.Cooper@warringtonccg.nhs.uk	06/03/2014
eoi-proforma Warrington GP Federations (2)	Warrington CCG	pdf	David.Cooper@warringtonccg.nhs.uk	07/03/2014
Knowsley draft Better Care Fund plan 20140214	Knowsley CCG	pdf	Paul.Brickwood@knowsleyccg.nhs.uk	03/03/2014
Children-and-Young-Peoples-Needs-Assessment2	Knowsley CCG	pdf	ian.stewart@knowsleyccg.nhs.uk	07/03/2014
knowsley-jsna-2011-full-report	Knowsley CCG	pdf	ian.stewart@knowsleyccg.nhs.uk	07/03/2014
Knowsley Public Health Annual Report Statistical Compendium 2012-13	Knowsley CCG	pdf	ian.stewart@knowsleyccg.nhs.uk	07/03/2014
Public Health Annual Report 2012-2013	Knowsley CCG	pdf	ian.stewart@knowsleyccg.nhs.uk	07/03/2014
CCG_Com_Planning_Template_FINAL	Knowsley CCG	xls	ian.stewart@knowsleyccg.nhs.uk	07/03/2014
ProvCom_Planning_Template_FINAL	Knowsley CCG	xls	ian.stewart@knowsleyccg.nhs.uk	07/03/2014

REPORT TO: Health and Wellbeing Board

DATE: 9 July 2014

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Wellbeing

SUBJECT: CHIMAT – Child Health Profile

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 The Child Health Profile (CHIMAT) is released every year by Public Health England and provides a summary of the health and wellbeing of children and young people in Halton.

2.0 RECOMMENDATION: That

1) The Board note the contents of the 2014 Child health profile and the progress that has been made against a challenging baseline. Out of the 32 areas 17 have improved (Green Arrow), 4 have stayed the same (=) and 5 are worse (Red Arrow). For 6 of the measures data changes mean the results cannot be compared;

2) Of the five areas showing poorer performance in 2014 when compared to 2013, for four of these indicators Halton was preforming either at or above the England average rate and continues to do so; and

3) Feedback any comments to the Director of Public Health.

3.0 **SUPPORTING INFORMATION**

3.1 Each year the Child and Maternal Health Observatory, which is now part of Public Health England, produce a report on the health indicators of children and young people in Halton. The data that is included is available at a national level and enables Halton to benchmark their health outcomes against the England average values.

3.2 Health outcomes are very closely related to levels of deprivation, the more deprived an area the poorer health outcomes that would be expected. Overall the health and wellbeing of children in Halton is generally worse than the England average, as are the levels of

child poverty. Halton is the 27th most deprived borough in England (out of 326 boroughs) and as such would be expected to have lower than average health outcomes. The infant and child mortality rates have both improved and are now similar to the England average.

3.3 There are 32 health and wellbeing indicators included in the CHIMAT report (see Appendix A). In the 2014 report there was an improvement in 17 outcomes. For five outcomes there was poorer performance in 2014 when compared to 2013, however for four of these indicators Halton was preforming either at or above the England average rate. Six indicators had new methods of reporting data and therefore cannot be compared to the 2013 report. The details in relation to performance are listed below.

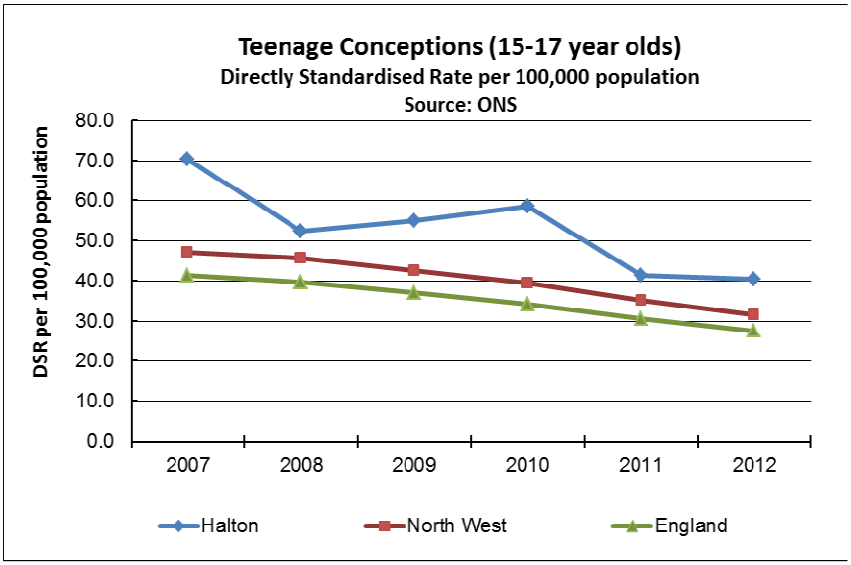
3.4 Halton has been successful in improving rates in the following areas:

- Infant and child mortality rates have reduced and are at the England average rate. This is a great success, given the level of deprivation in the borough. Work that impacts upon this includes improving maternity services and women booking in early, accident prevention work and preventing sudden infant deaths (SIDs)

- The number of low birth weight babies has improved and the Halton percentage is now below the England average, but not significantly different. Improvements in birth weight are achieved through maternity services, smoking cessation and improving maternal health.

- Teenage conception rates have shown a dramatic improvement from 63.3 to 41.5, Chart 1 shows the extent of the reduction since 2007. A range of interventions are in place, such as 'Teens and tots' programme and Healthitude in schools.

Chart 1: Under 18 conceptions



- The number of teenage mothers has remained static and is similar to the England average.

- MMR rates continue to improve (for the first dose by age 2 years), and is better than the England average rate, at 94.4%. MMR rates are very close to the 95% target, which provides good protection against an outbreak. Provisional data for 2013/14 suggests that the uptake for Halton has increased to 95.1%, and has therefore met the target.

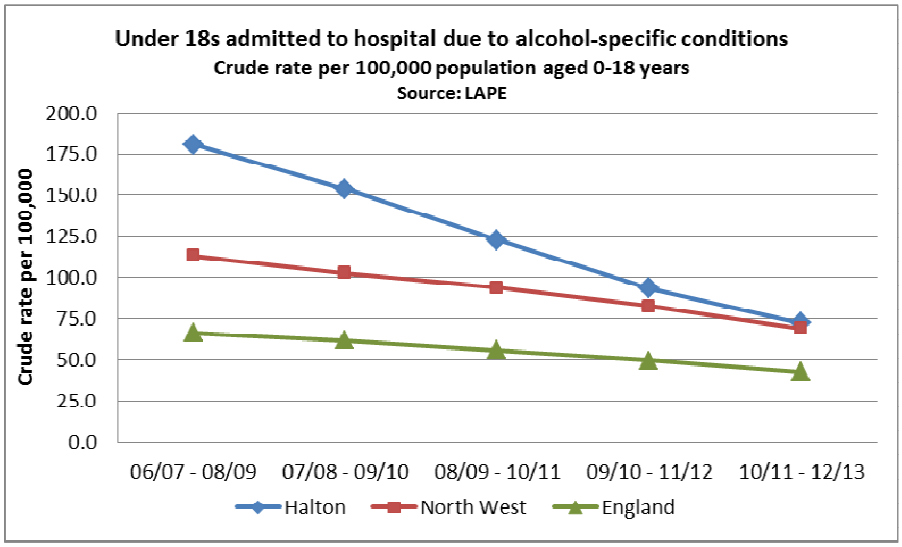
- The percentage of reception age children who are obese has remained the same as in 2010/11 and the percentage of obese children in year 6 has improved. There is a comprehensive weight management programme delivered in the school setting with children and families.

- The percentage of GCSE's achieved (5A*-C) has improved and is slightly above the England average, but statistically similar. The rate of GCSE's achieved (5A*-C) for children in care has not previously reported in the child health profile. No children in care have achieved this level in Halton, however this is statistically similar to the England average rate.

- The number of children and young people who are Not in Education, employment or training (NEET) has improved, but remains worse than the England average rate.

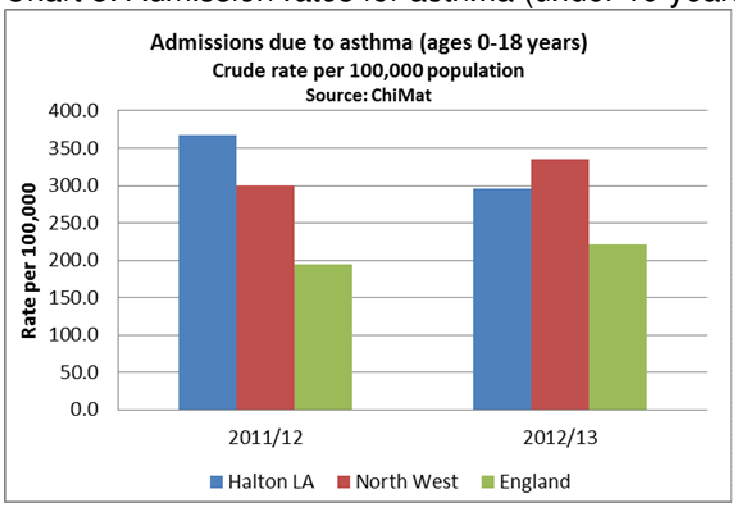
- Halton has seen a reduction in the rate and number of 0-17 year olds being admitted to hospital for alcohol specific conditions. Chart 2 shows the improvements that have been made since 2006/7-2008/09.

Chart 2: Hospital admissions due to alcohol specific conditions (under 18s)



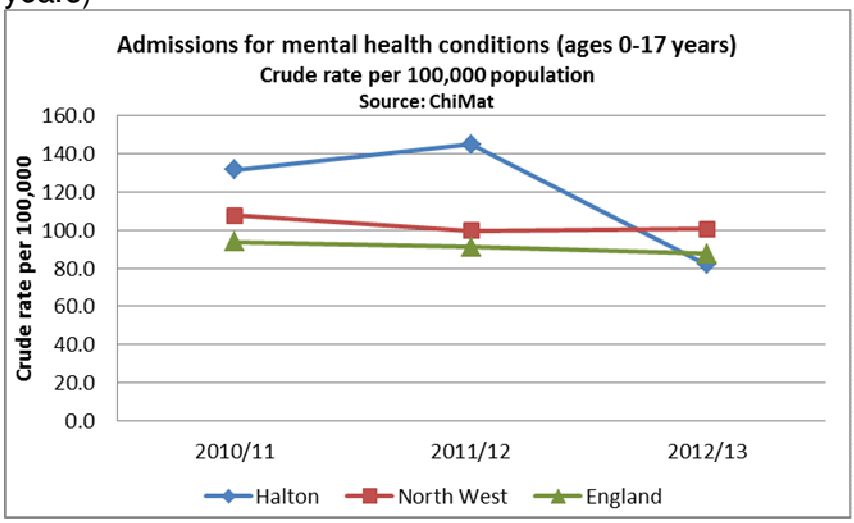
- There have been reductions in the rate of hospital admissions for asthma in 0 to 18 year olds, this is shown in chart 3.

Chart 3: Admission rates for asthma (under 19 years) 2011-2013



- Hospital admissions for mental health conditions have improved and are now similar to the England average. Chart 4 shows the trend over the past 3 years. It is believed that reduced waiting times and improvements to the service's triaging of patients will have impacted upon this figure.

Chart 4: Hospital admissions for mental health conditions (0-17 years)



- There have been reductions in the number of women who are smokers at the time of the birth of their baby, which is illustrated in chart 5 (for Halton and St Helens PCT) and chart 6 (recently available data for Halton only). Performance remains worse than the England average.

Chart 5: Smoking status at time of delivery PCT level.

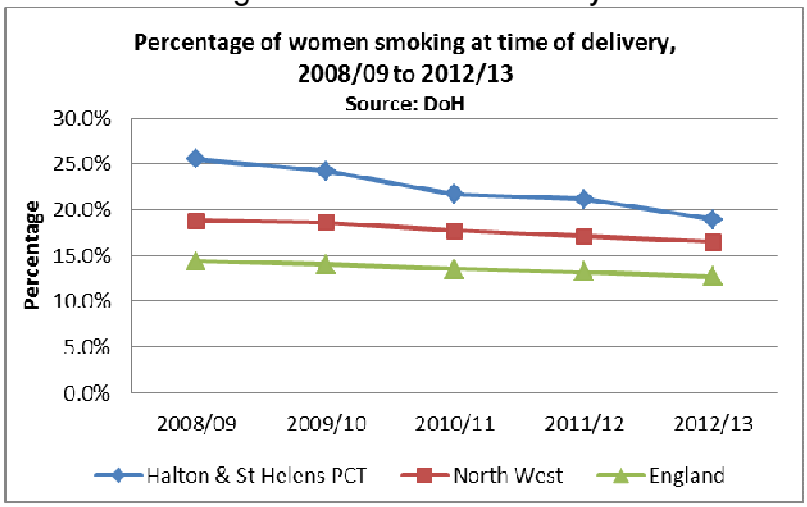
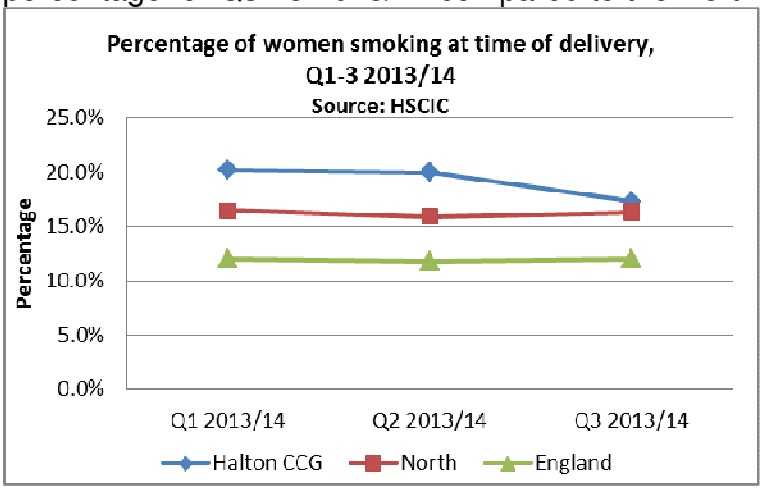


Chart 6: Smoking status at time of delivery for Halton CCG percentage for Qs1-3 2013/14 compared to the North and England



- There has been a small increase in the number of women who initiate and maintain breastfeeding, but the percentage remains significantly worse compared to the England average.
- The rate of children living in poverty has reduced but remains worse than the England average.
- First time entrants to youth justice system have more than halved, but remain worse than the England average.

3.5 Halton has maintained:

- The rate of immunisation for children in care remains above the England average, at 94.4%.
- Primary immunisation rates are similar to the England average, and have remained static. They are meeting the required 95% coverage rate.
- The rate of family homelessness has increased slightly but remains better than the England average rate.
- The number of children killed or seriously injured in road traffic accidents has increased, but isn't significantly different to the England average rate.
- The number of children in care has increased and is lower than but not statistically different to the England average rate.

3.6 Areas where performance in Halton remains lower than the England average:

- The measure for child development has changed so cannot be compared to last year. When the rankings are compared performance remains low. Child development is one of the priority areas for the Health and wellbeing board, and as such has a targeted action plan, this work is continuing with additional focus on bonding

and parenting.

- Child tooth decay in 12 year olds is significantly worse than the England average, however this data is for 2008/9, and is due to be measured again in 2014. Early indications from 5 year old data indicate that local programmes have reduced tooth decay by approximately 22%. A toothpaste and toothbrush distribution programme is in place for school aged children. Evidence suggests this to be a very effective intervention in areas where water is not fluoridated.

- Breastfeeding initiation and at 6-8 weeks remain below the England average. An action plan is being implemented to improve breastfeeding rates, and will be driven through the Health and Wellbeing board (HWB) child development action plan. An infant feeding co-ordinator and a team of breastfeeding support workers work in partnership to support local women to successfully

- Smoking at the time of delivery has improved but remains worse than the England average. Pregnant women have access to an incentive scheme to support them to give up smoking during pregnancy. Smoking is also being picked up through HWB child development action plan.

- While reductions have been seen in the rate of hospital admissions for areas that can be compared (alcohol specific conditions, mental health conditions, substance misuse and asthma). Hospital admissions for injury and self-harm cannot be compared due to changes in data. Halton has worse than the England average admission rates for all of these areas except admissions for mental health conditions. Through the Health and Wellbeing board strategies have been developed to address admission rates for alcohol, substance misuse and mental health conditions.

The full CHIMAT report can be found at
http://www.chimat.org.uk/profiles/static

3.7 **Recommendations**

Child health remains a challenge for Halton. In many areas the trend is moving in the right direction and improvements to child health have been made. We need to work to maintain these improvements and continue to reduce the gap between Halton's outcomes and the England average.

3.8 The Board is asked to support work in the areas listed above where performance remains worse than the England average. It is also recommended that where progress has been made, programmes in these areas are supported to continue. The main areas identified in CHIMAT where further improvements are needed include:
- Child development

-Children and young people who are Not in Education, Employment or training and Youth justice
-Hospital admissions (all causes other than for mental health conditions)
-Breastfeeding rates and Smoking at the time of delivery
-Child poverty

4.0 POLICY IMPLICATIONS

4.1 CHIMAT data is used to identify progress against key performance indicators, many of which are part of the Public Health Outcomes Framework. The data is included within the Joint Strategic Needs Assessment (JSNA) and should be used to inform commissioning decisions in relation to Halton's health priorities for Children and Young People.

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

6.2 **Employment, Learning & Skills in Halton**
Employment, learning and skills opportunities are measured in this report, and will influence health outcomes for the population of Halton. All issues outlined in this report focus directly on this priority

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

6.4 **A Safer Halton**
This report identifies progress against areas of risk taking behaviour in children and young people, and should inform priorities for the Safer Halton agenda.

6.5 **Halton's Urban Renewal**
Child poverty will be linked to local employment opportunities and renewal programmes.

7.0 RISK ANALYSIS

7.1 Halton Borough Council may be at risk of not meeting national targets if the priority areas are not noted and prioritised. There are no financial risks. The recommendations do not require a full risk assessment.

8.0 EQUALITY AND DIVERSITY ISSUES

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

9.0 **Appendix A**

Table 1:Health Outcomes for children and young people in Halton, comparing 2014 CHIMAT data to the 2013 report

Indicator Number	Indicator	2013	2013 Signif to Eng	2014	2014 Signif to Eng	↑/↓/=
1	Infant mortality rate	4.8		4.1		↓
2	Child mortality rate (age 1-17 years)	20.6		9.6		↓
3*	MMR immunisation (by age 2 years)	91.7		94.4		↑
4*	Diphtheria, tetanus, polio, pertussis, Hib immunisations (by age 2 years)	95.5		95.5		=
5	Children in care immunisations	100		94.4		↓
6	Acute sexually transmitted infections (including Chlamydia)	38.9		42.4		↑
7	Children achieving a good level of development at the end of reception	N/A	N/A	37.0		
8	GCSE achieved (5A*-C inc. Eng and maths)	59.0		62.5		↑
9	GCSE achieved (5A*-C inc. Eng and maths) for children in care	-	-	0.0		
10	16-18 year olds not in education, employment or training	10.3		8.9		↓
11	First time entrants to the Youth Justice System	1259.5		594.0		↓
12	Children in poverty (aged under 16 years)	27.3		26.7		↓
13	Family homelessness	0.9		1.3		↑
14	Children in care	44.0		51.0		↑
15	Children killed or seriously injured in road traffic accidents	24.6		32.2		↑
16	Low birthweight of all babies	8.5		6.8		↓
17	Obese children (age 4-5 years, residents)	9.6		11.8		=
18	Obese children (age 10-11 years, residents)	19.5		23.1		↓
19	Children with one or more decayed, missing or filled teeth	N/A	N/A	33.6		
20	Teenage conception rate (age under 18 years)	63.3		41.5		↓
21	Teenage mothers (age under 18 years)	1.5		1.5		=
22	Hospital admissions due to alcohol specific conditions	122.9		72.3		↓
23	Hospital admissions due to substance misuse (age 15-24 years)	149.4		150.3		=
24*	Smoking status at time of delivery	21.1		18.9		↓
25*	Breastfeeding initiation	51.1		52.3		↑
26*	Breastfeeding prevalence at 6-8 weeks after birth	22.0		22.1		↑
27	A&E attendances (age 0-4 years)	535.0		511.2		↓
28	Hospital admissions caused by injuries in children (0-14 years)	N/A	N/A	130.6		
29	Hospital admissions caused by injuries in young people (15-24 years)	N/A	N/A	211.1		
30	Hospital admissions for asthma (age under 19 years)	367.9		296.1		↓
31	Hospital admissions for mental health conditions	145.1		82.1		↓
32	Hospital admissions as a result of self-harm (10-24 years)	N/A	N/A	636.4		

* PCT value			not significantly different to England average
			significantly better than England average
N/A	Not included in previous profile/new indicator		significantly worse than England average
-	Data suppressed or not available		
			data should be ignored due to an issue with
For the definitions of the indicators please see the ChiMat profile			the height measurement equipment

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

None.

Compiled by: Julia Rosser, Public Health Consultant and Jen Oultram, Intelligence Office

REPORT TO: Health and Wellbeing Board

DATE: 9 July 2014

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Wellbeing

SUBJECT: Children's Joint Strategic Needs Assessment

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To provide members of the Board with an update on the Joint Strategic Needs Assessment.

2.0 RECOMMENDATION: That the report be noted.

3.0 SUPPORTING INFORMATION

3.1 Background to the children's JSNA

Joint strategic needs assessments (JSNAs) analyse the health needs of populations to inform and guide commissioning of health, well-being and social care services within local authority areas. The JSNA underpins the health and well-being strategy and commissioning plans. The main goal of a JSNA is to accurately assess the health needs of a local population in order to improve the physical and mental health and well-being of individuals and communities.

The Health and Social Care Act 2012 outlines the continuing role for JSNAs to bring together partners from across the NHS, local government and the voluntary sector to analyse current and future health needs of populations.

Increasingly the JSNA is being seen as a continual process rather than a single document produced at a point in time.

The last two JSNA overall summary documents have adopted a life course approach which has met with favourable responses from the Board and from various partnerships and stakeholders. As a consequence the Children's Trust Executive Group requested that the next iteration of the 'children's element' of the JSNA used broadly the same approach. By doing this it is hoped that the JSNA better describes the needs children & young people have at different

stages of their lives and to better reflect the full range of local needs.

3.2 **Local development of the children's JSNA**

Following papers on the JSNA to the Children's Trust Executive and Commissioning Partnerships a small working group of Children's Trust officers was established to consider what was needed and develop a framework for the development of the new JSNA. This consisted of a series of life stage chapters with additional chapters to reflect vulnerable groups, as follows:

1. Introduction, Key Findings & Methodology
2. Population and socio-economic profile
3. Maternal health
4. Early Years: 0-4 years
5. Health & Wellbeing of School Age Children: 5-18 years
6. Educational Attainment and Employment
7. Safeguarding
8. Children with Disabilities & Complex Health Needs, including learning disabilities and autism
9. Children in Care
10. Engagement and Participation

Authors for each chapter were identified with some guidance notes on what to include. Data was gathered by the Public Health Intelligence Team with support and input from the Customer Intelligence Team, Children & Enterprise Directorate's Performance & Improvement Team, CCG, Police, Youth Offending Service and Health Improvement Team. Other information was also provided by commissioners and officers across the Children's Trust and Safeguarding Children Board.

The scope of the Safeguarding and Children in Care chapters were agreed with the Halton Safeguarding Children Executive Board in October 2013 and presented to the Halton Safeguarding Children Board in December 2013.

Two rapid health needs assessments were also conducted to support reviews of joint Halton Borough Council and Halton Clinical Commissioning Group services. These covered Child & Adolescent Mental Health and Speech, Language and Communication Needs. Halton Public Health also commissioned an in-depth needs assessment of learning disabilities and autism covering children and adults on a Liverpool City Region footprint (data reported at local authority level) which was published October 2013.

All of these form part of the JSNA.

3.3 **Outputs**

All JSNA chapters have now been completed and uploaded on to the Children's Trust website.
http://www.haltonchildrenstrust.co.uk/index.php/jsna/

Each chapter has a set of key findings and priorities. The key findings and priorities from each chapter have been replicated in the first chapter Introduction, Key Findings & Methodology. Whilst most are specific to the life stage or population group they relate to, some overarching themes have emerged.

Key themes emerging:

- Emotional health & wellbeing and mental ill health
- Accidents
- High levels of hospital admissions compared to England and North West. In addition to accidents the admission rates for asthma, diabetes and epilepsy are comparatively high.
- Maintaining good results for many indictors and continuing to drive them in the right direction
- Some issues remain significant and resistant to change. These include breastfeeding. Small improvements have been made but levels remain low compared to the national and regional averages.
- Even for issues that have improved e.g. education attainment, there remain inequalities across the borough that need to be addressed.
- Significant time of change: new services and payment tariffs, organisational change and financial pressures against a back-drop of welfare reforms and continuing economic hardship.

Risk taking behaviour is a key issue detailed in the school-age children chapter.

The key findings and priorities were agreed with the Children's Trust Executive group February 2014. They also fed into the development of the 2014 Children & Young People's Plan.

The Safeguarding and Children in Care chapters will be presented to the Halton Safeguarding Children Board Executive Board April and June meetings and to the main Board in July.

3.4 **Using the children's JSNA**

Already the JSNA has been used to inform the Children & Young People's Plan and work on Children in Care Sufficiency Report. The Children's Trust have also agreed to use the JSNA to focus discussions on their priorities and action plans throughout the year.

The JSNA has been used in providing information for various strategies and will continue to be the main source of data for ones due to be developed during 2014/15. It will also support officers in preparing for Ofsted inspections.

The JSNA has been shared with colleagues in Cheshire West & Chester public health team to enable a similar approach to be developed there, albeit with the need to reflect their local approach to JSNA and needs of their population.

Further work to understand the health and wellbeing needs of young offenders across the Youth Offending Service footprint of Halton, Warrington and Cheshire West & Chester, has been identified and will be progressed during 2014/15.

3.5 Overall JSNA developments for 2014/15

Recent discussions with Halton Borough Council and CCG commissioners have resulted in a number of issues emerging for the 2014/15 JSNA:

- Cardiovascular disease, including diabetes
- Physical and sensory disabilities amongst adults (a separate chapter has already been produced on children)
- Pharmaceutical Needs Assessment (this is a separate and statutory duty but forms part of the overall JSNA)
- Urgent care
- Environment (scope to be determined)
- Mental health and emotional wellbeing remains a priority and we need to consider how best to keep information in the JSNA on this issue up-to-date (note this cuts across the life course)

4.0 POLICY IMPLICATIONS

4.1 The needs identified in the JSNA have been used to support the development of the Children & Young People's Plan.

The JSNA provides a robust and detailed assessment of need and priorities across Halton borough. As such is should continue to be used in the development of other policies, strategies and commissioning plans and reviews.

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**

The Children's JSNA looks at the health and wellbeing needs of

children and young people across a number of life stages and amongst certain vulnerable groups.

6.2 **Employment, Learning & Skills in Halton**
The above priority is a key determinant of health. The Children's JSNA has identified this as an area of improved outcomes but recognises that there are internal gaps between overall educational attainment and employment changes and those seen in certain groups such as Children in Care and children with disabilities.

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

6.4 **A Safer Halton**
Reducing the incidence of crime, improving community safety and reducing the fear of crime have an impact on health outcomes, particularly on mental health. Issues relating to accidental injury, bullying, alcohol and crime are included in the children's JSNA.

6.5 **Halton's Urban Renewal**
The environment in which we live and the physical infrastructure of our communities has a direct impact on our health and wellbeing and will therefore need to be addressed within the JSNA.

7.0 RISK ANALYSIS

7.1 Developing the JSNA does not in itself present any obvious risk. However, there may be risks associated with the resultant commissioning/action plans developed based upon it and these will be assessed as appropriate.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 The JSNA seeks to provide intelligence on which to base decisions on action to tackle health inequalities. This includes analysis of a range of vulnerable groups and the need for targeted as well as universal services to meet the range of needs identified.

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

None.

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Halton Joint Strategic Needs Assessment 2014

Background, Methodology and Key Findings

myhalton living life well

Halton Children's Trust ...Working together to make the difference

HALTON Safeguarding Children Board

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Related documents	none

Please quote the JSNA

We would like to know when and how the JSNA is being used. One way, is to ask people who use the JSNA when developing strategies, service reviews and other work to quote the JSNA as their source of information.

List of Abbreviations

A&E	Accident and Emergency (also called 'Casualty' – hospital facility)
CAF	Common Assessment Framework
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CICOLAs	Children In Care Outside Local Authority
CYPP	Children and Young People's Plan
DCSF	Department for Children, Schools and Families
DfE	Deaprtment for Education
FSM	Free school meals
HSCB	Halton Safeguarding Children Board
HNA	Health Needs Assessment
HSE	Health Survey for England
JSNA	Joint Strategic Needs Assessment
LAIT	Local Authority Interactive Tool (DfE indicator tool)
LSCB	Local Safeguarding Children Board
NEET	Not in education, employment or training
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
MMR	Measles, Mumps and Rubella (usually used to refer to the triple vaccine)
SEN	Special Educational Needs

Contents

1. Introduction

The Joint Strategic Needs Assessment (JSNA) is a systematic way of assessing the health and social needs of the local population. The JSNA should enable strategic partnerships and commissioning leads to make informed decisions about local action and services across a wide range of needs. It not only looks at the overall health and social needs of children & young people, but considers inequalities in outcomes and experience for specific groups. This relates to children living in areas of deprivation, to age and gender, to disability, and to vulnerable groups.

Increasingly JSNAs are being seen as a process of continuous development and improvement, rather than single documents produced once every few years.

Whilst there are no direct policy implications in revising the JSNA in itself, the findings should inform commissioning decisions, including the Children & Young People's Plan. As such the findings may impact on policy and commissioning decisions.The value of the JSNA lies in the degree to which it is understood and valued by strategic partnerships and commissioning leads - the extent to which it is a useful tool to inform their decision making. To fulfil this, it needs their active engagement to ensure it is 'fit for purpose'.

Responsibility for developing the JSNA

The Health & Wellbeing Board has overall responsibility for the JSNA and its development is led by the public health team.

Although the JSNA has been in existence since 2008 and has been used by commissioners to inform decision making, the Children's Trust Executive Board wanted a fresh approach to the next iteration of the children's JSNA. In particular the impact of the Marmot review on health inequalities, has laid the foundations for local areas to relook at their approaches. The life course approach advocated by Marmot has been used in the development of the Health & Wellbeing Strategy and its action plans and is now used to summarise the JSNA on an annual basis.

A working group, made up of members from the Children's Trust Executive Board andCommissioning Partnership, developed a framework for the refresh of the children's JSNA. This follows the life course but allows for the needs of vulnerable groups to be considered in detail as well.

In addition there is a local protocol between the Health & Wellbeing Board and the Halton Safeguarding Children Board (HCSB) which includes recognition for the need for joint ownership for the JSNA between these two boards. A paper was taken to the October 2013 HSCB Executive Board to agree the scope of this element of the JSNA. It was agreed it

needed a more in depth approach than the current chapter, titled 'vulnerable children'. Authors were identified from the HCSB and the scope agreed. A paper was also presented to the December 2013 HSCB on the framework for the Safeguarding chapter. This is detailed in the methodology section alongside the overall JSNA framework.

Regular progress reports were provided to the Children's Trust Executive Group, the Children's Trust Commissioning Partnership and the HCSB Executive Board at key stages of development.

2. National Policy Context for JSNA

2.1. What is JSNA?

The definition from the Department of Health's JSNA Guidance[1] is:

> *"Joint Strategic Needs Assessment describes a process that identifies current and future health and wellbeing needs in light of existing services and informs future service planning taking into account evidence of effectiveness".*

JSNA identifies 'the big picture', in terms of the health and wellbeing needs and inequalities of a local population. The basis of a high quality and robust JSNA is the analysis of current and predicted health and well-being outcomes. The JSNA process should be underpinned by partnership working, community engagement and evidence of effective interventions to address the issues identified.

Breaking the phrase down into its constituent parts is useful in defining what it means in practice:

Joint -The duty to undertake JSNA was introduced in 2007 in recognition that strategic planning for health and wellbeing was best done in partnership, and based on evidence. It is intended to provide a powerful model for joint working in every locality. The Health & Social Care Act sets out the role that JSNA, and its local evidence of need, should play in the work of the Health & Wellbeing Board and the Joint Health & Wellbeing Strategy.

Thus, a key element of the JSNA is that it should involve all the important stakeholders in identifying needs and acting upon them. Crucially the JSNA provides a new framework for health and social care to collectively work in partnership to identify the needs of the population they serve and to work together in commissioning services to meet those needs.

Strategic - the JSNA should identify those needs and service requirements that are most relevant and important to its population. The needs assessment process should provide health and social care organisations with evidence based identification of the key needs of its population and should therefore define the strategic direction in commissioning of

1.Department of Health (2013) Statutory guidance published on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategieshttp://webarchive.nationalarchives.gov.uk/20130805112926/https://s3-eu-west-1.amazonaws.com/media.dh.gov.uk/network/18/files/2013/03/Statutory-Guidance-on-Joint-Strategic-Needs-Assessments-and-Joint-Health-and-Wellbeing-Strategies-March-20131.pdf

services. This strategic direction should consider both today's and future health and social care needs.

Needs assessment - there are many definitions of needs assessment. In order to identify health and wellbeing needs the assessment process should make use of existing information, identify information gaps and should include the views of service users, patients and the population. Importantly the needs assessment must include outputs that can be translated into actions for the commissioning and delivery of health and social care services, health improvement and wellbeing programmes and other interventions. The process should consider social inclusion and should identify inequities and inequalities in health and well-being and in current service delivery.

2.2. How should a JSNA be done?

Whilst producing a JSNA is a mandatory requirement, keeping with the 'light touch' approachfrom national government, Department of Health guidance on the preparation of the JSNA allows for local initiative and discretion. The guidance does however make it clear that the JSNA should be seen as an evolving process of understanding local needs and establishing agreed priorities, rather than as a traditional planning document to be produced at a single point in time.

3. National and Local Policy Context for Child Health & Wellbeing

Since the publication of the National Service Framework for Children in 2004 there have been a wide range of national policy directives concerned with improving the health and wellbeing of children and young people and ensuring the most vulnerable in society are protected from harm and helped to achieve their full potential. One of the most recent reports is the 2012 annual report of the Chief Medical Officer.

3.1. Chief Medical Officer's annual report 2012. Our children deserve better: prevention pays[2]

The Chief Medical Officer for England chose to focus the 2012 annual report on the health and wellbeing needs of children and young people. This was done for a number of reasons:

- The evidence base for the life course approach is strong. What happens early in life affects health and wellbeing in later life. There is increasing evidence that, in England, we are not doing as well as we should to achieve good health and wellbeing outcomes for our children and young people – when we compare both historically and within and between countries for mortality, morbidity, wellbeing, social determinants and key indicators of health service provision.
- The variation we see within our country shows us what 'good' looks like and what is possible: we know we can do better.
- While our economic future may be challenging, there is a growing business case for improving the lives of children and young people. Improving health has the potential to benefit our nation economically.

This report is published in two volumes.

The first chapter is the CMO response to the evidence base underpinning the challenges facing children and young people today. The report highlights issues that require specific focus by policy makers, health and social care commissioners, police and crime commissioners, and providers of health, social care, education, housing and beyond.

Volume two focuses on an examination of the life course stages experienced by those up to the age of 25 years. In addition, four other groups of children and young people were focused on: those with neurodevelopmental disabilities, those with mental health problems, looked after children, and those in the youth justice system. The report also looks at the economic argument for early intervention. The report contains a sizeable annex, the *Atlas of*

2.https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2012-our-children-deserve-better-prevention-pays

variation in healthcare for children and young people, which describes some of the variation in health and healthcare across England.

3.2. Children and Families Bill[3]

The Children and Families Bill takes forward the Coalition Government's commitments to improve services for vulnerable children and support strong families. It underpins wider reforms to ensure that all children and young people can succeed, no matter what their background. The Bill will reform the systems for adoption, looked after children, family justice and special educational needs. It will encourage growth in the childcare sector, introduce a new system of shared parental leave and ensure children in England have a strong advocate for their rights.

This is a joint Bill, presented by the Secretary of State for Education and on behalf of the Departments for Business, Innovation and Skills, Work and Pensions and the Ministry of Justice. The Bill's provisions have been developed following several independent reviews and extensive consultation. Key reforms within the Bill are commitments to:

- Have more children being adopted by loving families with less delay.
- Improving life chances for all looked after children by improving educational attainment levels. The Bill requires every local authority to have a 'virtual school head' to champion the education of children in the authority's care, as if they all attended the same school.
- Reforming the family justice system to help deliver better outcomes forchildren and families who go to court after family separation or where children may be taken intocare.
- Transforming the system for children and young people with special educational needs (SEN), including those who are disabled, so that services consistently support the best outcomes for them. The SEN system will be expanded from birth to 25, giving children, young people and their parents greater control and choice in decisions and ensuring needs are properly met.
- Reforming childcare to ensure the whole system focuses on providing safe, high-quality care and early education for children.
- Make sure that the Children's Commissioner can act as a strong advocate for children, helping to embed a culture where children's rights and interests are duly recognised. The Bill will help improve the Children's Commissioner's effectiveness, taking forward recommendations in John Dunford's Review of the Office of the Children's Commissioner.
- Encouraging the full involvement of both parents from the earliest stages of pregnancy, including by promoting a system of shared parental leave, and to extending the right to request flexible working to all employees.

3.www.education.gov.uk/childrenandfamiliesbill

3.3. Fair Society Healthy Lives[4]

This report, published in February 2010, often referred to as the 'Marmot Review' was an update on previous reports on health inequalities. Lead by Professor Sir Michael Marmot, this independent review drew on national and international research, which showed that the elements contributing to excellent opportunities and outcomes for children and young people are wide ranging. However, in countries where children and young people have the best outcomes, four common features were identified that have the most significant impact:

Family and parenting – This involves good relationships between parents and their children; a warm, firm and positive parenting style; a stable family unit; good relationships between children and extended family members and between siblings.

Pregnancy and early years support – This includes support throughout pregnancy to age five through childcare, pre-school education, physical and emotional health.

Education – Where children have a solid foundation that promotes lifelong learning, those aged five to 18 achieve good learning outcomes within formal education or training. This is enhanced by access to and achievement within higher education.

Material wellbeing –The quality of environment and the personal and public resources available to a child or young person as they grow up impacts on their outcomes. Children's personal resources are often determined by their parents' prosperity.

The review concluded that reducing health inequalities would require action on six policy objectives which were split across the life course:

1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill-health prevention.

An outcomes approach using this life course would need to include measures to ensure all children and young people can:

- be happy and enjoy their childhood
- have access to sufficient material resources
- build and maintain positive relationships and good social skills
- develop respect and responsibility for themselves, for others and their community
- have good emotional health and wellbeing

4.http://www.instituteofhealthequity.org/Content/FileManager/pdf/fairsocietyhealthylives.pdf

- have good physical health
- enjoy good educational achievement
- develop realistic, but challenging aspirations
- be safe and learn to make good decisions regarding safety
- have access to the appropriate information and services
- be able to access stimulating and enjoyable leisure and cultural opportunities.

3.4. Early Intervention is essential

A range of reviews conducted by:

- Professor Sir Michael Marmot: Fair Society, Healthy Lives
- The Rt Hon Frank Field MP: The Foundation Years: Preventing Poor Children Becoming Poor Adults
- Graham Allen, MP: Early Intervention, the next steps
- Dame Clare Tickell: Review of the Early Years Foundation Stage
- Professor Eileen Munro: Review of Child Protection

Have all made it clear that early intervention and support is vital to enable all children to maximise their potential. **The *Allen Report***[5]sets out the working definition for "Early Intervention" in that it shouldbe used to describe the "general approaches, and the specific policies and programmes,which help to give children aged 0-3 the social and emotional bedrock they need toreach their full potential, and to those which help older children become the goodparents of tomorrow" (0-18 years old). The report also sets out the "core message onEarly Intervention" which defines it as an approach "which offers our country a realopportunity to make lasting improvements in the lives of our children and forestall anypersistent social problems and end their transmissions from one generation to the next and to make long term savings in public spending". It notes the current context that"many programmes and policies across the world have been given the title and kudos of 'Early Intervention'. Not all of them deserve this status".

It sets out the rationale for and Early Interventionapproach namely that:

> *"Many of the costly and damaging social problems in society arecreated because we are not giving children the right type of support in their earliestyears, when they should achieve their most rapid development".*

5. http://www.dwp.gov.uk/docs/early-intervention-next-steps.pdf

3.5. Making Sure the NHS meets the needs of children and young people

Sir David Nicholson asked Professor Sir Ian Kennedy to undertake this independent review amid widespread concern about the services provided by the NHS to children and young people. The resulting report ***Getting it right for children and young people***[6] concentrates on understanding the role of culture in the NHS. It focuses on those areas where there are cultural barriers to change and improvement. It examines the NHS's position in a wider system of care and support, so as to understand and improve the NHS's provision of services to children and young people.

The review uncovered many cultural barriers standing in the way of improving services for children and young people. These were created, and operate, at a number of levels, from Whitehall, through regional and local organisations, to contacts between individual professionals, and with children, young people and those looking after them. The report makes several recommendations for improvement.

The review was published at the same time as an engagement document, ***Achieving Equity and Excellence for Children***[7] in which the Government sets out a new vision for the health of children and young people. It is the beginning of an ongoing dialogue on how to ensure high-quality services for children and young people.

In the past, the NHS was not always set up to put the needs of patients and the public first. Too often patients were expected to fit around services rather than services around patients. Nowhere has this been more evident than for children, young people and their families, as Sir Ian Kennedy has shown in his report.

Children and young people are mostly healthy and therefore, thankfully, will never feature highly where decisions are taken based on the burden of disease or on cases of premature death. But illness and injury can have a long-lasting impact on a young person's life and ultimately on their life chances and therefore on our economy and society. In turn this can impact significantly on their family's life.

6.Download full review (PDF, 5195K)
7.Achieving Equity and Excellence for Children

3.6. Continuing to Improve Outcomes

3.6.1. National Outcomes Frameworks

In recognition of the changes to the health and social care system, as a result of the Health & Social Care Act, three new outcomes frameworks have been developed:

- Public Health Outcomes framework
- NHS Outcomes Framework
- Social Care Outcomes Framework

Many of the old national indicators for children and young people were incorporated into these, especially the public health outcomes framework, which includes indicators for child poverty, school readiness, immunisations, obesity and many others. Using the latest year for which comparable data is available, Halton's outcomes against each national outcome framework indicator is detailed in Table 1 (note not all data is currently available at local authority level or for NHS outcomes framework at CCG level).

Table 1: Halton outcomes against national outcomes framework indicators

Public Health Outcomes Framework indicators	How well is Halton doing against this indicator? (using latest comparable data available)
1.01i - Percentage of all dependent children under 20 in relative poverty (living in households where income is less than 60 per cent of median household income before housing costs)	Significantly worse England average
1.01ii - % of children in low income families (children living in families in receipt of out of work benefits or tax credits where their reported income is < 60% median income) for u-16s only	Significantly worse England average
1.02i-ii - School Readiness: All children achieving a good level of development at the end of reception as a percentage of all eligible children.	Worse England average across all school readiness indicators (significantly worse for most of the indicators)
1.03 - % of half days missed by pupils due to overall absence (incl. authorised and unauthorised absence)	Better England rate
1.04 - Rate of 10-17 year olds receiving their first reprimand, warning or conviction per 100,000 population	Rate similar to England
1.05 - % of 16-18 year olds not in education, employment or training (NEET)	Rate worse England but has been improving
2.01 - % of all live births at term with low birth weight	Rate higher than England but not statistically worse
2.02i - % of all mothers who breastfeed their babies in the first 48hrs after delivery (initiation)	Rates worse than England average but signs that they are beginning to improve.
2.02ii - % of all infants due a 6-8 week check that are totally or partially breastfed	
2.03 - % of women who smoke at time of delivery	Rates above England average
2.04 - Rate of conceptions per 1,000 females aged 15-17 (<18s)	Rate has reduced substantially but remains about North West and statistically worse than national average
2.04 - Rate of conceptions per 1,000 females aged 13-15 (<16s)	Rate higher than England but not statistically worse

2.06i-ii - % of children aged 4-5 (Reception) and aged 10-11 (Year 6) classified as overweight or obese	Rates have fallen but remain above the North West and worse than England averages
2.07i-ii - Rate of hospital admissions caused by unintentional and deliberate injuries in children aged 0-14 years per 10,000 resident population and in young people aged 15-24 per 10,000 resident population	Rates for both age groups statistically worse than England averages
2.08 - Average difficulties score for all looked after children aged 4-16 who have been in care for at least 12 months on 31st March (emotional wellbeing of looked after children)	Score similar to North West and England ones. Not statistically comparable.
3.02i-iii - Crude rate of chlamydia diagnoses per 100,000 young adults aged 15-24 using CTAD data	Rates are higher than England
3.03i-xii Population vaccine coverage	Coverage above England rates for most vaccinations.
4.01 - Rate of deaths in infants aged under 1 year per 1,000 live births (Infant mortality)	After years of being above the England average, local reductions mean Halton now has similar rates to England.
4.02 - Tooth decay in children aged five years	After years of being above the England average, local reductions mean Halton now has similar rates to England.
NHS Outcomes Framework indicators	**How well is Halton doing against this indicator? (using latest comparable data available)**
Potential years of life lost from causes considered amenable to healthcare: adults, children and young people	Only available at England level
Reducing deaths in babies and young children	Neonatal and still births rate higher than England but local numbers low.
Unplanned hospitalisations for asthma, diabetes and epilepsy in under 19s	Higher than England but rate not statistically significantly higher.
Emergency admissions for children with lower respiratory tract infections	Statistically significantly higher than England. Higher rate than Merseyside but not statistically significant difference.
Women's experience of maternity services	Indicator at CCG level not yet available
Improving children and young people's experience of healthcare :	Indicator under development

3.6.2. The Children and Young People's Health Outcomes Forum Report[8]

Informed by engagement with some two thousand people – children and young people and their families and those working in the wider health and social care system – this sets out a case for change.

There is clear evidence that pregnancy and the earliest years are critical to the future health and wellbeing of children and adults and that evidence based early intervention can have significant shorter and longer term positive impacts. Smoking, alcohol, poor nutrition, and

8. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216854/CYP-Public-Health.pdf

stress or the absence of a warm loving relationship can have significant shorter and longer term negative impacts.

Early intervention can prevent ill health and reduce mortality and morbidity for children and young people. Healthy behaviours in childhood and the teenage years set patterns for later life. Continued support for children and young people can mean that society as a whole can reap all the benefits of a resilient next generation, which is healthier and happier.

The causes of avoidable childhood deaths are complex and differ at each stage of childhood. Securing a reduction in mortality and morbidity, requires a multifaceted approach, encompassing effective public health interventions in pregnancy, the early, school and teenage years, alongside improvements in health care from conception to adulthood. It also requires a focus on the groups of children who experience the worst outcomes.

High quality, evidence based and safe care are what should define health services for children and young people. We know how important it is to children, young people and their families that they are able to access the care and treatment that is right for them, as close to home as possible.

The need for integrated care coordinated around and tailored to the needs of the child or young person and their family is clear and fundamental to improving their health outcomes. Integration means the joins between services and commissioning responsibilities are invisible because organisations are working in partnership to deliver the best care across whole pathways and life stages. It means children, young people and parents don't have to keep repeating their information, that records are not lost or duplicated, that individuals and their needs do not fall between gaps and that resources are focused on the same goals.

In January 2014 the Child and Maternal Health Intelligence Network, CHIMAT (now part of Public Health England), published a first version of the Children and Young People's Health Outcomes Framework[9].

This new resource brings together and builds on health outcomes data from the Public Health Outcomes Framework and the NHS Outcomes Framework. It responds to the Children and Young People's Health Outcomes Forum's recommendation that a version of these frameworks be created which highlights areas of particular relevance to improving the health outcomes of children and young people.

A number of important additional indicators were also recommended by the Children and Young People's Health Outcomes Forum. These will be added to the Framework over the next year, as the data becomes available, together with increased detail for existing

9. http://fingertips.phe.org.uk/profile/cyphof

indicators. These indicators, when viewed together, will inform discussions and encourage improvements in services and health outcomes for children and young people.

This section details the main national policies which affect the health and wellbeing of children and young people. There are many more, including many that relate to particular groups or young people or conditions. Many are detailed in specific chapters of the JSNA. The most up-to-date and comprehensive list of these can be found on the CHIMAT website at http://www.chimat.org.uk/youngpeople/govpol

A useful source of national guidance to improve outcomes for children and young people can be found at the Centre for Excellence and Outcomes in Children and Young People's Services via their website http://www.c4eo.org.uk/

4. Methodology

4.1. Local approach

As detailed in section 2 there is no set way of developing the JSNA. Locally, it was agreed that a standard approach to developing the individual elements of the JSNA may not be the most appropriate. Some issues may be best dealt with by short 'profiles' e.g. the section on detailing the population breakdown and socio-economic circumstances of children & young people in the borough. For other issues in-depth needs assessments would be more appropriate.

A number of strategies were written during the latter half of 2013 with others planned for 2014. These include those written to support health & wellbeing strategy priorities as well as other public health priority issues. Rapid needs analyses have been/will be conducted for these and this information will support the JSNA. These cover:

- Cancers (completed)
- Mental health strategy (completed)
- Drugs strategy (completed)
- Alcohol Strategy (January-June 2014)
- Sexual health (2014: dates TBC)

A separate piece of intelligence work has been carried out to support the Child & Family Poverty Strategy and action plan. This is summarised in the demographics profile section of the JSNA. Two rapid health needs assessments have already been conducted to support reviews of joint Halton Borough Council and Halton Clinical Commissioning Group services. These covered Child & Adolescent Mental Health and Speech, Language and Communication Needs. Halton Public Health also commissioned an in-depth needs assessment of learning disabilities and autism covering children and adults on a Liverpool City Region footprint (data reported at local authority level) which was published October 2013. All of these form part of the JSNA. Summary information has been taken from other needs assessments with links to full documents.

4.2. Overseeing development of the JSNA

4.2.1. The working group

Once it was agreed to review and revise the children's JSNA a small working group was established to take this forward.The group began by looking at existing needs assessments that should feed in to the JSNA, mapped the 'what', 'who', 'when' and 'review schedule' of these. The working group split into a number of smaller 'author groups' for each chapter,

supported by information leads from Public Health, Customer Intelligence Unit and Performance.

A template, slightly revised from the 2011 JSNA, was used to guide construction of each chapter. However, it was more important to cover each issue as information emerged rather than follow a template strictly. Therefore the breadth and depth of each chapter was dictated by the issues it covered rather than being restricted to page limits. Some of the chapters had not featured to any great extent in previous JSNAs, others had been covered within topic-based chapters and a few subject to in-depth needs assessments over the last year or two. The working group continued to meet at regular stages of JSNA development to ensure momentum was maintained as well as dealing with consistency and duplication issues.

The JSNA schedule was developed to ensure key findings were available in time to support the development of the 2014 Children & Young People's Plan (CYPP). The JSNA lead is a member of the CYPP working group.

4.2.2. Frameworks for the JSNA

A framework for the development of the new JSNA has been agreed with authors identified for each section. This was presented to the Children's Trust Executive Group October 2013 and refined to combine elements on physical and learning disability and complex needs in to one section. The framework is across the life course, in line with the Marmot review of health inequalities, with additional sections to reflect vulnerable groups.

The framework for the 2014 children's JSNA is:

1. Background, methods and key findings
2. Population and socio-economic profile
3. Maternal health
4. Early years: 0-4 years
5. School age children 5-18 years
6. Educational attainment and employment
7. Safeguarding
8. Children with disabilities & complex needs, including learning disabilities and autism
9. Children in Care
10. Engagement and user views

There is a chapter in the 2011/12 JSNA on vulnerable children which needed updating for the 2014 JSNA. However, many issues relating to safeguarding are not covered in it. A number of external JSNAs were examined prior to see how other areas have looked at this issue. Most were brief documents and sections, primarily limited to descriptions of the

number and rate of children in need, children subject to Child Protection Plans with some including reasons for this. Some looked at child and adult safeguarding together. The HSCB Executive Board examined these and decided to adapt one to cover:

- *Protection from maltreatment e.g.* Child sexual exploitation, bullying, domestic violence and abuse, neglect, parental substance misuse, parental mental health, parental learning disability
- *Protection from impairment to health or development e.g.* teenage pregnancy, sexual health, self-harm, young carers, substance misuse in young people, children with mental health problems, young offenders
- *Ensuring Safe and effective care e.g.* Children referred to social services, children in care, children subject to a Child Protection Plan
- *Ensuring a Safe Environment e.g.* Child deaths, unintentional injuries, Accident and Emergency attendances, Road Traffic Accidents, Young people as victims of crime
- Complex and Multiple Needs
- Safeguarding Processes and Targeted Provision

Duplication with other chapters was discussed and the detail included in one chapter with summary information and a web link in the other.

4.3. Data analysis, including access to data and information

The JSNA uses a wide variety of data from both national and local sources, including:

- Office of National Statistics (census population data)
- Index of Multiple Deprivation
- Health & Social Care Information Centre
- Department for Education (including Local Authority Interactive Tool: LAIT, February 2014)
- Local Performance systems
- Local providers
- CHIMAT
- Research papers
- National policy

The JSNA uses routinely collected data to profile the local population in terms of numbers who may potentially be at risk of a range of developing a range of conditions and problems. Where appropriate, it uses research to stratify the overall population, according to different levels of severity and types of condition.

The JSNA uses estimated data as well as numbers known to services. In this way, it attempts to describe any gaps between the total population who may have a need/condition and those known to services.

In this way the JSNA uses the same methodology as in-depth health needs assessments (HNAs). HNAs are a way of estimating the extent and nature of a population so that appropriate support is planned accordingly. The needs assessment can help:

- Estimate the current and future needs of a population
- Indicate the distribution of need: geographically and/or by sub-groups within the population of interest
- Identify the gap between met and unmet need.

HNA is a systematic method for reviewing the health needs and issues facing a given population, leading to agreed needs (priorities) for that population. The starting point in HNA is a defined population. This population can be defined in a number of ways. By:

- Geographic location – e.g. people living in a neighbourhood or catchment area
- Setting – e.g. school, workplace, prison or hospital
- Social experience – e.g. age, ethnicity, homelessness
- Experience of a health condition – e.g. disease, mental illness or physical disability.

Various models have been developed but the main components of the model used by public health are:

- *An epidemiological approach* – an examination of available information on incidence and prevalence, including hospital and primary care contacts, local audits, and estimates from local and national surveys
- *A comparative approach* – comparing local estimates of disease and/or activity with other similar areas or national data to assess if need is greater or lesser than expected
- *A corporate approach* – this approach gathers information on perceived needs from a wide range of health professionals, other sectors, patients and the community.The benefit of this approach is that it can be responsive to local concerns and encourages ownership of the issues that need to be addressed. The disadvantage is that if it is carried out in isolation it can focus on the stakeholders concerns, which may be influenced by political agendas, and can identify demands rather than need.

Thus, evidence of population need is collected in a systematic way from multiple sources from which the most important needs will emerge from more than one source.

Being able to describe the needs, using normative, comparative and expressed data is only part of the process of conducting a health needs assessment. It is also important to know which interventions are best suited to addressing which needs. Each chapter includes a list of national best practice from sources such as NICE (National Institute of Health & Clinical Excellence), Department of Health, Department for Education as well the Marmot Review Team and others.

The breadth and depth of the JSNA is only as good as the information we have access to. There were delays in accessing some of the previously routinely collected data. This has been managed by the Public Health Intelligence Manager, supported by both Customer Intelligence Unit, Children & Enterprise Directorate performance and data quality staff and CCG colleagues, to ensure as much data as possible was available to authors. Access to outcomes data from services has been patchy with changes in both commissioning and provider organisations as well as IT changes having contributed to this, with some new systems still not operational. This has meant authors have had to, at times, take a pragmatic approach on data/information availability. Any core data that was not available at time of writing or that could not be accessed has been reported on in the specific chapter section it relates to.

Data was collated by the Public Health Team and provided to each chapter group.

4.4. Benchmarking borough outcomes: use of national, regional and statistical neighbours

Is important to be able to contextualise local data to determine whether outcomes seen locally are as expected, better or worse than other areas. Traditionally, North West and England averages are used to compare local data and this is replicated in the JSNA. However, a more robust approach which enables comparison with boroughs that are statistically similar is also presented where the data is available. Thus outcomes can be compared to a broadly similar population.

The Department for Children, Schools and Families (now Department for Education) commissioned a Children's Services Statistical Neighbour Benchmarking model in February 2007. The model defined for each local authority a robust set of statistical neighbours for all Local Authorities. This statistical neighbour grouping continues to be used e.g. by the Department for Education Local Authority Interactive Tool (LAIT), the latest version of which was published December 2013. Halton forms part of a statistical neighbours grouping with 10 other local authorities. The statistical neighbour comparison data shown throughout the JSNA uses an average derived from all 11 boroughs in the group. There may be some under calculation where 1-2 boroughs' data is not represented in national datasets due to small numbers. Statistical neighbour averages are not calculated where 3 or more borough's data

is not available for a particular indicator. The group is made up of the following local authorities:

- Halton
- Darlington
- Hartlepool
- North East Lincolnshire
- Redcar & Cleveland
- Salford
- South Tyneside
- St. Helens
- Stockton on Tees
- Sunderland
- Tameside

Statistically neighbours analysis is not available for all indicators presented in the JSNA. Whilst individual areas data may be available, it is often only presented as crude or directly age standardised rate. It has not been possible to calculate statistical neighbour group averages when data has only been available as a rate. In this case only North West and England comparisons have been made.

5. Key Findings and Priorities

Most children lead happy, healthy lives with good relationships with family and friends. However, some do experience ill health or exhibit behaviours which put them at risk of harm or development of ill health. The findings and priorities emerging from the JSNA highlight the main areas of ill health, low levels of achievement and risk taking behaviours that contribute to these. Whilst many findings and priorities are specific to a particular life course stage or group, several themes did emerge across the JSNA.

Key themes:

- Emotional health & wellbeing and mental ill health
- Accidents
- Maintaining good results for many indictors and continuing to drive them in the right direction
- Some issues remain significant and resistant to change. Even for issues that have improved e.g. education attainment for children in care compared to general population, there remain inequalities across the borough that need to be addressed.
- Significant time of change: new services and payment tariffs, organisational change and financial pressures against a back-drop of welfare reforms and continuing economic hardship.

Maternity

1. Monitoring the impact of the introduction of a maternity Payment by Results tariff on local services, and mitigating any unforeseen consequences
2. Family Nurse Partnership - commission of the service and project implementation, including streamlining with existing services
3. Comprehensive universal service to all women and families, including the additional antenatal visits made by health visitors
4. Early access to antenatal services for all women, targeting vulnerable groups
5. Concentrated work on early recognition, treatment and support for maternal emotional health
6. Breastfeeding initiation – monitor initiation rates by borough when available, focused work to improve rates.
7. Improving women's awareness of the harm caused by alcohol and smoking during pregnancy. Monitor Smoking at the time of delivery by borough when available and commission accordingly.
8. Sudden infant death syndrome awareness raising, information to women
9. Method of delivery, including, Caesarean section rates

Early Years

1. Maintain and improve the delivery of a comprehensive universal offer to all young families
2. Focusing efforts to improve child development through:

    a. Physical health
    b. Communication and language skills
    c. Personal, social and emotional development
    d. Maximising the mother and child bond, and parenting skills
    e. Improved breastfeeding rates, particularly initiation rates

Delivery of high quality early years provision

3. Immunisations:

    a. Maintain increases in rates for children under 24 months,
    b. Capture children under 5 who missed their primary immunisations
    c. Catch up campaigns for older children, such as MMR[10] (in response to outbreaks)

5. Hospital admissions: Rates of emergency hospital admission in Halton are high compared to England. Admissions for gastroenteritis are statistically higher than the England average, in order to improve this priorities include breastfeeding and weaning practices, in respect to healthy eating.
6. Accidents: The rate of hospital admissions and accidents is higher in Halton than the England average. Commissioners should endeavour to ensure all services working with young families promote accident prevention to their clients and signpost as appropriate. Ensure providers are meeting NICE[11] guidelines in respect to accidents and road traffic accidents.
7. Obesity: continue work in the early years on breastfeeding, weaning, healthy eating and exercise which all contribute to reduce obesity in reception aged children.
8. Improvements in dental health of 5 year olds needs to be maintained and further improvements made, through evidence based oral health programmes.

10. MMR = triple vaccination for Measles, Mumps and Rubella
11. NICE – National Institute for Health & Clinical Excellence

School Age children

1. Maintain and improve reductions in teenage pregnancy, substance use (tobacco, alcohol and drugs), hospital admissions due to alcohol.
2. Maintain current reduction and continue to reduce the proportion of children who are overweight and obese. Do this through whole systems plans to tackle the 'obesenogenic' environment, as well as programmes to help children and their families who are already overweight to achieve and maintain a healthy weight.
3. Develop whole system, co-ordinated approaches to tackle high Accident & Emergency attendances and hospital admissions due to accidental injuries. Use NICE guidance to ensure a systematic, strategic approach to accident prevention is required with action aimed at the home (where most younger children have their accidents) and the wider built environment including the roads.
4. Look at ways to gather local intelligence on levels of mental wellbeing as well as mental ill health and factors that contribute to both.
5. Ensure integrated preventative and support services are in place that are family-focused to help both parents and children cope with parental mental health, alcohol and substance misuse problems.
6. The prevention, diagnosis, and early access to treatment for individuals with mental health problems should be a priority, including a clear pathway and adequate provision of CAMHS. This work is underway.
7. Hospital admissions due to self-harm although reducing are high in Halton. Commissioners should strive to improve the emotional resilience, peer support and access to appropriate service for children and young people who regularly self-harm.
8. There are high rates of immunisation against cervical cancer. The uptake rates for HPV in Halton are the highest in the North West. These should be maintained.

Education and Employment

1. Attainment in the Early Years Foundation Stage: Focusing upon the prime areas of learning and development as identified in the Framework for the Early Years Foundation Stage:

    a communication and language
    b physical development
    c personal, social and emotional development

There are four specific areas through which the prime areas are strengthened and applied:

    d literacy
    e mathematics
    f understanding the world

g expressive arts and design

Closing the gap in educational attainment for vulnerable groups including:

a Children and young people with Special Educational Needs (SEN)
b Children in Care
c Children and young people in receipt of Free School Meals (FSM)
d Young people with an academic age of 16-18 years who are not in education, employment or training (NEET)
e Children and young people in any other identified vulnerable groups including gender gaps

3. Children and young people with English as an Additional language (EAL) has been identified as an emerging rising need

Safeguarding

Based on the Halton Safeguarding Children Board Annual Report 2012/13 and supported by JSNA analysis the following priorities are outlined in the Local Safeguarding Children Board (LSCB) Business Plan 2013/15:

1. Identify and prevent children suffering harm – The rationale being that the LSCB identified that Halton had a low Child in Need population compared with statistical neighbours. Children were coming into care who were not known previously to Children's Social Care. Address the low number of CAF (Common Assessment Framework).
2. Protect children who are suffering or at risk of suffering harm – The rationale being the low Child in Need population, low number of children subject to Child Protection Plan, and the low number of children subject to Child Protection Plan for a second or subsequent time compared with statistical neighbours. The LSCB also identified that the Escalation Policy was not being used, with a lack of apparent challenge by partners.
3. Ensure that children are receiving effective early help and support – The rationale being the number of children coming into care previously not known to Children's Social Care. Also the low number of CAFs and high percentage of Lead Professionals from Children's Services and primary schools, indicating a lack of engagement in early help and support by other partners.
4. Support the development of a safe and informed workforce, including volunteers – The rationale being that all LSCBs have functions relating to learning and improvement, training and safer workforce.
5. Engage with Children and Young People, their Families and Communities in developing and raising awareness of Safeguarding – The rationale being that

awareness raising is a function of all LSCBs, and that the LSCB sees safeguarding children as everyone's business.

Embedded across all of these priorities is a focus by the LSCB on particularly vulnerable groups of children and young people. This includes: children at risk of sexual exploitation; Missing children; children with disabilities; Young Carers; Children in Care and Care Leavers.

Disabilities

1. Research undertaken into the pattern of child disability suggests that there has been an increase in the number of disabled children. This is especially so for those with complex needs and this increase is projected to continue, with improvements in medical technology as well as population changes being the drivers.
2. The rate of children with life limiting conditions is higher in Halton than for the North West and England. This appears to be due to improved medical technologies rather than an increase in incidence. Such children are more likely to need complex care packages and palliative care.
3. The percentage of Halton school children with a Special Educational Need is higher than the North West, statistical neighbours and England averages. These figures should be read in context; Halton schools and settings, in conjunction with Local Authority officers services and health, work proactively to develop innovative ways of supporting all school children & young people, without the need to place them into a set category within the graduated approach. Our Early Help policies and interventions will continue to become embedded within all areas of practice in the next few years and this, along with the new approach enshrined within the draft Code of Practice 2013, should ensure that there is a continuing reduction in the identification of SEN within existing classifications.
4. The percentage of Children in Need assessed as having a disability is lower in Halton than for its comparators. However, this is likely to be due to the borough's approach to early help and support and the range of services such as short breaks.
5. Three conditions account for over 90% of emergency admissions for children under 19s with long-term conditions. These are asthma, diabetes and epilepsy. For all three of these conditions the borough has higher rates of emergency hospital admissions than England. Work is needed to address these.
6. National research indicates that obesity levels are significantly higher for children who have disabilities, especially where this includes a learning disability. Local action needs to consider ways of supporting children who may find it difficult to participate in current service options.
7. Mental health and emotional support needs of children with disabilities need to be tailored to meet their specific needs

Children in Care

1. The borough has a lower rate of children in care than comparators. However, numbers have risen. This rise may put pressure on placement stability and impact on outcomes for children in care.
2. The borough is a net importer of children in care from other local authorities (CICOLAs). This put considerable additional capacity issues into local service provision.
3. Compared to statistical neighbours, NW and England, the Children in Care in Halton:
    - See a higher proportion having placement stability
    - Are more likely to be placed in the borough (70%, 86% within 20 miles of home)
    - Are more likely to be up-to-date with their immunisation schedule, have had their annual health check, to have had their annual dental check
    - Have slightly lower mental wellbeing scores
    - Have higher proportions reaching their expected level of educational achievement.
4. There remains a gap in educational achievement between children in care and non-Children In Carein the borough although the gap is narrowed. In particular there are gaps in English and Maths at all key stages for Children in Care compared to Halton overall and England overall achievement. This is consistent with regional and national experience. Positive discrimination to provide additional educational support to children in care should be considered.
5. Due to the way that the Pupil Premium funding is calculated the rising numbers of children in care are placing financial pressure on being able to meet the funding allocations for children and schools. This has occurred this year and with the changes in the eligibility criteria from April 2014 this is likely to continue. This will inevitably have an impact on schools' ability to provide additional support for Children in careand therefore may have an detrimental impact on their educational outcomes.
6. National research suggests Children in Care are more likely to suffer mental health and emotional wellbeing problems. Although there is no data at a local level to determine this, the annual health assessments undertaken for Children in Carefor 12 months or more does show emotional and behaviour difficulties to be the most prevalent issues identified. Commissioners should ensure opportunities to improve the health and wellbeing for Children in Care are maximised, and that the health of Children in Care is a priority.

REPORT TO: Health & Wellbeing Board

DATE: 9 July 2014

REPORTING OFFICER: Strategic Director Children and Enterprise

PORTFOLIO: Children, Young People & Families

SUBJECT: Child Protection-Information Sharing Programme

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 This report provides an overview on the new Halton Children & Young People's Plan (CYPP) 2014-17.

2.0 RECOMMENDATION: That the Board

1) **notes the contents of the report;**

2) **ensures that the appropriate requirements are in place from a Health perspective as outlined under Section 4; and**

3) **supports the staged approach to implementing the programme as set out in Section 7.**

3.0 SUPPORTING INFORMATION

3.1 The Child protection information sharing programme is a government initiated programme which will become a statutory responsibility in April 2015. The aim of the programme is to integrate crucial information into the health database and allow information to be reported by health straight into Local Authority social care record for children and young people. The data is required to be updated every 24 hours by all three systems, CSC, Health and the central data system.

3.2 Not all information will be shared for all children. The targeted group of young people are those subject to Child Protection Planning and those children who are in the care of the local authority. Children are considered children in care when they are:

- accommodated under section 20 of the Children Act 1989,
- are subject to an Interim care order or full care order under the same act
- who have no legal guardians able to assert Parental Responsibility (PR) such as unaccompanied asylum seekers,
- children who have no persons with parental responsibility and in accordance with the Children Act the Local Authority

therefore assumes PR.

3.3 For those children and young people who fall into the categories identified above information will be shared with the central system which speaks with both the Health Care systems and Children's Social Care systems.

3.4 The aim is to ensure that a child can attend any medical facility throughout the country and upon presentation will be identified as a child at risk or in care and as a consequence actions and treatment provided will consider the presenting risks. The data in respect of their visit to a medical establishment will then be uploaded and sent back to the local authority and appropriate action taken.

3.5 Gerald Meehan (Strategic Director has put Halton forward as wave two of the role out, this means we have confirmed our intention to be up and running by April 2015 with our target date being September 2014.

4.0 What is required

4.1 In order for the process to work the technical support needs to be in place. This means that CSC and Health organisations must have the capability to talk to the central system that collates and amends the data. As a result each party is required to have an N3 connection. In addition CSC will require Care First to be able to report on the required data, aggregate the data and send it via the N3 to the central system. This same process will apply to health colleagues and their data systems.

4.2 OLM the owner and creator of the Carefirst CSC system is currently identifying how Carefirst will aggregate the data and send it to the central record. It is likely that there will be cost implications for this but assurances have been given by CP-IS that they will challenge companies that charge too much and have stated that it should cost no more than £1000.

4.3 In respect of the data collection, the Local Authority is required to produce procedures detailing how and who will be responsible for ensuring the data is recorded appropriately onto the system. This is particularly important as in the event that an NHS number is wrong the whole dataset will be returned.

5.0 Recording the Data

5.1 It is proposed that for Children becoming subject of Child protection planning the Safeguarding Unit will impute the NHS number on the day of the plan being made. Marie Fairbrother has confirmed that from the 30/06/14 all Health visitors and school health advisors will include on their health report for conference the child NHS number.

5.2 In cases were the child is an unborn, the mothers NHS number is added

to the system and amended upon the child's birth. The quickest way to update the NHS number in these situations is for specified health professionals to be given limited access to the CSC record, so that they can immediately update the system when a child is born. As Halton does not have this in place a process will need to be agreed that minimises delay in the recording of the data.

5.3 For children in Care the collection of the NHS number can be undertaken on the day that the child comes into care via the social worker and CIC nurse. Marie Fairbrother is considering other methods of receiving this data in order to reduce the risk of delay. Discussions are scheduled to take place around Some health professionals having access to the Carefirst system will would support the timely completion of data for CIC and Newborn babies.

6.0 Receiving of data

6.1 Until Carefirst has determined how they intend to send and receive the data it is not possible to confirm the exact process of how the information will be responded to. However initial conversations with Tracey Overs have confirmed that the central point of contact for the data being received will be CART and EDT if the electronic record is not immediately updated by the central system. EDT will need to determine upon receipt of the information whether an immediate response is required and respond appropriately. In respect of CART their responsibility will be to ensure the data is logged on Carefirst and notification sent to the allocated social worker practice/principal managers and the team duty desk.

6.2 In the event that the Carefirst system will update automatically Peter Cartledge will be looking into the system sending an alert on to the workers and practice managers desk tops for action.

7.0 Next steps

1. Send a comprehensive list of all CP children and CIC children to CP-IS so that the NHS numbers can be recorded on Carefirst **Katherine Appleton**
2. Confirm what OLM plans are to ensure the system can undertake the notification tasks required. **Peter Cartledge**
3. Meet with Colleagues from health who are leading on the programme to determine where they are up to.
4. Confirm whether Health colleagues will be given access to the Carefirst system **Marie Fairbrother** / **Gerald Meehan**
5. Write the procedures to be followed by Children's social care **Katherine Appleton**
6. Implement data transfer by end of September 2014.

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

None under the meaning of the Act.

REPORT TO: Health and Wellbeing Board

DATE: 9 July 2014

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Wellbeing

SUBJECT: Healthy Start Programme – Vitamins

WARD(S): Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To provide information on a pilot to increase the provision and distribution of Healthy Start vitamins in Halton.

2.0 RECOMMENDATION: That the Board

1) **notes the content of the report; and**

2) **supports the proposals to pilot the universal distribution of Healthy Start vitamins to all pregnant and breastfeeding women (regardless of income) and to all infants at six months of age.**

3.0 SUPPORTING INFORMATION

3.1 The Healthy Start Programme is a Department of Health-funded programme that provides low-income families which include a pregnant woman or a child under the age of four years (and all pregnant women under the age of 18 years), with vouchers to spend on food and to exchange for vitamins.

3.2 Weekly food vouchers can be spent on milk, fruit and vegetables, or infant formula milk. Eligible pregnant women (more than 10 weeks pregnant) and those with a baby under the age of one year are entitled to free maternal vitamins. Children aged between six months and four years are entitled to vouchers for free vitamin drops. Each voucher is exchanged for an eight-week supply of vitamins.

3.3 Healthy Start vitamins contain the recommended amount of vitamin A, C and D for young children, and folic acid and vitamin C and D for pregnant and breastfeeding women. Healthy Start vitamins are intended to supplement the diets of low-income children and mothers, whose diets are more likely to be deficient in key vitamins.

3.4 Vitamin A is used by the body to fight infection, and is also important for ensuring good vision in dim light. Vitamin C boosts immunity and aids wound

healing. Vitamin D is essential for healthy teeth and bones and prevention of rickets. Vitamin D status in infants is determined by both exposure to sunlight and maternal vitamin D status during pregnancy. Folic acid supplementation is recommended for all pregnant women, and can reduce the incidence of neural tube defects, including spina bifida. This means that adequate maternal vitamin intake during pregnancy is crucially important for infant health.

3.5 Nationally, there has been an increase in the incidence of infant rickets. Although levels in Halton are not as high as other areas due to the proportion of mothers who use formula milk, there is a need to encourage expectant mothers to breastfeed their babies and provide the maximum support for breastfeeding mothers.

3.6 In Halton, Healthy Start vitamins are currently distributed via two health centres in Runcorn, and two health centres in Widnes. The Healthy Start Programme requires pregnant women and new mothers to register for the scheme, after which they receive vouchers which are exchanged for vitamins on a bottle-by-bottle basis. The numbers accessing the scheme are very low equating to less than **1%** of all pregnant women, new mothers and infants.

3.7 Until recently pregnant women and new mothers who were ineligible for the voucher scheme were able to purchase Healthy Start vitamins from NHS Trusts at a much lower cost than branded vitamins sold on the high street. However, due to regulatory changes NHS Trusts will no longer be able to do this and there is concern that this could have a significant impact on the numbers accessing the recommended vitamins. This lack of vitamin supplementation is likely to have a detrimental effect on the nutritional status of new mothers and infants within the borough.

3.8 It is proposed that Healthy Start vitamins are distributed free of charge to all pregnant and breast feeding women in the Borough regardless of income via midwives, health visitors and through the children's centre network and one bottle of vitamins is provided to all infants at six months of age.

3.9 It is proposed that this pilot will run from 1st August 2014 to 31st August 2015.

3.10 The existing voucher scheme for low income families will continue and it is proposed that the availability of the voucher scheme is extended to Children's Centres, which are at the heart of local communities, to increase access and encourage take up. An awareness raising campaign will help promote both the universal availability of free vitamins and the voucher scheme for eligible infants.

3.10 The cost of the scheme, based on an initial 90% uptake rate with 'fall off' among subsequent uptake is estimated at £5,325.12. There has been a clear rationale to the calculation of these uptake rates, based on evidence consisting of research and current local intelligence. The cost of the promotional marketing campaign will be £2,500.

3.11 The move to universal provision of maternal vitamins for mothers will contribute to improving the nutritional status of the most vulnerable mothers and children in the borough, who are at most risk of vitamin deficiency. This 'invest to save' strategy will reduce rates of infectious disease within the borough and has the potential to reduce rates of health services use. Greater uptake of maternal Healthy Start vitamins will subsequently reduce infants' risk of developing rickets due to vitamin D deficiency, protect against spina bifida and improve mothers' immune systems to help protect them from infectious diseases. Improving vitamin D status will also increase calcium absorption, preventing dental caries.

3.12 Evidence suggests that universal provision is the most cost-effective strategy for improving uptake among eligible groups. Universal provision will increase awareness of the scheme among health professionals, and will ensure that they prioritise the scheme, overcoming barriers to access for pregnant women and new mothers.

4 POLICY IMPLICATIONS

4.1 The Healthy Start vitamins programme forms part of the Healthy Child programme. It will improve population health within Halton thereby contributing to the Child Development priority within Halton's Health and Wellbeing Strategy.

5 OTHER/FINANCIAL IMPLICATIONS

5.1 The total cost of the scheme is £7,825. It will cost £5,325 to deliver the Healthy Start vitamins to pregnant women on a universal basis (at a majority uptake rate). The cost of the promotional marketing campaign will be £2,500. This funding will be from the Public Health budget.

6 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children and Young People in Halton**
All issues outlined in this report focus directly on this priority.

6.2 **Employment, Learning and Skills in Halton**
No direct implications have been identified.

6.3 **A Healthy Halton**
All issues outlined in this report focus directly on this priority. The Healthy Start vitamins programme will reduce inequalities in nutritional intake in Halton.

6.4 **A Safer Halton**
No direct implications have been identified.

6.5 **Halton's Urban Renewal**
No direct implications have been identified.

7 RISK ANALYSIS

7.1 Children who are deficient in vitamins – particularly vitamin C – are at risk of increased hospital admissions because they have a lowered ability to fight infections. Children who are vitamin deficient are at increased risk of nutrition-related disorders such as rickets. The recommendations do not require a full risk assessment.

8 EQUALITY AND DIVERSITY ISSUES

8.1 The scheme will have a positive impact on pregnant women and low income families.

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

None

Compiled by: Julia Rosser, Public Health Consultant; Beth Milton, Speciality Registrar in Public Health; and Delima Khairudin, F2 Doctor.