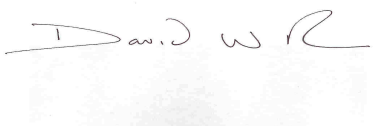
Public Document Pack

Health and Wellbeing Board

Wednesday, 17 September 2014 2.00 p.m.
Karalius Suite, Halton Stadium, Widnes



Chief Executive

Please contact Gill Ferguson on 0151 511 8059 or e-mail gill.ferguson@halton.gov.uk for further information.
The next meeting of the Committee is on Wednesday, 12 November 2014

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

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HEALTH AND WELLBEING BOARD

At a meeting of the Health and Wellbeing Board on Wednesday, 9 July 2014 at Karalius Suite, Halton Stadium, Widnes

Present: Councillors Philbin, Polhill and Woolfall and S. Banks, S. Boycott, P.Cook, K. Appleton, K. Dee, K. Fallon, G. Ferguson, A. McIntyre, D. Parr, M. Pickup, J. Rosser, N. Rowe, R. Strachan, A. Stretch, N. Sharpe, M. Shaw, A. Waller, S. Wallace Bonner.

Apologies for Absence: Councillor Wright and E. O'Meara, I. Stewardson, S. Yeoman, D. Lyon, C. Richards, D. Sweeney, D. Johnson, J. Wilson.

Absence declared on Council business: None

ITEM DEALT WITH UNDER DUTIES EXERCISABLE BY THE BOARD

Action

HWB1 MINUTES OF LAST MEETING

The minutes of the meeting held on the 7th May 2014 were taken as read as a correct record.

HWB2 PRESENTATION - PUBLIC HEALTH ENGLAND CENTRE CHESHIRE AND MERSEYSIDE

The Board received a presentation on behalf of Public Health England (PHE) Centre Cheshire and Merseyside from Katie Dee, who outlined to Members details on:-

- a summary of the changes since PHE Centre Cheshire and Merseyside was established in April 2013;
- PHE's mission, role, core functions and national priorities;
- its achievements in 2013/14 and priorities for 2014/15; and
- details on the 2014/15 Business Plan.

Arising from the discussion the Board discussed the administration of prescribed medicines in schools by staff. It was noted that changes to the Children's Act would address this. In addition, partnership working between PHE and other organisations was discussed. It was noted that when

approached to work with Commissioners, PHE had said there would be cost implications and a decision had been made not to pursue the proposed partnership project. In response the Board was advised that the PHE Centre role as a provider would become clearer.

RESOLVED: That the presentation be received.

HWB3 PRESENTATION NHS HALTON CCG - END TO END ASSESSMENT WORK

The Board received a report which set out an overview of the outcomes of the End to End Assessment Project which was delivered by Capita on behalf of NHS Halton CCG with NHS Knowsley, St. Helens and Warrington CCGs and NHS England. The End to End Assessment Project was commissioned to provide a:-

- High level retrospective review of healthcare 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.

It was noted that the Capita End to End Assessment work had shown that the Mid Mersey CCGs all had similar strategic commissioning intentions. The Capita and i5 work suggested that the plans of NHS Halton CCG in partnership with Halton Borough Council and local providers were achievable but there were significant challenges ahead.

It was reported that the outcomes of the NHS End to End Assessment work would be factored into the 5 Year Strategy for NHS Halton CCG.

RESOLVED: That the report be noted.

HWB4 CHIMAT- CHILD HEALTH PROFILE

The Board received a report from the Director of Public Health, which provided an update on the Child Health Profile (CHIMAT) which was released every year by Public Health England and provided a summary of the health and wellbeing of children and young people in Halton. The data

that was included in the Child Health Profile was available at a national level and enabled Halton to benchmark their health outcomes against the England average values.

It was noted that health outcomes were 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 was generally worse than the England average, as were the levels of child poverty. Halton was the 27th most deprived borough in England (out of 326 boroughs) and, as such, would be expected to have lower than average health outcomes.

Members were advised that there were 32 health and wellbeing indicators included in the CHIMAT report and details in relation to performance were outlined in the report. With regard to the 32 indicators it was highlighted that:-

- there had been improvement in 17 indicators;
- for five outcomes performance was poorer in 2014 when compared to 2013, however for four of these indicators Halton was performing either at or above the England average rate;
- Six indicators had new methods of reporting data and therefore could not be compared to the 2013 report.

Members were further advised that child health remained a challenge for Halton. However, in many areas, the trend was moving in the right direction and improvements to child health had been made. It was important to maintain these improvements and continue to reduce the gap between Halton's outcomes and the England average. The Board was asked to support work in the areas where performance remained worse than the England average. It was also recommended that in areas of work were progress had been made, programmes in these areas continue to be supported. The main areas identified in CHIMAT where further improvements were needed included:-

- Child Development;
- Children and Young People who were Not in Education, Employment of Training and Youth Justice;
- Hospital Admissions (all causes other than for mental health conditions);
- Breastfeeding rates and smoking at the time of delivery; and
- Child Poverty.

RESOLVED: That

1) the contents of the 2014 Child Health Profile and the progress that has been made against a challenging baseline be noted. Out of the 32 areas 17 had improved, 4 had stayed the same and 5 were worse. For six of the measures data changes meant the results could not be compared;

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

HWB5 CHILDREN'S JOINT STRATEGIC NEEDS ASSESSMENT

The Board received a report of the Director of Public Health, which provided an update on the Children's Joint Strategic Needs Assessment (JSNA). It was noted that the last two JSNA overall summary documents had adopted a life course approach which 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 use broadly the same approach. By doing this it was hoped that the JSNA better described the needs children and young people had at different stages of their lives and better reflected the full range of local needs.

Members were advised that a small working group of Children's Trust officers was established to consider what was needed and to 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.

The Board was advised that all JSNA chapters had now been completed and uploaded onto the Children's Trust website. Each chapter had a set of key findings and priorities. It was noted that key themes emerging included:

- emotional health and wellbeing and mental 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 were comparatively high;

- maintaining good results for many indicators and continuing to drive them in the right direction;
- some issues remained significant and resistant to change, including breastfeeding, although small improvements had been made, levels remained low compared to the national and regional averages;
- although some issues that had improved for example, educational attainment, inequalities across the borough remained and needed to be addressed; and
- there were new services and payment tariffs, organisational change and financial pressures against back-drop of welfare reforms and continuing economic hardship.

It was also noted that the Children's JSNA had already been used to inform the Children and Young People's Plan and work on the Children in Care Sufficiency Report. The Children's Trust had also agreed to use the JSNA to focus discussions on their priorities and action plans throughout the year.

Arising from the discussion it was suggested that a future JSNA could cover 'later life over 65's'.

RESOLVED: That the report be noted.

HWB6 CHILD PROTECTION INFORMATION SHARING PROGRAMME

The Board considered a report of the Strategic Director, Children, Young People and Families, which provided an update on the Child Protection Information sharing Programme (CP-IS). The CP-IS was a Government programme which would become a statutory responsibility in April 2015. The aim of the programme was to integrate crucial information into the Health database and allow information to be reported by Health straight into local authority Social Care records for children and young people. It was noted that the targeted group of young people were those subject to Child Protection Planning and those children who were in the care of the local authority. For those children and young people, information would be shared with the central system which speaks with both the Healthcare systems and the Children's Social Care systems.

It was also noted that a further aim of the programme was to ensure that a child could attend any medical facility throughout the country and upon presentation would be identified as a child at risk or in care and, as a consequence, actions and treatment provided would consider the

presenting risks. The data in respect of their visit to a medical establishment would then be uploaded and sent back to the local authority and appropriate action taken. The data was required to be updated every 24 hours by all three systems, Child Social Care (CSC), Health and the central data system.

Members were advised that in order for the process to work the CSC and Health organisations must have the capability to talk to the central system that collated and amended the data. As a result, each party was required to have an N3 connection. In addition, CSC would require Carefirst to be able to report on the required data, aggregate the data and send it via the N3 to the central system. The operators of the Carefirst CSC system were currently identifying how Carefirst would aggregate the data and send it to the central record. It was likely that there would be cost implications for this but assurances have been given by CP-IS that they would challenge companies that charged too much and had stated that it should cost no more than £1,000.

In respect of the data collection, the Local Authority was required to produce procedures detailing how and who would be responsible for ensuring the data was recorded appropriately onto the system. This was particularly important as in the event that an NHS number was wrong, the whole dataset would be returned. The report outlined details of the staged approach to implementing the programme and the next steps involved before the data transfer at the end of September 2014.

Halton had agreed to be part of wave two of the roll-out and consequently would be operational by April 2015 with a target date being September 2014.

RESOLVED: That

1) the contents of the report be noted;

2) the Board ensures that the appropriate requirements were in place from a Health perspective as outlined in the report; and

3) the staged approach to implementing the programme be supported.

HWB7 HEALTHY START PROGRAMME VITAMINS

The Board considered a report of the Director of

Public Health, which provided information on a pilot to increase the provision and distribution of Healthy Start vitamins in Halton. The Healthy Start Programme was a Department of Health funded programme that provided low-income families which included a pregnant woman or a child under the age of 4 years (and all pregnant women under the age of 18 years), with vouchers to spend on food and to exchange for vitamins. It was noted that the numbers accessing the scheme were very low equating to less than 1% of all pregnant women, new mothers and infants.

Until recently pregnant women who were ineligible for the voucher scheme were able to purchase Healthy Start vitamins from NHS Trusts at a lower cost. However due to regulatory changes NHS Trusts were no longer able to do this and there was a concern that this could have a significant impact on the numbers accessing the vitamins. It was therefore proposed that Healthy Start vitamins would be distributed free of charge to all pregnant and breastfeeding women in the Borough regardless of income via midwives, health visitors and through the children's centre network and one bottle of vitamins would be provided to all infants at 6 months of age. It was proposed that this pilot would run from 1st August 2014 to 31st August 2015.

It was noted that the existing voucher scheme for low income families would continue and it was proposed that the availability of the voucher scheme would be extended to Children's Centres, to increase access and encourage take-up. An awareness raising campaign would help promote both the universal availability of free vitamins and the voucher scheme for eligible infants.

The cost of the scheme based on an initial 90% uptake rate with fall off among subsequent uptake was estimated at £5,325.12. With the cost of the promotional marketing campaign at approximately £2,500.

Arising from the discussion it was suggested that any promotional material regarding the free vitamins scheme could be included in the Halton Housing Trust Welcome packs.

RESOLVED: That

1) the content of the report be noted; and

2) 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 be supported.

Meeting ended at 3.10 p.m.

REPORT TO: Health and Wellbeing Board

DATE: 17th September 2014

REPORTING OFFICER: Strategic Director Communities

PORTFOLIO: Health and Wellbeing

SUBJECT: Approval of the draft Better Care Fund Submission 2014

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To request that the Board approve the final draft Better Care Fund for submission to the Local Government Association and NHS England by 19th September 2014.

2.0 **RECOMMENDATION: That the Board**

i) note the content of the report

ii) approve the final draft Better Care Fund submission (Appendix 1)

3.0 **SUPPORTING INFORMATION**

3.1 Members of the Board will recall that the initial draft Better Care Fund was submitted to the Local Government Association (LGA) and NHS England on 4th April 2014, following approval by the Board.

3.2 After receiving the submissions, NHS England and the LGA re-issued new guidance and new templates, changing the some of the focus of the plan. For example, the payment for performance is now purely focussed on non-elective admissions, instead of across health and social care performance metrics.

3.3 The final re-submission of the Better Care Fund is due on Friday 19th September 2014 no later than 12 noon.

4.0 **POLICY IMPLICATIONS**

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

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

5.0 FINANCIAL IMPLICATIONS

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

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

Summary	**Better Care Fund 2015/16 £'000s**
Expenditure on new projects	2,717
Contingency	518
Expenditure on existing projects	38,171
TOTAL	**41,406**

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

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

6.2 Employment, Learning & Skills in Halton

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

6.3 A Healthy Halton

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

6.4 A Safer Halton

None identified.

6.5 Halton's Urban Renewal

None identified.

7.0 RISK ANALYSIS

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

8.0 EQUALITY AND DIVERSITY ISSUES

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

Updated July 2014

Better Care Fund planning template – Part 1

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

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

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

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**HALTON BOROUGH COUNCIL**
Clinical Commissioning Groups	**NHS HALTON CCG**
Boundary Differences	**Co-terminus**
Date agreed at Health and Well-Being Board:	**17/09/14**
Date submitted:	**19/09/14**
Minimum required value of BCF pooled budget: 2014/15	**£533,000**
2015/16	**£10,594,000**
Total agreed value of pooled budget: 2014/15	**£35,374,000**
2015/16	**£41,406,000**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	NHS Halton CCG

By	Simon Banks
Position	Chief Officer
Date	<date>

<Insert extra rows for additional CCGs as required>

Signed on behalf of the Council	Halton Borough Council
By	David Parr
Position	Chief Executive
Date	<date>

<Insert extra rows for additional Councils as required>

Signed on behalf of the Health and Wellbeing Board	Halton
By Chair of Health and Wellbeing Board	Rob Polhill
Date	<date>

<Insert extra rows for additional Health and Wellbeing Boards as required>

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

Document or information title	Synopsis and links
Joint Strategic Needs Assessment (JSNA)	Joint local authority and NHS HCCG assessments of the health needs of the local population in order to improve the physical and mental health and wellbeing of the people of Halton. http://www3.halton.gov.uk/Pages/health/JSNA.aspx
Future impact of demographic changes on unplanned hospital care in Halton	This document identifies areas with a potential for increased demand over the next five years in relation to demographic changes in the borough. These potential areas for increased demand are reflected within our aims and objectives.  Future of Health in Halton - Public Health
Halton Health and Wellbeing Strategy	The Health and Wellbeing Strategy sets out the priorities and actions which the Health and Wellbeing Board are currently implementing. http://www3.halton.gov.uk/Pages/health/PDF/health/Halton_Health_and_Wellbeing_Strategy.pdf
CCG 5 year strategic plan	Detailed plans by the CCG delivery of services and associated performance measures and efficiency targets. http://www.haltonccg.nhs.uk/public-info/Publications.aspx
CCG 2 year operational plan	Detailed plans by the CCG delivery of services and associated performance measures and efficiency targets.

	http://www.haltonccg.nhs.uk/public-info/Publications.aspx
Urgent Care Strategy	The Urgent Care Strategy outlines the strategic direction for the delivery of urgent care in Halton over the next five years. The Strategy facilitates a common approach to provision and creates a framework within which care providers and commissioners can work to ensure seamless, high quality and appropriate care. It will help ensure that unplanned care becomes better planned and understood by the people of Halton, those responsible for managing urgent care services and the work force required to deliver them.  Urgent Care Strategy (Final).docx
Falls Prevention Strategy	This strategy proposes the development of an integrated falls care pathway with sufficient capacity to deliver an agreed model of care to older people in Halton who are at risk of falling. The model would build on an agreed model of care that is highlighted in the local prevention and early intervention strategy.  Falls Strategy.docx
Market Position Statement (MPS)	This statement provides a powerful signal to the market, summarising important intelligence and explaining how the local authority intends to strategically commission, and encourage the development of high quality provision to suit local populations. http://www3.halton.gov.uk/Pages/councildemocracy/pdfs/adultsocialcare/Adult%20Social%20Care%20Market%20Position%20Statement.pdf

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

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

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

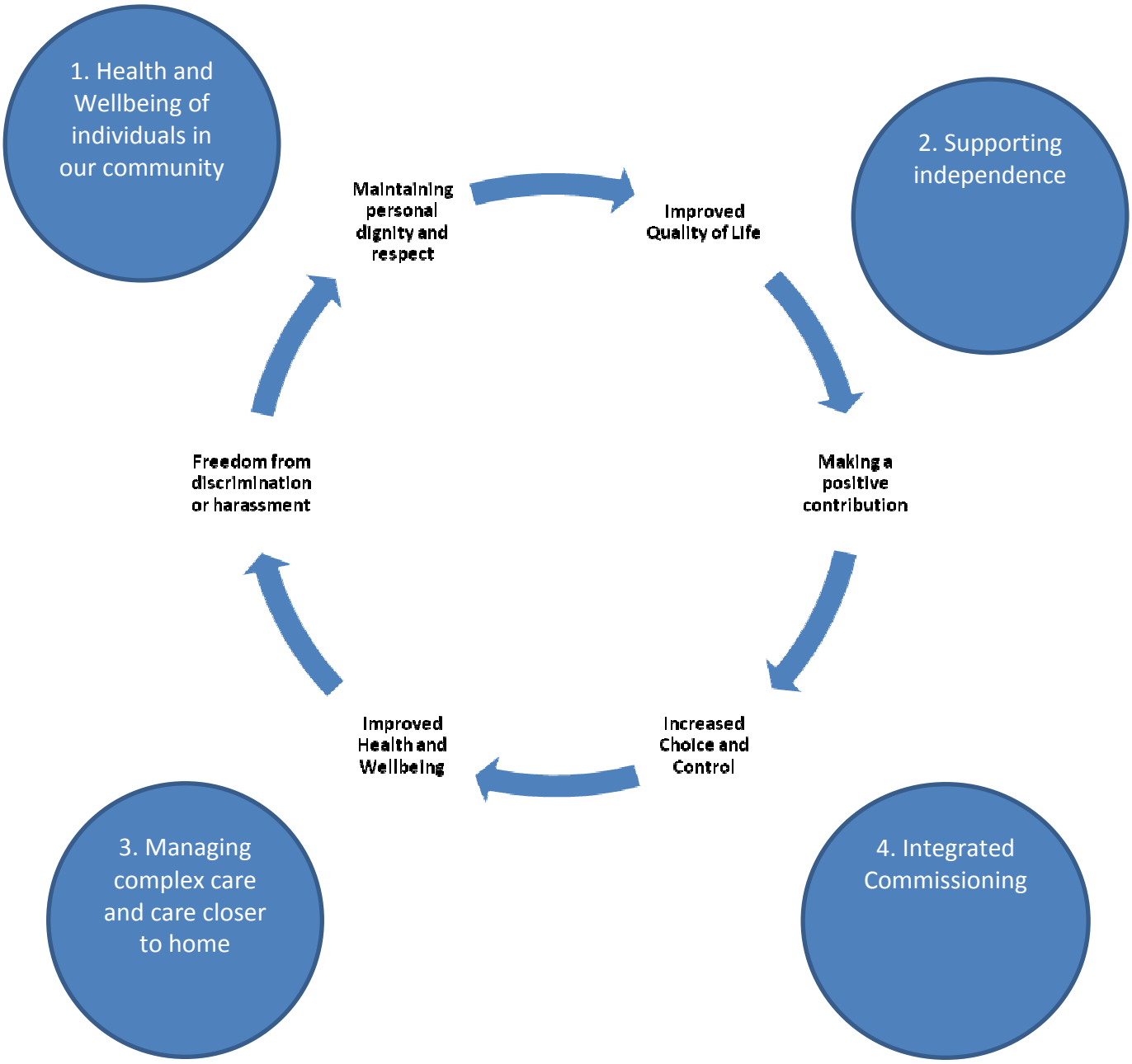
Parity of esteem is a way to embrace the physical and mental to ensure equity of provision for people with mental health problems. Currently people with Mental Health conditions die several years prematurely from people without these conditions. This is the result of a number of both physical and mental health factors. Medication improvements and investment into mental health after care will significantly reduce this inequality. Amidst reducing budgets, Halton is investing a further £400k during 2014/15 to address this issue. This is specifically around Hospital Liaison, Children's Services and anti-stigma/preventative approaches to health.

b) What difference will this make to patient and service user outcomes?

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

We will ensure that we:

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


1. Health and Wellbeing of individuals in our community
2. Supporting independence
Maintaining personal dignity and respect
Improved Quality of Life
Making a positive contribution
Increased Choice and Control
Improved Health and Wellbeing
Freedom from discrimination or harassment
3. Managing complex care and care closer to home
4. Integrated Commissioning

Case Study

The following case study is from the Like Minds campaign in Halton. The campaign has been developed by a team of dedicated mental health specialists based at Bridgewater Community Healthcare NHS Trust and Halton Borough Council. The team works tirelessly to help local people recognise, overcome and deal with mental health issues on a daily basis. Its focus is to promote healthy life choices that help us all have a positive mental health.

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

and I used to feel lonely

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

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

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

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

Based on the above patient and service user outcomes, we have concentrated our BCF on the three National performance metrics shown in the table below, and one local performance metric and detailed our reasoning behind the targets that we have set. Further detail of these can be found in ***Template 2, under Tab 6 "HWB Supporting Metrics"***.

Supporting Performance Metrics

Permanent Admissions to Residential and Nursing Care	Baseline 13/14	Planned 14/15	Planned 15/16
Numerator	125	134	138

Our planned target for permanent admissions to residential and nursing care for 14/15 from the 13/14 baseline figure is an increase of 7.2% and for 15/16 is an increase of 3%. In previous years Halton had low rates of permanent residential and nursing home admissions compared to National and Regional figures, so it is unrealistic to assume our figures will drop considerably, especially with the added factor of the population growth in our Older People population.

Reablement	Baseline 13/14	Planned 14/15	Planned 15/16
Numerator	65	73	77

Halton operate a criteria for assessment within Intermediate Care. The range of services available enable people with higher levels of medical acuity and those within the last three months of life to be cared for. This places people at risk of hospital admission and of dying whilst in receipt of and when discharged from Intermediate Care services and is reflected in the target set.

Delayed Transfers of Care	Baseline Q4 13/14	Planned 14/15 Q4	Planned 15/16 Q4
Numerator	793	519	388

Although the baseline appears to show a reduction in excess of 14% the annual reduction from 13/14 to 14/15 is in the region of 5%. The large annual reduction is due to a large spike in activity in Q4 2013/14 which was not typical either of the year or the same period in 2012/13. Winter pressure schemes are in place to prevent this level of increase and forecast activity has been planned using more consistent historical data rather than the one off spike seen in Q4 2013/14'.

Local Metric – Hospital Readmissions where original admission was due to a fall	Baseline	Planned 14/15	Planned 15/16
Numerator	184	192	191

Falls prevention is a priority for Halton based on our demographics and the population growth of Older People within the Borough. Implementing new and improved preventative measure will help support a reduction in this metric in the longer-term. The planned targets for 14/15 and 15/16 take into account the growth in the older people population within Halton.

NB - Halton have chosen to use the National Patient/Service-User Experience metric once it has been developed.

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

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

The changing landscape of health and social care provision over the past two years has enabled us to re-evaluate our overall approach to the commissioning and delivery of health and social care services and examine how we could do things differently to not only ensure value for money, but ensure that services are affordable, sustainable and meet the needs, wants and aspirations of our community. There is a long tradition of working across organisational boundaries to achieve positive outcomes for local residents. The health and social care community is committed to taking current developments forward and knitting them into a coherent and integrated whole in order to achieve our vision of delivering person centre coordinated care within Halton. The HBC Public Health document "Future Impact of Demographic changes on unplanned hospital care in Halton" identifies areas with potential for increased demand over the next five years in relation to changes in demographics of the borough. These potential areas for increased demand are reflected within our aims and objectives, and outcomes and metrics.

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

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

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

In order to provide independent, assurance as to the benefit of integrating care services in Halton an independent health economics organisation, i5 Health Ltd, was commissioned to do this. In addition, Capita, were commissioned to provide a retrospective, current and future view of health and social care activity, spend and patient flows across the Mid Mersey Area; covering NHS Halton, Knowsley, St Helens and Warrington CCG's. This additional analysis has also provided assurance that the current focus of commissioning is the correct one and that significant savings are possible in Acute Care without destabilising the Acute Care providers.

The analysis provided by Capita includes:
"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."

One of the main conclusions from the Capita End-to End assessment highlighted the necessity to work towards greater integration.
"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."

NHS Halton CCG commissions acute services primarily from two providers, specific analysis has been undertaken on three patient groups identified as having the most to benefit from greater integrated care, this analysis concluded:
"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.
The i5 report focussed on how schemes across the whole health economy in Halton (including both the CCG and the Local Authority) would impact on specific patient cohorts with specific conditions with regard

to hospital admissions and lengths of stay.

The outcome of this report was that overall both the i5 and Capita assessments give assurance that the Halton Health Economy's plans are focussed in the right areas (Acute care, Older people),and that the level of savings identified in the financial and operational plans are broadly achievable, although at the top end of what is possible.
Within Halton some of the specific analysis done highlighting the improvements that integration of services can bring has highlighted the following.

- Including BCF a governed pooled arrangement worth 42m
- The Pool showing month on month savings currently at 158k
- Halton LA & CCG 50/50 funding of intermediate care ensures the reduced need for Residential/Nursing placements
- Integrated safeguarding teams
- Integrated care home teams showing a continued reduction in A&E attendances and subsequent admissions.
- Integrated discharge teams resulting in little to no delays for Halton residents. LOS maintenance & improvements
- Pooled budgets for CHC resulting one assessment one package, this counter acts the data which shows low assessment for Halton
- Pooled arrangement and BCF in line to meet the challenges of Care Act
- Integrated care home project showing clear reduction of care home admissions.
- BCF and CCG investment to provide two Urgent Care Centres to further reduce A&E activity and NELs

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

Our plan of action is attached at **Annex 3** and details the schemes and funding attached to the schemes that form part of the Better Care Fund.

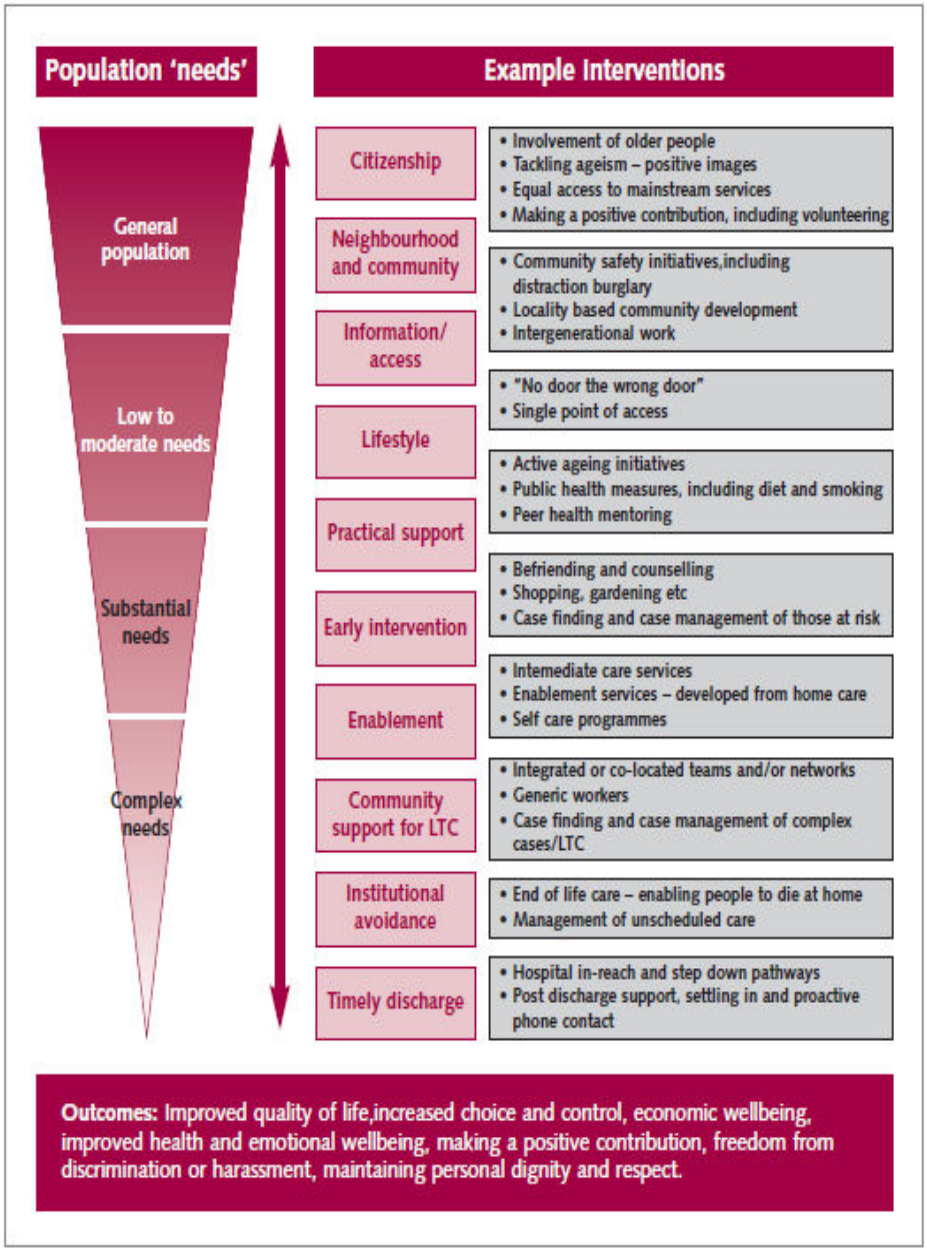
The Action Plan details both new and existing schemes within the BCF. It is useful to note that some of the schemes are also part-funded from other sources. The expenditure plan within Template 2 gives a breakdown of the finances for each scheme stating area of spend and commissioner. The following information is a brief finance summary which describes the detailed breakdown of spend for 2014/15 and 2015/16 and highlighting which monies are new during 2015/16.

Project Description	**2014/15 £'000**	**Total 2015/16 £'000**	**Of Which is new in 2015/16 £'000**
Contingency	-	518	-
1 - Integrated Wellness Service	-	20	20
2 - Prevention	-	1,145	8
3 - Integrated Approach to Dementia	-	160	60

4 - FALLS Prevention	-	130	130
5 - Telecare	140	140	-
6 - DFG HICES & Adapts	1,548	1,658	83
7 - Reablement & Intermediate Care	5,460	5,696	-
8 - Integrated Social Care & Health	27,652	27,977	606
9 - Integrated Adult Safeguarding Unit	-	391	50
10 - Integrated MH Services	-	496	80
11 - Out of Borough Placements	-	256	-
12 - LD Nurses & Therapy Services	55	448	-
13 - Urgent Care	100	690	690
14 - Carers & National Eligibility Criteria	359	809	450
15 - End of Life	-	192	-
16 - Integrated Care Homes Support	-	350	350
17 - Reduce Delays in Discharge and length of Stay	60	210	150
18 - Information Technology Strategy	-	100	100
19 - Joint Quality Assurance & Performance Unit	-	20	20
Total Contribution	**35,374**	**41,406**	**2,797**

Within our plan of action and the schemes listed above, Halton's Strategy is focussed on prevention of ill health and poor emotional wellbeing, early detection of disease, support people to remain independent at home, manage their long-term conditions, wherever possible avoid unnecessary hospital admissions and in situations where hospital stays are unavoidable ensure that there are no delays to their discharge. This is described in the diagram below:

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



b) Please articulate the overarching governance arrangements for integrated care locally

Within Halton, governance arrangements and accountability structures for integrated health and social care report into the Health and Wellbeing Board.

The Board has adopted a membership that adequately reflects its key responsibility of providing an integrated response to local needs, which has early intervention and prevention at the forefront. The work of the Board is supported by a number of strategic partnership boards/groups which are intended to drive forward developments, particularly concerned with integration, within their respective fields.

Attached at **Annex 4** is the current governance structure which outlines the key strategic partnership board/groups within Halton.

The governance arrangements and accountability structures adopted demonstrate a significant level of

trust and confidence in shared governance structures and a shared commitment to improving outcomes for service users and patients and their carers making effective and efficient use of public resources.

In summary, the partnership boards/groups undertaken a number of functions, including:

- Giving feedback in relation to commissioned activity and performance;
- Ensuring that there is a clear relationship and understanding to support a co-ordinated and coherent approach to commissioning activities;
- Being open, transparent and inclusive in order to gain ownership and commitment to broader and specific commissioning proposals;
- Effectively monitoring and reviewing the progress of programmes to contribute to key targets and ensure dissemination of learning and good practice;
- Disseminating and sharing strategies and action plans in order to facilitate cohesive partnership/integrated working; and
- Promoting collaboration, co-ordination and communication in health and social care partnerships.

c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

Following the establishment of formal pooled budget arrangements (via a Section 75 agreement) between Halton Borough Council (HBC) and NHS Halton Clinical Commissioning Group (CCG) in 2013, Halton established the Complex Care Board, whose overall aim was to ensure that an integrated system was developed and appropriately managed to ensure that the resources, including the pooled budget, available to both Health and Social Care were effectively used in the delivery of personalised, responsive and holistic care to those who are most in need within our community.

The Complex Care Board was supported by a Complex Care Executive Commissioning Board (ECB) who would aid the work of the main Board by overseeing the implementation of the decisions made by the Board etc. on issues relating to the strategic, commissioning and operational direction of Complex Care in Halton.

Membership of the Complex Care Board and ECB consists of senior representation from both HBC and CCG; whilst the Chair of the main Board is the Executive Portfolio holder for Health and Wellbeing within Halton.

As a result of the introduction of the Better Care Fund, in May 2014 the Complex Care Board agreed that the existing mechanisms and structures created for the oversight and management of the Complex Care Pool were appropriate ones for the oversight and management of the Better Care Fund and as such the remit of both the main board and associated ECB were changed to include the BCF and as such the names of the Board and ECB have changed to reflect this; Complex Care Board is now known as the Better Care Board, whilst the ECB is now named the Better Care ECB. This Board links in to the CCG's Governing Body

and send through monthly reports to them.

An action plan (as outlined in Section 4a) has been developed which outlines all the schemes associated with the Better Care Plan and this action plan will be updated and monitored via the ECB on an ongoing basis. This will not only allow for progress to be regularly reported through to the Better Care Board on an ongoing basis, but will allow the ECB to take timely remedial action if needed on any programmes which are not effectively meeting the performance targets that have been established.

d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Based on patient/service-users' needs, the following schemes form part of the Better Care Fund. Some are existing schemes and some are new schemes. With existing schemes, there are options for redesign of some of those schemes. The impact of each scheme aligns to either national or performance metrics along with benefits within the plan. Each scheme has a Detailed Scheme Description with further detail, but below we have highlighted some key points, for ease of reference. Our Action Plan at ***Appendix 3*** also details the schemes with the breakdown of costs, responsible officer, accountable group and notes which strategic aim the schemes relate to.

Ref no.	Scheme
1	**Integrated Wellness Service – new scheme** Evidence base includes "A review carried out by the Liverpool Public Health Observatory in 2010 highlights a number of benefits of providing a whole system integrated wellness service, including benefits to the service user, cost benefits…"  ANNEX 1 Scheme 1.docx
2	**Prevention – some existing, some new**, e.g. information campaign linked to the Care Act Anticipated outcomes of this service include a contribution toward: Reduction in unplanned hospital admissions; Reduction in primary care visits; Increase in people accessing information; and an Increase in the number of people supported to maintain their own independence.  ANNEX 1 Scheme 2.docx
3	**Integrated Approach to Dementia – new and existing scheme.** The strategic objective of this scheme is to promote early diagnosis of dementia to keep people living at home for longer and reduce long-term care.  ANNEX 1 Scheme 3.docx
4	**Falls Prevention – New scheme** The overarching strategic objective of this scheme is to enhance the provision of falls prevention services within the borough to reduce hospital admissions due to a fall, to reduce hospital admissions due to an injurious fall and to reduce readmissions when the

	first admission is due to a fall.  ANNEX 1 Scheme 4.docx
5	**Telecare – Existing scheme** National research drawn from 3 million lives highlights the key role of telecare in reducing the need for residential care, reducing hospital admissions and re-admissions, promoting quick and safe hospital discharges, reducing falls and promoting social inclusion. If achieved these will reduce costs in acute and residential care. The project will evaluate the impact of telecare against these key outcomes.  ANNEX 1 Scheme 5.docx
6	**DFG, HICES and Adaptations – some aspects existing, some new**, e.g. capital investment for the Care Act – the two main objectives are to prevent admissions to hospitals or care homes; prevent delayed transfers of care; prevent or delay deterioration in health; and enable individuals to continue to carry out everyday tasks and maintain their independence in the community.  ANNEX 1 Scheme 6.docx
7	**Reablement and Intermediate Care – Existing scheme – the two main objectives are to:** reduce reliance on and use of, secondary care for frail older people through admission avoidance and early supported discharge; and provide comprehensive assessment to manage current and future risks such as falls.  ANNEX 1 Scheme 7.docx
8	**Integrated Social Care and Health – some new** e.g. community MDTs, Early Assessment and Reviews, preparation of the Care Act (Section 256), residential and nursing joint contracts.  ANNEX 1 Scheme 8.docx
9	**Independent Safeguarding Unit – existing scheme** The Integrated Adult Safeguarding Unit has been based on a hub and spoke model in order to provide a specialist flexible and efficient safeguarding service for the borough. Following the publication of the Winterbourne Report and other high profile Serious Case Reviews, it was felt that the borough would benefit from a specialist safeguarding unit to meets the needs of Halton residents.  ANNEX 1 Scheme 9.docx
10	**Integrated Mental Health Services – redesign of preventative services – some aspects**

	are new some are existing An initial six-month pilot has already taken place between the Mental Health Outreach team which has shown very positive results. Of the people engaged with by the service, all have shown improvements in their functioning and mood, as evidenced by a self-assessment process. On an individual basis, suicide attempts have reduced, some people are substantially more engaged with their communities and there is reduced use of surgery time and prescribed medication (by agreement with the GP).  ANNEX 1 Scheme 10.docx
11	**Out of Borough Placements – PBSS – existing scheme** The PBSS services were founded on the principles of improving the lives of a small number of individuals that challenge services: Over a third of individuals with an Intellectual Disability under care of local authorities reside in out of borough placements (Whelton, 2009, see: McGill et al, 2010); Prominent in this group are individuals who exhibit behaviour that presents a challenge to services (Emerson & Robertson, 2008, see: McGill et al, 2010); Out of borough placements are often high cost and of dubious quality; The recent outcome of the Winterbourne View investigation highlights concerns about the quality and safety of such provision; and such placements frequently occur as a reaction to crisis situation.  ANNEX 1 Scheme 11.docx
12	**LD Nurses and Therapy Services – existing scheme** - Key success factors include: Supporting people with learning disabilities to live at home for longer; to reduce the number of non-elective admissions for people with learning disabilities; and to reduce the number of placements in long-term care for people with learning disabilities.  ANNEX 1 Scheme 12.docx
13	**Urgent Care – some aspects new, such as 7 day working, some existing** In 2012/13 NHS Halton Clinical Commissioning Group undertook a review of Urgent Care Services within Halton. This review combined with a winter pressures Accident and Emergency Department (AED) audit helped inform an options appraisal as to how urgent care services within the Borough could potentially be reconfigured to ensure it met local demand/pressures.  ANNEX 1 Scheme 13.docx
14	**Carers and National Eligibility Criteria – New scheme relating to the Care Act -** Improve the quality of life for carers' in Halton, and prevent or delay the need for care and support, therefore reducing non-elective admissions to hospital and reducing the need for long-term placements.  ANNEX 1 Scheme 14.docx

15	**End of Life – Existing scheme –** the impact of the scheme includes: prevent unnecessary admission to hospital; prevent unnecessary admission to care homes; enable patients to remain at home, if that is their wish, at the end of life; and ensure the service is available 24 hours a day, 7 days a week. ANNEX 1 Scheme 15.docx
16	**Integrated Care Home Support – Existing scheme - t**his scheme incorporates pro-active health and care planning and support the improvement in the quality of care within the sector and contribute to the reduction of non-elective admissions to hospital, reduced lengths of stay and a reduction in long-term care. ANNEX 1 Scheme 16.docx
17	**Reduced Delayed Discharges and Lengths of stay – New Scheme** This scheme is aligned to the benefit for reducing delayed transfers of care. Other outcomes include: Length of Stay; Number of referrals; Delayed Transfers of Care; Number of Assessments completed via each discipline; and Assessment outcomes. ANNEX 1 Scheme 17.docx
18	**Information Technology Strategy – existing** It is anticipated that there will be a number of outcomes associated with the development and implementation of an IM&T strategy within Halton in line with the main objectives of improved communication, increased efficiency and enhanced integration. These will include: Improved patient pathways; Reduction in patient delays; and Reduced admissions. ANNEX 1 Scheme 18.docx
19	**Joint Quality Assurance Team – New scheme** ANNEX 1 Scheme 20.docx

5) RISKS AND CONTINGENCY

a) Risk log

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

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

There is a risk that:	**How likely is the risk to materialise?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**
Improvements in the quality of care and in preventative services will fail to translate into the required reductions in the acute sector by 2015/16, impacting the overall funding available to support core services and future schemes.	2	5	10	Our integrated commissioning process is engaging a clinical lead and economist to work through the activity of all our provider trusts. This work will highlight further efficiencies by determining the activity that brings best value. Activity below the criteria of significant impact may need to stop to achieve this.
Not linking in with Boards from across connected areas could result in poor mechanisms for sharing information and monitoring the BCF.	2	4	8	Look into the possibility of joining Health and Wellbeing Boards across connecting areas, e.g. Warrington, St Helens and Knowsley.
The introduction of the Care Act 2014 will have implications in the cost of care provision, partnership working, policies and procedures and skilled and informed workforce.	2	4	8	Strategic Group was established in October 2013 to begin to identify the implications of each element of the Care Act. A 12 month temporary Principal Policy Officer is currently being recruited to to lead on this.
Financial fragility	2	5	10	Work on-going to forecast financial situation and continue to identify efficiencies across both organisations.

Legal Challenge	2	4	8	Robust consultation processes in place, clear application of eligibility criteria, with policies and procedures in place to support decision-makers.
Failure to identify and manage cultural issues across the HBC and NHS Halton CCG could result in staff feeling isolated; anxious and worried; and a reduction in job performance.	2	3	6	Building trust through effective communication, shared values, equal opportunities and effective leadership is crucial to the successful development of integrated teams.
Shifting of resources to fund new joint interventions and schemes will destabilise current service providers, particularly in the acute sector.	2	4	8	Our current plans are based on the strategies we have in place covering all service areas and linking in to the priorities of the Joint Health and Wellbeing Strategy and Joint Strategic Needs Assessment.
Operational pressures will restrict the ability of our workforce to deliver the required investment and associated schemes to make the vision of care outlined in our BCF submission a reality.	2	3	6	Organisational development is an important factor in the successful delivery of health and adult social care outlined in our BCF submission. On-going evaluation of teams and skill mix will ensure the infrastructure and capacity to deliver the schemes identified.
Communication	2	3	6	• Joint Local Authority and NHS HCCG commissioning team meetings take place on a bi-monthly basis communicating the vision and plans for the future and involving staff at the outset. • Communication and media tools have been identified as a future scheme to ensure the

				public are fully aware and involved in all aspects of the BCF and integration.

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

Performance against the key milestones identified against each project will be reported in a performance dashboard. Regular review of this dashboard will allow effective and timely responses to manage situations as they arise. In addition an early warning dashboard will provide an at-a-glance view of performance against a series of measures including, infection control, quality, risk and safety measures, these will provide effective early markers of possible provider problems or service failure and more can be added as and when appropriate. Actions identified will also report to an oversight group or be part of a new or existing programme of work. Where this is the case the performance will be reviewed by this oversight group.

Risk Assessment & Mitigation

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

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

Controls to mitigate against these risks fall into three categories.

1) **Financial systems**

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

2) **Internal governance**

These arrangements are intended to ensure that decisions are properly considered and approved and that all involved are assured that risks are being properly managed. These include the performance management arrangements described earlier. Other elements are the Audit Committee, Finance and Performance Committee and meetings of the Governing Body and membership; internal and external auditors will test the robustness of NHS Halton CCG's internal controls and systems. The Board Assurance Framework and Risk Register are well developed and highlight the controls and assurance in place for the identified risks.

3) **Relationships and risk sharing**

Examples of this include the creation of the pooled budget arrangements between NHS Halton CCG and Halton Borough Council for Continuing Health Care (CHC) adults and social care cases. Each party agrees to share the financial risk. Should NHS Halton CCG still be faced with significant financial pressures despite the controls outlined above then options to deliver short-term financial balance would be considered.

Should the level of emergency admissions not reduce as planned this will impact on the total amount of funds available in the CCG budget, this may result in the prioritisation of commissioning intentions with those with the greatest impact taking priority and the possibility of some intentions being delayed or carried forward. The CCG may need to reduce the amount of money planned to be carried forward as a surplus or use the contingency to fund essential services. In addition the failure to reduce emergency admissions may have an impact on the acute providers directly as this may impact on the capacity to provide timely planned admissions and increase waiting times. Reducing avoidable emergency admissions also improves the quality of life for people with long term conditions and their families. By investing resources into improving access to GP and community services, closer integration between Health and social care in the provision of care as well as ensuring that acute services are only used by those with acute needs by developing the urgent care centres and encouraging their use as an alternative to A&E this will prevent avoidable emergency admissions with the negative implications that arise.

The close working between NHS Halton CCG and Halton Borough Council has led to the development of a list of shared risks to the delivery of the required changes and the risk mitigations in place. The table above identifies a number of high level risks that we have identified as being the most significant. The Health and Wellbeing Board have been consulted on the plan of action.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

The plans within the Better Care Fund are aligned to other initiatives related to care and support that are underway within the borough of Halton. The integration of commissioning, system realignment and multi-disciplinary teams provide Halton with the means to work effectively towards the overarching priority of improved health and emotional wellbeing.

This is led by Halton's JSNA and an in-depth health needs assessment entitled ***The Future Impact of Demographic Changes on Unplanned Hospital Care in Halton 2013 to 2018*** which identifies areas and levels of increased hospital demand in the next 5 years in line with our ageing population. Halton have developed a clear framework and rationale to support an increased shift to improving our approach to Health and Wellbeing. The focus is on:

- Maintaining independence, good health and promoting wellbeing. Interventions include combating ageism, providing universal access to good quality information, supporting safer neighbourhoods, promoting health and active lifestyles, delivering practical services etc.

- Identifying people at risk and to halt or slow down any deterioration, and actively seek to improve their situation. Interventions include screening and case finding to identify individuals at risk of specific health conditions or events (such as strokes, or falls) or those that they have existing low level social care needs.

- Use of enabling technologies such as telecare and telehealth.

We recognise that housing conditions have a causal link to an extensive variety of chronic health conditions linked to an ageing population. With this increase in older people over the next few years, there is an expectation that this will lead to an increased need for specialist accommodation and an expansion of support services.

In Halton, the proportion of households made up solely of people of pensionable age is expected to

increase from 23% to 30% - an increase of 6,000 households by 2026. This represents an increase in this group of households of around 50% in just 16 years. HBC and NHS HCCG have found that working in partnership with Housing Associations to jointly fund adaptations to the homes of their disabled tenants' works successfully, and have significantly reduced backlogs and waiting times for essential works.

There is currently one extra care housing scheme in Halton, providing 47 housing units. The model of providing independent accommodation with on-site support for personal care and health needs has become very popular on a national basis. We are actively working with Housing developers in the local area to identify opportunities to develop additional extra care units.

Halton is working very closely with the Voluntary, Community and Social Enterprise Sector (VCSE) to help address urgent care pressures in terms of preventative work and ensuring that patients have better access to support at home following their discharge. With the Community Wellbeing Practices initiative we have established referral pathways with the discharge teams at both Warrington and Whiston Hospitals. This work is also supported by Sure Start to Later Life and the British Red Cross.

HBC and the NHS HCCG have a joint Policy, Procedure and Practice for Personal Budgets for Social Care and Health (For Direct Payments). The purpose of the policy document is to inform staff of their roles and responsibilities with regards to Personal Budgets (PBs), both in respect of Social Care and Health, specifically in relation to the process to be followed in the establishment of a Direct Payment. Work is continuing in this area to promote the use of personal budgets, in particular via a Direct Payment.

There are many other initiatives related to care and support underway and all of these are connected through the Better Care ECB (details of governance under questions 4 b and c). This ensures we have ongoing communication and linkages across the Local Authority and CCG with all our initiatives.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

NHS Halton CCG and Halton Borough Council are already working together and moving towards full integration of health and social care for the benefit of the people of Halton to improve outcomes for both patients and people receiving health and social care services. The BCF and the 5 year strategic plan have the shared vision 'to improve the health and wellbeing of Halton so they live longer, healthier and happier lives'. In addition to the endorsement of Halton Borough Council's Executive Board and NHS Halton CCG's Governing Body, our approach to integration has the full endorsement of the Health and Wellbeing Board. NHS Halton CCG's operational plan includes all the metrics developed for the BCF, including local measures. The commissioning intentions cross reference where those schemes fit with the Better Care Fund and the actions within the BCF plan of action cross reference where they align with the CCG operational plan. Both CCG plan and the BCF action plan have been developed together as part of an integrated approach with the Local Authority and the CCG.

The next Halton SRG has been dedicated to align the Acute sector plans with LA, CCG plans. NHS Halton plans have been given positive feedback from NHSE who have given the green light to proceed with delivery. We are not naive enough to expect all the plans to totally align from a target perspective. This is due to the differing demands on each of the organisations. However we are confident our vision, ethos, overall aims align and the system will work in partnership to attain our joint objectives.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

The BCF plans are featured through NHS Halton CCGs Primary Care redesign. NHS Halton has expressed an interest in co –commissioning and intends to scope out the detail of what that entails, not only for the CCG but the implication's and opportunities for its integrated partners inclusive of the BCF principles.

LA stakeholders (including politicians) are key members of the change board facilitated by NHS IQ. This change program has already aligned plans and strategies (including BCF) within its main body of strategic planning.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

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

- NHS and Community Care Act 1990 and associated regulations
- The Care Act 2014 that meet the assessed eligible social care needs of people who are ordinarily resident in Halton

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

The BCF will help to protect these services by:

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

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

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

There has been a significant and growing emphasis, in recent national strategy reports, on the need to change the way services are delivered in response to the demographic challenge of an ageing population,

and on the need for a whole system response built around personalised services with increased emphasis on well-being. Community engagement with an assets based approach, prevention of illness and early detection will lead to more people having healthy disability free lives, being able to live independently and a reduction in emergency admissions.

The population of Halton was 125,700 in the 2011 Census and is projected to reach 126,800 in 2014. It is estimated that the total population will grow by 3% between 2011 and 2021. This growth will not be uniform across the age groups. It is projected that there will be:

- An increase in the younger age group, 0-15 years, of 10%
- A decrease in the working age group, 16-64 years, of 5%
- An increase in the older age group, 65 and over, of 33%
- An increase in the older age group, 70-74 years of 56%
- An increase in the very old age group, 85 and over of 36%

There will be a very significant growth in the population of older people in Halton between now and 2030 with an increase in the number of people over 65 in Halton of 63% compared to a national average increase of 53%. This is anticipated to be accompanied by a corresponding increase in limiting long-term illness, for people in this age range, of 64% for Halton, the national average increase being forecast to be 55%. Without further development of prevention and early intervention measures the increased numbers of older people, many with limiting long-term illnesses will be likely to significantly increase the local demand for residential and acute hospital care.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

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

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

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

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

The information below shows the total amount from the BCF that has been allocated for the protection of adult social care service, including our proportion of funding for the implementation of the new Care Act duties.
Total amount from the BCF allocated to protecting adult social care services is **£1,756,000**. Of that amount, the headings below show the new Care Act duties split.

Quality Provider Profiles	- £ 14k
Assessment and Eligibility	- £140 k
Safeguarding	- £ 22k
Information and Advice	- £ 68k
Carers	- £136k
Personalisation	- £ 8k
Veterans Disregard	- £ 7k
TOTAL for Care Act duties:	**£395K**

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

Implementation of the Care Act 2014 over the next two years will be a challenge involving many changes to the delivery of local services. These result from the Act's greater emphasis on: the promotion of wellbeing; an enhanced assessment and national eligibility process that fully incorporates carers as individuals; the provision of information and advice; market shaping and commissioning of social care and support. These changes will centre on such key areas involving workforce, IT/ informatics, funding and communication. In parallel with this is the Better Care Fund (2015/16) which also emphasises the importance of joint commissioning to provide prevention and health and social care at home.

Halton has a plan to deliver the Care Act reforms and governance arrangements are already in place to achieve this. A small team will lead on both strategic and operational issues to accommodate the full impact of the Act across all its services. This has links with its NW Regional counterpart and the Liverpool City Region Working Group. By the end of September we expect to have an accurate estimate of the likely increase in the number of self-funders. This is crucial as it has implications for systems planning around such areas as workforce, IT and the cost of implementation. Changes to IT systems over the period April 2015 to April 2016 will be required to process assessments, Care Account applications, Deferred Payment Agreements, the introduction of the cap on care costs, the rate of progress toward the cap and this data will have to portable between LAs.

At present estimating the likely cost of implementing the Act over 2015/ 16 is difficult due to the need for further support and guidance from the DoH particularly in respect to the Cap. The council's commissioning strategy involving both the Better Care Fund and the Joint Strategic Needs Assessment provides an added level of complexity to the system yet vital as a means of targeting interventions where they can have most impact. Clearly, future strategic NHS and local government plans will need to be more closely aligned and this will incur a cost. Halton fully appreciates the importance of communicating its plans, both internally and externally to local people, providers and its NHS partners, so that they are aware of the key principles of the Care Act and the Better Care Bill and how they are related through preventive strategies, home-based care and the importance of carers as significant contributors to

wellbeing, enabling individuals to remain longer at home. To this end Halton has a well-established integration structures and excellent communication between itself and the CCG.

v) Please specify the level of resource that will be dedicated to carer-specific support

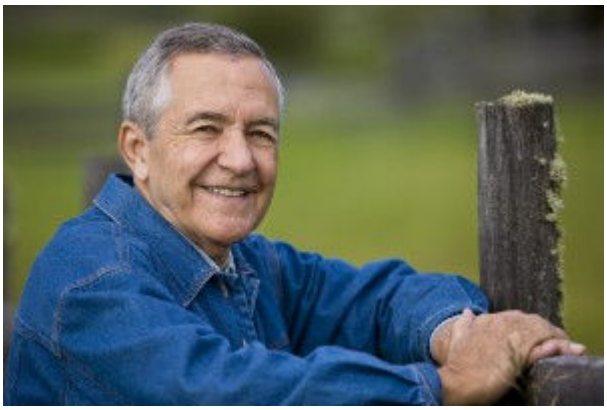
In providing carer specific support services, the Council and CCG have pooled their budgets and agreed that the Council will take the lead on commissioning carers services. The total budget available for commissioning carer specific support services is **£843,968** (Halton CCG; **£358,943** & Halton Borough Council; **£485,025**).

The pooled funding will be used in three ways:

- To provide a budget for carers direct payments following assessment
- To re-design support services at Halton Carers Centre
- To widen the scope and availability of activities and peer support for carers in the Borough

From a carers perspective this will mean that there will be:

- a streamlined carers assessment and direct payment process
- improved access to advice and information around social care and health services, self-management of well-being and raising concerns about the safety and well-being of an adult who has needs for care and support
- an improved emphasis on finding 'hidden' carers
- targeted support for those carers experiencing difficulties as a result of their caring role
- a range of opportunities to provide feedback to Commissioners and Providers their experience of using health, social care and carer support services.



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

suffered from depression

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

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

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

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

The case study above is just one example of a "real life" story from Halton to support our submission.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

There has been no change to the Local Authority's budget.

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

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

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

The process of moving to 7/7 working is a Health Economy issue, not solely an issue for Acute Trust. The Better Care Fund and our commissioning plans with others, including the Borough Council and NHS England, will deliver whole system 7/7 working over the next 2-5 years. The CCG's *Integrated Commissioning Strategy* is clear that the CCG intends to commission hospital based services only where they are absolutely necessary, and sets out intentions to invest in and develop services outside of acute hospital settings to support 7/7 working on a Health economy footprint across all providers.

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

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

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

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

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

With this in mind, HBC and the NHS HCCG propose to embark on a dynamic interoperability programme which will have far reaching benefits for patients and the wider health economy in Halton. Through the sharing of clinical views from detailed care records and associated clinical documentation via a secure data exchange, clinicians will have access to accurate, timely information that supports patient care and joins up health provision in an unprecedented way. This will be facilitated through the utilisation of the Medical Interoperability Gateway (MIG).

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

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

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

Since 2012, we have had in place a Data Sharing Agreement which covers two-way data sharing between the NHS Halton CCG and Halton Borough Council, Communities Directorate. To allow detailed analysis to be undertaken in relation to the use of hospital and social care services by individuals registered with a General Practitioner in Halton or residing in Halton. This will assist the planning of health and social care services for individuals and the wider community.

This agreement is a Tier 2 Information Sharing Agreement, so that we can match hospital admissions data with Carefirst care package information at a client/patient level. The Agreement details exactly what data can be shared.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

The NHS HCCG have all of the appropriate IG controls in place. The Local Authority is compliant and has now received approval for 2014 for its submission on the IG Tool kit.

Caldicott 2 has recently been released and the Local Authority is working through the document to ensure compliance.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

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

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

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

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

In line with NHS England Avoiding Unplanned Admissions (AUA) guidance, 2% of each practice population is identified as being at high risk of hospital admission in the next 12 months. PRISM predictive tool plus intelligence from health and social care professionals (Community Nurses, GPs, social workers and pharmacists discuss potential people for enrolment to the risk register at MDT).

Community Nursing, social care, mental health and alcohol service users registers have also been sourced to assist in identification.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

The risk stratified data is used by General Practice through a multi-agency meeting to discuss patients, agree an assessment and joint care planning approach and identify an appropriate lead GP and professional. This will be further strengthened by the planned changes to the GP contract in 2014 in relation to named GP.

A monthly MDT takes place in each practice. Invitees include GP, Senior Community Nurses, Medicines Management representative, social worker, Wellbeing Officer and any other health or social care worker may be invited as deemed appropriate (e.g. Hospital Consultant, Housing officer, Alcohol services, Palliative care team etc.)

The individual is discussed, usually following an assessment, by the person who knows them best within the team. Notes may have been prepared for discussion prior to the meeting by the other disciplines (e.g. social worker will usually have reviewed case history prior to meeting). Pre assessments usually include dementia and depression screening and carers information is updated at this point; carers assessments are arranged as appropriate.

The lead professional (now referred to as care coordinator in AUA information) is decided and allocated at MDT.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

2% of each practice population will have a care plan as per NHS recommendations (example included). Some practices have adapted the NHSE template but they all contain the same minimum data set.

The care plan is formulated in collaboration with the patient and their carers and loved ones. A copy is provided for the patient which is intended as a self-care guide, as the plan is written in the form of "I statements", individualised to the person's needs.

GPs are supported by Clinical Facilitators from the CCG and those health and social care professionals who are the core MDT members.

Those with dementia in care homes are included within the 2% register and the Clinical Facilitator has begun targeted work with each home around care planning and prompt review (within 3 days) of those on the register.

The patient knows who their lead GP and care coordinator are, as this is clearly identified on the care plan and includes contact numbers. They are advised in a supporting letter/leaflet, provided by the practice alongside the care plan, what their role is and to contact them as first contact as appropriate.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

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

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

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

On 29 October 2013, two HPHF events were held with hundreds of local people attending to learn about healthcare commissioning intentions for 2014-15 as well as have their say on the future of local health and social care services by taking part in a debate on NHS England's 'The NHS belongs to the people: a call to action' campaign, which is calling on patients and the public to talk about the future shape of the NHS, so it can plan how best to deliver services, now and in the years ahead.

The Better Care Fund was also highlighted at these two events and our direction of travel was shared. In

January 2014, the draft "plan" was shared with the HPHF for their comment and input into the document. Feedback can also be seen at **http://www.youtube.com/watch?v=_tLdKCxyk9s&feature=youtu.be**

Following approval of the plan, continued engagement will take place between patients, service users and the public through the forums mentioned above.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

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

There has been considerable engagement on this plan with a range of provider stakeholders including 5 Borough Partnership Mental Health Trust, Halton GPs and the System Resilience Group. There was also a specific meeting organised with the Director of Service Modernisation at St Helens and Knowsley Teaching Hospitals NHS Trust, and Chief Operating Officer and Deputy Chief Executive at Warrington and Halton Hospitals NHS Foundation Trust to discuss the plan during August 2014. It has also been discussed at length with the operational adult social care team within the borough council. Providers have advised how pathways can be improved, teams reconfigured to increase quality and productivity, systems be more efficient and teams more integrated. These changes coupled with the introduction within care pathways of appropriate technology will enable people to live independently, avoid emergency admissions, benefit from reablement services if necessary and have a better patient experience.

ii) primary care providers

Systems Resilience Group provides multi-disciplinary strategic direction and guidance across health and social care in relation to non-elective and elective care. The group is responsible for ensuring that locally there are quality processes in place which are safe and efficient for patients and cost effective. Membership of the group is reflective of the whole system of health and social non-elective and elective care within Halton. This group has been fully engaged with the Better Care Fund.

The ***Service Development Committee*** ensures member practices are setting the commissioning agenda for the organisation and supporting the setting of operational delivery. It's remit is:

- To ensure the two way engagement with member practices
- To enable involvement of member practices
- Review service improvements and development and present options and advice to the Governing Body for approval/ratification.

iii) social care and providers from the voluntary and community sector

HBC and HCCG have strong Governance arrangements in place and our structure ensures service area Boards are established to plan, manage and monitor the schemes that form part of this plan. The Boards and Groups incorporate representatives from the voluntary and community sector and we continue to involve and engage with these groups on the initiatives that form part of the Better Care Fund. Some examples include:

The ***Carers Centre*** has been engaged in the development of the plan through a series of meetings with the Commissioners and the Carers Strategy Group.

The ***Dementia Board*** meets on a monthly basis and involves Fire Service, Cheshire Police, Wellbeing Enterprises, Alzheimer's Disease Society. The Board has an Action Plan which includes the Integrated Approach to Dementia scheme.

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

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

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

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

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

Local provider plans for 2015/16 have been shared and discussed at the Systems Resilience Group during August 2014 to ensure they are consistent with the BCF plan.

Based on the above implications for the Acute Sector, the main metrics the BCF is focussed on is around the non-elective admissions. The table below shows a summary of our baseline and targets over the coming months linked to the Payment for Performance. ***Further detail around this can be found in Template 2, under Tab 5 "HWB P4P Metric".***

Non-Elective Admissions (general and acute)	Q4 Jan 14 to Mar 14	Q1 Apr 14 to Jun 14	Q2 Jul 14 to Sept 14	Q3 Oct 14 to Dec 14
Baseline	4,242	4,220	4,133	4,164
	Q4 Jan 15 to Mar 15	**Q1 Apr 15 to Jun 15**	**Q2 Jul 15 to Sept 15**	**Q3 Oct 15 to Dec 15**
Numerator (Targets)	4,139	4,008	3,922	3,954

The figures above equate to a 4.4% decrease in non-elective admissions over the next 2 years, in line with the NHS Halton CCGs 2 year operational plan and 5 year strategic plan. The Payment for Performance saving is £1,096,640 which links in with the HWB Benefits Plan on Tab 4 of Template 2.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Halton
Name of Provider organisation	St. Helens & Knowsley Hospitals NHS Trust
Name of Provider CEO	Ann Marr
Signature (electronic or typed)	*Ann Marr*

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	7559
	2014/15 Plan	7370
	2015/16 Plan	6992
	14/15 Change compared to 13/14 outturn	-2.5%
	15/16 Change compared to planned 14/15 outturn	-5.1%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	189
	How many non-elective admissions is the BCF planned to prevent in 15-16?	378

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	The Trust can confirm that the intentions within the BCF plan are aligned with the Trust IBP/LTFM. However, given that the health and social care economy has never delivered a sustained reduction in urgent care demand the Trust cannot at this stage be confident that the BCF plan will bring about the improvements as per the stated intention. Further work is required across the whole system to provide assurance that the plan will have an impact at the scale and pace required.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	The BCF submission includes a comprehensive list of schemes which are intended to improve services although several of these are described as a "continuation of" or "maintenance of" and as such these are not new. Where new schemes are identified these lack clarity with regard to scheme specific

		methodology, milestones, programme management plan, performance metrics etc. The Trust is also as yet unclear as to how the proposed governance system will function; who will be represented on what committees, what decisions will be made etc. The Trust would welcome further discussion with regard to this.
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	If the BCF plan does not deliver at scale and pace the impact upon the Trust will be considerable as pressures in the urgent care pathways will continue to rise. In the last three years the Trust has been operating at full capacity with many occasions when demand exceeded available beds. During this period admissions to "specialty beds" have continued to rise. Even if activity levels remain the same as the last two years there will be many occasions when capacity will be exceeded. In late 2013 the Trust initiated a Medicine Redesign Programme without funding and made a significant investment into AED, nursing, and ward based discharge planning teams all of which has underpinned service delivery. These services cannot be continued if they are not funded and this is the highest priority for the Trust this winter and beyond

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Halton
Name of Provider organisation	Warrington and Halton Hospitals NHS Foundation Trust
Name of Provider CEO	Mel Pickup
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	8287
	2014/15 Plan	8081
	2015/16 Plan	7665
	14/15 Change compared to 13/14 outturn	-2.5%
	15/16 Change compared to planned 14/15 outturn	-5.1%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	206
	How many non-elective admissions is the BCF planned to prevent in 15-16?	416

For Provider to populate:

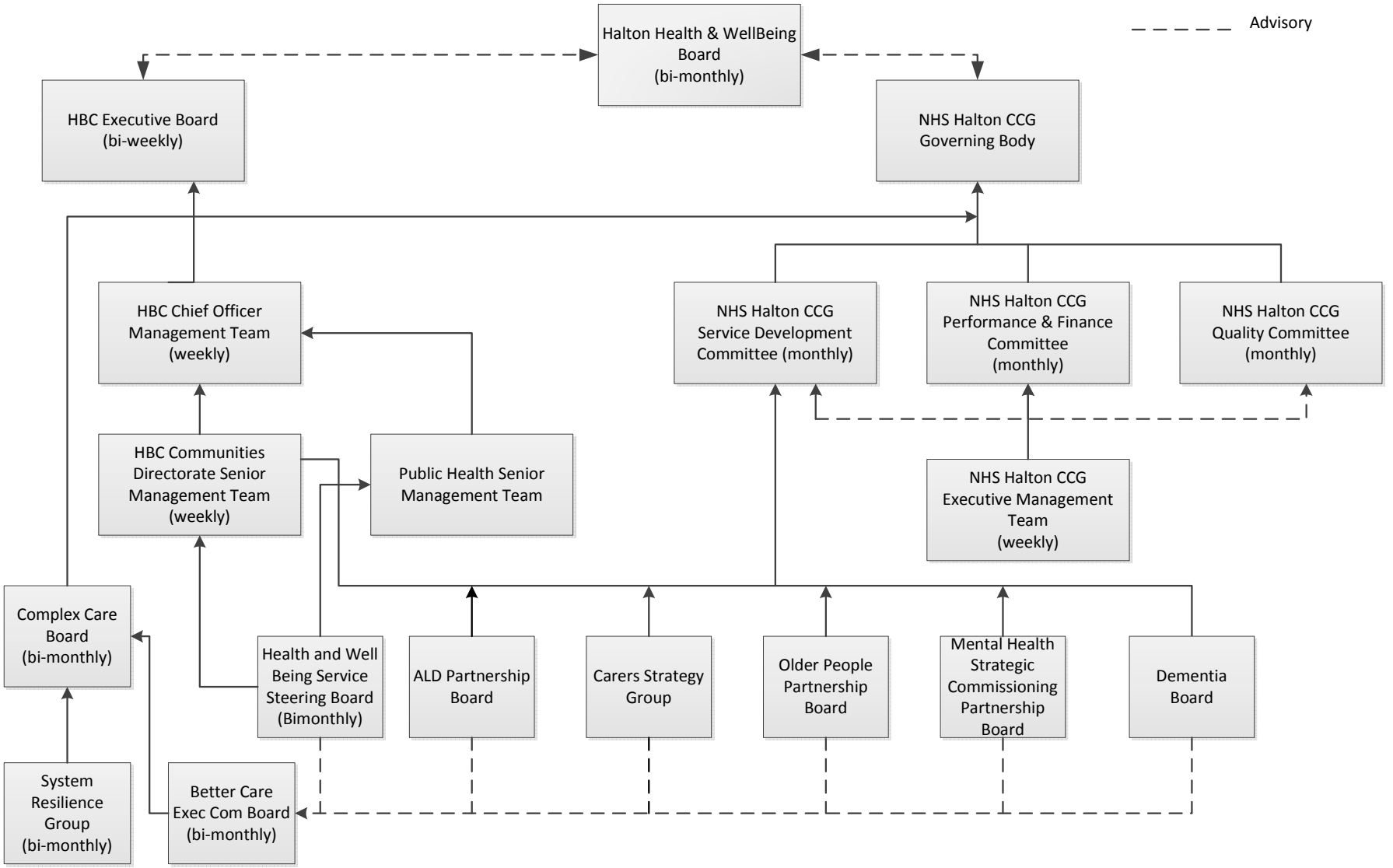
	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	In recognising the work carried out by our commissioner our Trust plans assume no growth in non-elective activity in 15/16. The Trust cannot agree the non-elective activity assumptions without a clearer understanding of the impact each action outlined will deliver on the interventions to avoid the admissions. The schemes listed will have an impact but to specify the absolute degree at this time is very difficult.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	The projected impact of population growth and the extent of the movement of the population into the most critical years for non-elective admissions means that the economy is facing an unprecedented challenge in demand for non-elective services.

		Whilst we believe the plans outlined in the paper will have a positive impact in slowing and potentially halting the year on year growth in admissions we are not able to confirm whether the plans will be sufficient to deliver the projected impact at this stage, indeed our own plans show no growth in the next 2 years. Considerable work has already been carried out with commissioner in our area to reduce the level of non-elective admissions and the specific work outlined by Halton CCG will have a positive impact, it is too early for us to confirm the absolute impact on number of patient admissions.
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	We have considered the implications on the services provided by our organisation and that is reflected in our general assumption about no growth in non-elective admissions in 15/16. If the schemes outlined are unsuccessful the impact with other commissioners included will be considerable and place the AED national target under pressure, additionally we will see the rapid acute expansion in beds to manage this influx of patients. Whilst physical capacity is available staffing would need to be accessed via agency and additional financial support required from commissioners.

Better Care Fund 2014 - 2016 : Action Plan

Ref. No.	Strategic Aim	Scheme Reference No.	Service Development	New or Existing ?	Option for possible redesign ? Y/N	Attributable Organisation (Finance)	Timescale	Investment (2014/15) as outlined in BCF (£000's)	Investment (2015/16) as outlined in BCF (£000's)	Responsible Officer	Accountable Group	Accountable Operational Director	Associated Performance Measures	Link to BCF Key Metric	On target for April 2015 Payment ? (Y/N or N/A)	Investment to Date in Service Development (2014/15)	R/A/G ?	Progress to Date ?
BCF01	Health and Wellbeing	2 - Prevention	Advocacy	Existing	Y	CCG		0	34	Mark Holt	BC ECB	Dave Sweeney & Sue Wallace Bonner						
BCF01	Health and Wellbeing	1 - Integrated Wellness Service	Health Inequalities	New	N			0	20	TBC	PH SMT	Eileen O'Meara						
BCF01	Health and Wellbeing	2 - Prevention	Information Campaign	New	N			0	8	Mark Holt	BC ECB	Sue Wallace Bonner						
BCF01	Supporting Independence	6 - DFG, HICES and Adaptations	Capital Investment for Act & pool e.g. IT etc.	New	N			0	139	Steve Williams	BC ECB	Paul McWade						
BCF01	Supporting Independence	18 - Information Technology Strategy	IT Joint Working (Capital)	Existing	Y	HBC		0	100	Lyndsey Abercromby	IT Strategy Group	Paul McWade						
BCF01	Managing Complex Care	8 - Integrated Social Care & Health	Section 256 (Preparation & Implementation of Act etc.)	New	N			483	463	Mark Holt	Care Act Group	Sue Wallace Bonner						
BCF02	Managing Complex Care	8 - Integrated Social Care & Health	Residential & Nursing Joint Contracts (Cost of Care Model)	New	N			80	0	Amanda Lewis	BC ECB	Sue Wallace Bonner						
BCF01	Managing Complex Care	13 - Urgent Care	7 Day Working - Hospital Discharge	New	N			0	75	Damian Nolan	System Resilience Group	Dave Sweeney & Sue Wallace Bonner						
BCF01	Managing Complex Care	14 - Carers and National Eligibility Criteria	Capacity Building for Care Act (inc. Recruitment and Training)	New	N			0	55	Mark Holt	Care Act Group	Sue Wallace Bonner						
BCF01	Managing Complex Care	14 - Carers and National Eligibility Criteria	£135m Care Act Split - Personalisation	New	N			0	8	Steve Eastwood	Care Act Group	Sue Wallace Bonner & Paul McWade						
BCF01	Managing Complex Care	14 - Carers and National Eligibility Criteria	£135m Care Act Split - Carers	New	N			0	136	Steve Eastwood	Care Act Group	Sue Wallace Bonner & Paul McWade						
BCF01	Managing Complex Care	14 - Carers and National Eligibility Criteria	£135m Care Act Split - Information Advice and Support	New	N			0	68	Steve Eastwood	Care Act Group	Sue Wallace Bonner & Paul McWade						
BCF01	Managing Complex Care	14 - Carers and National Eligibility Criteria	£135m Care Act Spit -Quality _ Provider Profiles	New	N			0	14	Steve Eastwood	Care Act Group	Sue Wallace Bonner & Paul McWade						
BCF01	Managing Complex Care	14 - Carers and National Eligibility Criteria	£135m Care Act Split - Safe Guarding Board Establishment	New	N			0	22	Steve Eastwood	Care Act Group	Sue Wallace Bonner & Paul McWade						
BCF01	Managing Complex Care	14 - Carers and National Eligibility Criteria	£135m Care Act Split - Assessment & Eligibility	New	N			0	140	Steve Eastwood	Care Act Group	Sue Wallace Bonner & Paul McWade						
BCF01	Managing Complex Care	14 - Carers and National Eligibility Criteria	£135m Care Act Split -Vetrans Disregard	New	N			0	7	Steve Eastwood	Care Act Group	Sue Wallace Bonner & Paul McWade						
BCF01	Supporting Independence	8 - Integrated Social Care & Health	Early Assessments & Reviews	New	N			0	28	Marie Lynch	Care Act Group	Sue Wallace Bonner						
BCF01	Managing Complex Care	15 - End of Life	End of Life	Existing	Y	CCG		0	192	Emma Alcock	Service Development Committee	Dave Sweeney						
BCF01	Managing Complex Care	10 - Integrated MH Services	Redesgin Mental Health	New/Existing	Y	Both		0	293	Lindsay Smith/Sheila McHale	MH Delivery Group	Paul McWade & Dave Sweeney						
BCF01	Managing Complex Care	11- Out of Borough Placements	Positive Behaviour Services	Existing	N	Both		0	256	Maria Saville	BC ECB	Paul McWade						
BCF01	Managing Complex Care	9 - Integrated Adult Safeguarding Unit	Safeguarding	Existing	N	Both		0	391	Helen Moir	HSAB	Sue Wallace Bonner						
BCF01	Supporting Independence	6 - DFG, HICES and Adaptations	Social Care Capital Remaining	Existing	N	HBC		351	121	Steve Williams	BC ECB	Paul McWade						
BCF01	Managing Complex Care	7 - Reablement and IC	Transitional	Existing	Y	CCG		0	192	Damian Nolan	BC ECB	Sue Wallace Bonner						
BCF02	Managing Complex Care	16 - Integrated Care Home Support	Care Homes Project	Existing	Y	CCG		0	350	Damian Nolan	Service Development Committee	Sue Wallace Bonner						
BCF03	Managing Complex Care	17 - Reduced Delayed Discharges & LoS	Early Supported Discharge - Stroke	New	N			0	150	Damian Nolan	Stroke Board	Sue Wallace Bonner						
BCF03	Managing Complex Care	10 - Integrated MH Services	Inglenook	Existing	Y	CCG		0	121	Sheila McHale	MH Delivery Group	Dave Sweeney						
BCF03	Managing Complex Care	17 - Reduced Delayed Discharges & LoS	Reablement - Early Supported Discharge	Existing	Y	HBC		60	60	Damian Nolan	Stroke Board	Sue Wallace Bonner						
BCF03	Managing Complex Care	8 - Integrated Social Care & Health	Section 256 - Increase 14/15	New	N			29	59	Damian Nolan	BC ECB	Sue Wallace Bonner						
BCF03	Managing Complex Care	8 - Integrated Social Care & Health	Section 256 - Maintaining Eligibility	Existing	N	HBC		1,647	1,647	Damian Nolan	BC ECB	Sue Wallace Bonner						
BCF03	Managing Complex Care	8 - Integrated Social Care & Health	Section 256 - Additional Short Term Residential & Domiciliary Services	Existing	N	HBC		500	500	Marie Lynch	BC ECB	Sue Wallace Bonner						
BCF03	Managing Complex Care	10 - Integrated MH Services	Ship Street	Existing	Y	CCG		0	81	Sheila McHale	MH Delivery Group	Dave Sweeney						
BCF01	Supporting Independence	14 - Carers and National Eligibility Criteria	Carers	Existing	Y	CCG		359	359	Steve Eastwood	Carers Strategy Group	Paul McWade & Dave Sweeney						
BCF01	Supporting Independence	3 - Integrated approach to Dementia	Dementia (inc. Integration)	New/Existing	Y	Both		0	160	Sheila McHale	Dementia Board	Dave Sweeney						
BCF01	Supporting Independence	4 - Falls Prevention	Falls	New	N			0	130	Peter Ventre	Falls Group	Sue Wallace Bonner						
BCF01	Supporting Independence	2 - Prevention	Independent Living Transport	Existing	Y	CCG		0	17	Mark Holt		Dave Sweeney						
BCF01	Supporting Independence	5 - Telecare	Section 256 - Telecare	Existing	Y	HBC		140	140	Helen Moir	BC ECB	Sue Wallace Bonner						
BCF02	Supporting Independence	6 - DFG, HICES and Adaptations	DFG	Existing	N	HBC		665	787	Helen Moir	BC ECB	Sue Wallace Bonner						
BCF02	Supporting Independence	7 - Reablement and IC	Intermediate Care	Existing	Y	Both		4,979	4,979	Damian Nolan	BC ECB	Sue Wallace Bonner						
BCF02	Supporting Independence	6 - DFG, HICES and Adaptations	Joint Equipment Service	New/Existing	Y	Both		497	597	Liz Gladwin	BC ECB	Sue Wallace Bonner						
BCF02	Supporting Independence	8 - Integrated Social Care & Health	Night Service	Existing	Y	Both		0	115	Helen Moir	BC ECB	Sue Wallace Bonner						
BCF02	Supporting Independence	7 - Reablement and IC	Reablement - Additional Hours	Existing	Y	HBC		416	416	Helen Moir	BC ECB	Sue Wallace Bonner						
BCF02	Supporting Independence	7 - Reablement and IC	Reablement - Equipment	Existing	Y	HBC		31	31	Liz Gladwin	BC ECB	Sue Wallace Bonner						
BCF02	Supporting Independence	7 - Reablement and IC	Reablement - IC Beds	Existing	Y	HBC		187	187	Helen Moir	BC ECB	Sue Wallace Bonner						
BCF03	Supporting Independence	8 - Integrated Social Care & Health	Care Packages	Existing	Y	Both		25,677	25,677	Marie Lynch	BC ECB	Sue Wallace Bonner						
BCF03	Supporting Independence	8 - Integrated Social Care & Health	CHC Assessment Team	Existing	Y	CCG		255	255	Damian Nolan	BC ECB	Jan Snoddon						
BCF03	Supporting Independence	8 - Integrated Social Care & Health	Community MDT	New	N			0	115	Damian Nolan	Service Development Committee	Sue Wallace Bonner						
BCF03	Supporting Independence	8 - Integrated Social Care & Health	SCIP	Existing	Y	CCG		0	143	Marie Lynch	Service Development Committee	Sue Wallace Bonner						
Contingency	Contingency	??????	Contingency	N/A	N	N/A		0	505	N/A	BC ECB	Sue Wallace Bonner						
BCF02	Supporting Independence	12 - LD Nurses & Therapy Services	Reablement - Therapy	Existing	Y	HBC		55	55	Damian Nolan	BC ECB	Sue Wallace Bonner						
BCF01	Managing Complex Care	13 - Urgent Care	UCC Development	New/Existing	N	Both		100	615	Damian Nolan	System Resilience Group	Dave Sweeney & Sue Wallace Bonner						
BCF01	Managing Complex Care	19 - Joint QA Team	Joint Quality Assurance Unit	New	N			0	20	Helen Moir	BC ECB	Sue Wallace Bonner						
BCF01	Health and Wellbeing	2 - Prevention	Prevention Services - Voluntary Grants	Existing	Y	Both		0	891	Mark Holt	BC ECB	Sue Wallace Bonner						
BCF01	Health and Wellbeing	2 - Prevention	Sure Start to Later Life	Existing	Y	HBC		0	195	Peter Ventre	BC ECB	Sue Wallace Bonner						
BCF03	Managing Complex Care	12 - LD Nurses & Therapy Services	LD Nurses	Existing	Y	HBC		0	393	Damian Nolan	BC ECB	Sue Wallace Bonner						
BCF03	Managing Complex Care	12 - LD Nurses & Therapy Services	LD Nurses (5 Boroughs)	Existing	Y	CCG		0	TBC	Damian Nolan & John Heritage	BC ECB	Sue Wallace Bonner						

INTEGRATED COMMISSIONING AND DELIVERY GOVERNANCE STRUCTURE



Health and Wellbeing Board Expenditure Plan

Halton

Please complete white cells (for as many rows as required):

Scheme Name	Area of Spend	Please specify if Other	Commissioner	if Joint % NHS	if Joint % LA	Provider	Source of Funding	Expenditure 2014/15 (£000)	Expenditure 2015/16 (£000)
Contingency	Other	Contingency	Joint	50%	50%		CCG Minimum Contribution		518
1 - Intergrated Wellness Service	Other		Local Authority			Private Sector	CCG Minimum Contribution		20
2 - Prevention	Other	Social Care/Continuing Care	Joint	43%	57%	Charity/Voluntary Sector	CCG Minimum Contribution		507
2 - Prevention	Other	Social Care/Continuing Care	Joint	43%	57%	Charity/Voluntary Sector	Local Authority Social Services		384
2 - Prevention	Social Care		CCG			Local Authority	CCG Minimum Contribution		17
2 - Prevention	Social Care		CCG			Charity/Voluntary Sector	CCG Minimum Contribution		34
2 - Prevention	Social Care		Local Authority			Local Authority	CCG Minimum Contribution		8
2 - Prevention	Social Care		Local Authority			Local Authority	Local Authority Social Services		195
3 - Intergrated Approach to Dementia	Mental Health		Joint	50%	50%	Charity/Voluntary Sector	CCG Minimum Contribution		160
4 - FALLS Prevention	Community Health		Joint	50%	50%	NHS Community Provider	CCG Minimum Contribution		130
5 - Telecare	Social Care		Local Authority			Local Authority	CCG Minimum Contribution		140
5 - Telecare	Social Care		Local Authority			Local Authority	Additional CCG Contribution	140	
6 - DFG, Equipment Store and Adapts	Continuing Care		Joint	57%	43%	NHS Community Provider	CCG Minimum Contribution		570
6 - DFG, Equipment Store and Adapts	Continuing Care		Joint	57%	43%	NHS Community Provider	Local Authority Social Services	245	
6 - DFG, Equipment Store and Adapts	Continuing Care		Joint	57%	43%	NHS Community Provider	Additional CCG Contribution	256	
6 - DFG, Equipment Store and Adapts	Continuing Care		Local Authority			NHS Community Provider	Local Authority Social Services		14
6 - DFG, Equipment Store and Adapts	Continuing Care		Local Authority			Private Sector	Local Authority Social Services	665	787
6 - DFG, Equipment Store and Adapts	Social Care		Local Authority			Private Sector	Local Authority Social Services	351	256
6 - DFG, Equipment Store and Adapts	Social Care		Joint	57%	43%	NHS Community Provider	Additional CCG Contribution	31	
6 - DFG, Equipment Store and Adapts	Social Care		Joint	57%	43%	NHS Community Provider	CCG Minimum Contribution		31
7 - Reablement & Intermediate Care	Acute		Joint	69%	31%	NHS Acute Provider	Local Authority Social Services	548	548
7 - Reablement & Intermediate Care	Acute		Joint	69%	31%	NHS Acute Provider	Additional CCG Contribution	1,241	1,241
7 - Reablement & Intermediate Care	Community Health		Joint	51%	49%	Local Authority	Local Authority Social Services	293	293
7 - Reablement & Intermediate Care	Community Health		Joint	51%	49%	Local Authority	Additional CCG Contribution	310	310
7 - Reablement & Intermediate Care	Community Health		Joint	51%	49%	NHS Acute Provider	Local Authority Social Services	196	196
7 - Reablement & Intermediate Care	Community Health		Joint	51%	49%	NHS Acute Provider	Additional CCG Contribution	206	206
7 - Reablement & Intermediate Care	Community Health		Joint	79%	21%	NHS Community Provider	Local Authority Social Services	122	122
7 - Reablement & Intermediate Care	Community Health		Joint	79%	21%	NHS Community Provider	Additional CCG Contribution	469	469
7 - Reablement & Intermediate Care	Continuing Care		CCG			Private Sector	CCG Minimum Contribution		192
7 - Reablement & Intermediate Care	Social Care		Joint	47%	53%	Local Authority	Local Authority Social Services	1,097	
7 - Reablement & Intermediate Care	Social Care		Joint	47%	53%	Local Authority	Additional CCG Contribution	978	
7 - Reablement & Intermediate Care	Social Care		Joint	47%	53%	Local Authority	Local Authority Social Services		1,097
7 - Reablement & Intermediate Care	Social Care		Joint	47%	53%	Local Authority	Additional CCG Contribution		419
7 - Reablement & Intermediate Care	Social Care		Joint	47%	53%	Local Authority	CCG Minimum Contribution		603
8 - Intergrated Social Care & Health	Community Health		Joint	50%	50%	NHS Community Provider	CCG Minimum Contribution		115
8 - Intergrated Social Care & Health	Continuing Care		CCG			CCG	Additional CCG Contribution	255	255
8 - Intergrated Social Care & Health	Continuing Care		Joint			Local Authority	CCG Minimum Contribution		97
8 - Intergrated Social Care & Health	Continuing Care		Joint			Local Authority	Local Authority Social Services		12
8 - Intergrated Social Care & Health	Continuing Care		Local Authority			Private Sector	Local Authority Social Services		14,394
8 - Intergrated Social Care & Health	Continuing Care		CCG			Private Sector	Additional CCG Contribution		7,954
8 - Intergrated Social Care & Health	Continuing Care		Local Authority			Private Sector	Local Authority Social Services	14,394	
8 - Intergrated Social Care & Health	Continuing Care		CCG			Private Sector	Additional CCG Contribution	7,954	
8 - Intergrated Social Care & Health	Continuing Care		Local Authority			Private Sector	Additional CCG Contribution	1,647	
8 - Intergrated Social Care & Health	Continuing Care		Local Authority			Private Sector	CCG Minimum Contribution		1,647
8 - Intergrated Social Care & Health	Mental Health		Local Authority			Private Sector	Local Authority Social Services	1,019	
8 - Intergrated Social Care & Health	Mental Health		CCG			Private Sector	Additional CCG Contribution	1,291	
8 - Intergrated Social Care & Health	Mental Health		Local Authority			Private Sector	Local Authority Social Services		1,019
8 - Intergrated Social Care & Health	Mental Health		CCG			Private Sector	Additional CCG Contribution		1,291
8 - Intergrated Social Care & Health	Other		Local Authority			Local Authority	Additional CCG Contribution	483	463
8 - Intergrated Social Care & Health	Other		Local Authority			Private Sector	Additional CCG Contribution	80	
8 - Intergrated Social Care & Health	Primary Care		CCG			Local Authority	CCG Minimum Contribution		143
8 - Intergrated Social Care & Health	Social Care		Local Authority			Local Authority	CCG Minimum Contribution		28
8 - Intergrated Social Care & Health	Social Care		Local Authority			Private Sector	CCG Minimum Contribution		559
8 - Intergrated Social Care & Health	Social Care		Local Authority			Private Sector	Additional CCG Contribution	529	
9 - Intergrated Adult Safe Guarding Unit	Social Care		Joint	49%	51%	Local Authority	CCG Minimum Contribution		391
10 - Intergrated MH Services	Continuing Care		CCG			Charity/Voluntary Sector	CCG Minimum Contribution		202
10 - Intergrated MH Services	Mental Health		CCG			Local Authority	CCG Minimum Contribution		294
11 - OB Placements	Social Care		Joint	44%	56%	Local Authority	CCG Minimum Contribution		256
12 - LD Nurses & Therapy Services	Social Care		Joint	50%	50%	NHS Acute Provider	Additional CCG Contribution	55	
12 - LD Nurses & Therapy Services	Social Care		Joint	50%	50%	NHS Acute Provider	CCG Minimum Contribution		55
12 - LD Nurses & Therapy Services	Social Care		Local Authority			Local Authority	Local Authority Social Services		393
13 - Urgent Care	Acute		CCG			NHS Acute Provider	Additional CCG Contribution	50	615
13 - Urgent Care	Acute		CCG			NHS Acute Provider	Additional CCG Contribution	50	
13 - Urgent Care	Social Care		Local Authority			Local Authority	CCG Minimum Contribution		75
14 - Carers & National Eligibility Criteria	Other	Carers	CCG			Charity/Voluntary Sector	Additional CCG Contribution	359	
14 - Carers & National Eligibility Criteria	Other	Carers	CCG			Charity/Voluntary Sector	CCG Minimum Contribution		359
14 - Carers & National Eligibility Criteria	Social Care		Local Authority			Local Authority	CCG Minimum Contribution		314
14 - Carers & National Eligibility Criteria	Social Care		Local Authority			Private Sector	CCG Minimum Contribution		136
15 - EOL	Primary Care		CCG			Local Authority	CCG Minimum Contribution		192
16 - Intergrated Care Homes Support	Community Health		CCG			NHS Community Provider	CCG Minimum Contribution		350
17 - Reduce Delays in Discharge & LOS	Acute		Joint			NHS Acute Provider	CCG Minimum Contribution		210
17 - Reduce Delays in Discharge & LOS	Acute		Joint			NHS Acute Provider	Additional CCG Contribution	60	
18 - Information Technology Strategy	Continuing Care		Local Authority			Local Authority	Local Authority Social Services		100
19 - Joint Quality Assurance & Performance Unit	Social Care		Local Authority			Local Authority	CCG Minimum Contribution		20
Total								**35,374**	**41,406**

REPORT TO: Health and Wellbeing Board

DATE: 17th September 2014

REPORTING OFFICER: Michael Shaw

PORTFOLIO: CCG Performance & Planning

SUBJECT: Final NHS Halton CCG 5-year strategy and 2-year operational plan with supporting economic assurance

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 This report presents the final NHS Halton CCG 5-year strategy and 2-year operational plan with supporting economic assurance.

2.0 **RECOMMENDATION: That:**

i) The 5-year strategy and 2-year operational plan be approved as demonstrating the strategic direction of the CCG in relation to the wider health economy in Halton, and that the specific operational intentions will contribute to achieving the strategy.

3.0 **SUPPORTING INFORMATION**

3.1 NHS Halton CCG 5-year strategy and 2-year operational plan

3.2 NHS England letter 01/08/2014 – “Everyone Counts Planning for Patients 2014-2019”

4.0 **POLICY IMPLICATIONS**

4.1 NHS Halton CCG Commissioning policy will need to be amended to accommodate purchasing entire pathways of care rather than the individual services within a pathway

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 Significant financial investment needs to be made by NHS Halton CCG to achieve the actions within the operational plan, this investment and associated risks are highlighted in the supporting

papers. Additional financial resources are being made by both the Local Authority and the CCG within the Better Care Fund of which a separate but linked operational plan has been produced.
This report indicates that the level of financial savings achievable within the CCG financial and operational plans are attainable

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

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

6.1 **Children & Young People in Halton**
Specific commissioning intentions have been identified in Appendix A highlighting the integrated work to be undertaken between the CCG and the Council in providing services to children and young people as part of the 2-year operational plan

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

6.3 **A Healthy Halton**
The Operational Plan priority areas identified in the plan highlight the areas in which NHS Halton CCG will focus efforts to improve the health and wellbeing of the people of Halton

6.4 **A Safer Halton**
Specific actions have been identified in the Operational Plan which will have a direct impact on safety of Halton Residents in receipt of healthcare. Particularly around priority areas 3. "Proactive prevention, health promotion and identifying people at risk early" and 5. "Reducing Health Inequalities" Pg 49-50

6.5 **Halton's Urban Renewal**

7.0 **RISK ANALYSIS**

7.1 *A financial risk analysis and scenario planning is included from pg39. A full financial risk assessment is included in the 5-year financial plan. An Additional activity risk analysis is included from pg 54. A Separate risk analysis has been completed for the Urgent Care Centres, this is not reported here.*

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 *NHS Halton Clinical Commissioning Group approved an Equality Objective plan in October 2013 in line with their specific duties and requirements under the Equality Act 2010. An Equality Delivery System Self-Assessment was completed between July and October 2013 and supported the development of the Objectives. The CCG were self-assessed as 'Developing', reflecting their status as a new commissioning organisation.*

No specific equality and diversity issues have been raised a full a breakdown of the further work to be done is reported on pg58-59 of the 5-year strategy document.

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

NHS
Halton Clinical Commissioning Group

Final NHS Halton CCG 5-year Strategy and 2-year operational plan with supporting economic assurance

5-year strategy and 2-year operational plan summary

The attached plan is the 5-year strategy and 2-year operational plan for NHS Halton CCG, this document is the result of consultation with providers, public, clinicians and other stakeholders including the local authority from July 2013 with data gathered from a number of sources to inform evidenced based decisions of the strategic direction of Halton health economy and the commissioning intentions which form the operational plan to achieve that aim.

Halton health economy is a system comprised of partners from primary, secondary and community care who have come together with Halton Borough Council and local population to agree, refine and implement the following vision: “To involve everybody in improving the health and wellbeing of the people of Halton”

To achieve this vision 8 priority areas have been agreed

1. Maintain and improve quality standards
2. Fully integrated commissioning and delivery of services across health and social care
3. Proactive prevention, health promotion and identifying people at risk early
4. Harnessing Transformational Technologies
5. Reducing Health Inequalities
6. Acute and Specialist services will only be used by those with acute and specialist needs
7. Enhancing practice based services around specialisms
8. Providers working together across interdependencies to achieve real improvements in the health and wellbeing of our population.

The stated aim of the plan is that by working of the priority areas the following ambitions will be achieved over the next 5 years.

1. Securing additional years of life for the people of Halton with treatable mental and physical health conditions by 18%
2. Improving the quality of life for people with long term conditions by 8%

3. To reduce the number of avoidable emergency admissions to hospital by 15%
4. To Increase the proportion of people living independently at home
5. To Increase the number of people having a positive experience of hospital care by 8%
6. To increase the number of people having a positive experience of care outside hospital by 18%
7. To reduce hospital avoidable deaths

The full list of commissioning intentions, associated metrics and targets to achieve the ambitions and priority areas is published in the plan.

The 5-year strategy and 2-year operational plan has been co- produced alongside the detailed financial plan and Better Care Fund plan.

The plan not only attempts to describe how the vision, priorities and ambitions will be achieved but also how this will be done in the context of the expected financial gap between supply and demand. Put simply 'doing nothing is not an option'

One significant development (both in terms of expected impact and financial risk/benefit) is the development of the 2 urgent care centres in Widnes and Runcorn on the sites of the existing Walk in Centre and Minor Injuries Unit. A separate series of working groups have been set up to look at this scheme, however two organisations (i5 Health and Capita) have been commissioned to provide independent analysis of the potential available by reducing the level of urgent care in Halton.

Economic Assurance Summary

Both i5 and Capita have used different methods to calculate the potential levels of benefit available in the health economy, however both paint a similar picture.

I5 reviewed actual Halton Acute 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 and the costs associated with the attendance and/or admittance i5 have calculated the actual cost of activity which could have been treated elsewhere

Capita have used a more statistical approach in that whilst they looked at the same data they have also looked at the variations between General Practices

and what the potential savings would be if some (but not all) of this variation could be removed. After taking into account variations in age and deprivation related heath there remain variations in activity such as A&E Attendance and Non-elective activity which are potential areas that savings could be made. Capita have calculated two levels of savings, one based on the reduction of the variation between practices to the best quartile of practices, the second level of savings is based on the schemes identified in the BCF and operational plans and in Capita's judgement would be the maximum amount of saving available.

Both i5 and Capita have assumed some growth in electives and capita goes into some detail around the significant shift in elective activity towards daycase.

Neither i5 nor Capita have factored in the cost of the schemes needed in the community or elsewhere to achieve the savings in the acute sector

Headline figures

Savings Identified, (figures in £,000's)					
Financial Plan (2 year)*	Financial Plan (5 year)*	Operational plan (2 year)	I5 Health***	Capita likely savings (5 year)*****	Capita Max savings (5 Year)******
3,708	7,951	3,930	3,638	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 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 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

Conclusion

Overall both the i5 and Capita assessments give assurance that the commissioning intentions are focussed in the right areas (Acute care, Older people),and that the level of savings identified in the financial and operational plan are broadly achievable, although at the top end of what is possible.

NHS England Assurance Summary

A copy of the NHS Halton CCG 5-year plan strategy and 2-year operational plan was submitted to NHS England on the 20th June 2014.

A response was received on the 1st August by the NHS England Merseyside Area Team Director, the full letter is attached at the end of this report, however in general the plan was well received.

“In relation to the Merseyside Area Teams desktop review, the plan was found to be well written with a clear vision and strategic intent”

There were some areas which they felt could be improved upon as they felt there were a high number of priorities and a greater risk on financial stability

Overall they did “feel this plan addresses the health needs of Halton’s population”.

Recommendation – ***That the 5-year strategy and 2-year operational plan be approved as demonstrating the strategic direction of the CCG in relation to the wider health economy in Halton, and that the specific operational intentions will contribute to achieving the strategy.***

1st August 2014
Our Ref: LTG\GI021

Simon Banks
Chief Officer – NHS Halton CCG
Runcorn Town Hall
Heath Road
Runcorn
WA7 5TD

Dear Simon,

Re: "Everyone Counts Planning for Patients 2014-2019"

Thank you for your planning submission on the 20th June 2014. I would like to acknowledge the high quality standard of work and effort made by the CCG and all partners.

In terms of next steps of the planning cycle, I can confirm that as an Area Team, we have undertaken a "vertical" desktop review, the outcome of which is detailed below. It is proposed that regional team assurance looks "horizontally" across all plans at discrete elements such as urgent and emergency care in order to get an overview across the North.

The regional team will review the plans for the following areas:

- Quality & Outcomes Ambitions.
- Finance & Activity
- Urgent and Emergency Care
- Reconfiguration schemes covering more than one area team
- Workforce

The aim is to identify common themes across the North; it will provide an understanding of the regional impact of the plans, common approaches and difficulties to help provide support to their implementation at regional level. Monitor and TDA have agreed to complete a high level triangulation of provider strategic plans, by the end of August, which will cover aspects such as:

- Vision: are commissioner and provider visions for the system aligned?
- System Engagement and Governance: is there evidence on both sides of good engagement and partnership working between commissioners, providers and other stakeholders (especially LAs)? Are there system level governance arrangements which include both commissioners and providers?
- Finance and activity: are the finance and activity trajectories for both commissioners and providers broadly aligned? If not, what are the differences in assumptions?

Clare Duggan| Director | NHS England – Merseyside| Regatta Place L3 4BL

- Major change programmes: are the major change programmes for the system recognised by both commissioners and providers?

In relation to Merseyside Area Teams desktop review, the plan was found to be well written with a clear vision and strategic intent. The plan could be strengthened in terms of particulars as there seems to be a high number of priorities and a number of actions which questions the deliverability of the plan. This is not saying to limit the ambition but to be clear on how the plan will be delivered over the next 5 years. It was also noted that there is a greater risk of financial stability which needs to be strengthened within the plan and it was suggested that you may want to demonstrate your ability to manage within allocated administrative resources. These budgets have been subject to efficiency targets and with a general increase expected in pay inflation/incremental drift and a change from outsourcing to insourcing (reduction in CSU contract etc.) which would be beneficial to show how you plan to meet these budget reductions as you move forward?

Finally notwithstanding the above areas of refinement, we would like to thank you for your submission to date and feel this plan addresses the health needs of Halton's population.

Yours sincerely

CLARE DUGGAN
Director

CC: Clifford Richards, Halton CCG Chair
Paul Brickwood, Halton CCG DOF

NHS
Halton Clinical Commissioning Group

5 Year Strategy
and
2 Year Operational Plan
2014-2019

V4.2 August 2014

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Halton Clinical Commissioning Group

NHS Halton CCG
5 Year Strategy
2014/15 – 2018/19

5-Year Strategic Plan on a page 2014/15 to 2018/19

NHS Halton Clinical Commissioning Group

Halton health economy is a system comprised of partners from primary, secondary and community care who have come together with Halton Borough Council and local population to agree, refine and implement the following vision:

"To involve everybody in improving the health & wellbeing of the people of Halton"

- Outcome Ambition 1 - Securing additional years of life for the people of Halton with treatable mental and physical health conditions by 18%
- Outcome Ambition 2 - Improving the quality of life for people with long term conditions by 8%
- Outcome Ambition 3 - To reduce the number of avoidable emergency admissions to hospital by 15%
- Outcome Ambition 4 - To Increase the proportion of people living independently at home
- Outcome Ambition 5 - To Increase the number of people having a positive experience of hospital care by 8%
- Outcome Ambition 6 - To increase the number of people having a positive experience of care outside hospital by 18%
- Outcome Ambition 7 - To reduce hospital avoidable deaths

Priority Area 1 – Maintain and improve Quality Standards: NHS Halton CCG is committed to maintaining and improving wherever possible the quality of care provided

Priority Area 2 – Fully integrated commissioning and delivery of services across health and social care: NHS Halton CCG will drive Collaborative Commissioning with joint strategy, planning and collaborative commissioning with NHS England and Halton Borough Council

Priori Area 3 – Proactive prevention, health promotion and identifying people at risk early: This will be at the core of all our developments with the outcome of a measureable improvement in our population's general health and wellbeing

Priority Area 4 – Harnessing transformational technologies: Technology will be central to supporting people to improve and maintain their health and wellbeing, offering a range of platforms and sophistication dependant on intensity of need and desired outcomes

Priority Area 5 – Reducing health inequalities: Halton's Health and Wellbeing service combines expertise from Public Health, Primary care and Adult Social Care, this will be developed to continue the good results already seen and reduce the health gap

Priority Area 6 – Acute and specialist services will only be utilised by those with acute and specialist needs: Bringing services closer to home will support the transformation of the acute hospital sector and associated demand management issues

Priority Area 7 – Enhancing practice based services around specialisms: NHS Halton CCG, will support member practices to develop to deliver sustainable general practice, to result in an increase in capacity, enable 7/7 working and increase patient choice and control.

Priority Area 8 – Providers working together across inter-dependencies to achieve real improvements in the health and wellbeing of our population: NHS Halton CCG will investigate the implementation of Prime Contractor arrangements for a whole pathway of care or model of care.

Governance

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

Overseen through the following governance arrangements

- Robust ledger and budgetary control system
- Internal and external audit
- Board Assurance Framework and Risk Register
- Performance management and oversight groups

Sustainability

NHS Halton CCG faces a 'do nothing' 5 year finance gap of £39m. For the health economy to be sustainable the goals are:

-All organisations within the health economy are financially viable in 2018/19

-System objectives are achieved

-Long term reduction seen in A&E activity

-Long term reduction seen in inappropriate non-elective admissions into secondary care

System Values and Principles

- Partnership
- Openness
- Caring
- Honesty
- -Leadership
- - Quality
- -Transformation

1. Introduction

NHS Halton CCG is the organisation that is principally responsible for the planning and purchasing of health services (known as commissioning) for the people of Halton. NHS Halton CCG is a clinically led organisation, formed from the 17 GP practices in the borough.

NHS Halton CCG commissions services in partnership with Halton Borough Council and NHS England. Halton Borough Council have responsibility for public health, education, housing, social care and a range of other services that impact on the health and wellbeing of people in the borough. NHS England are responsible for commissioning GP services, pharmacies, opticians, dentists and specialised services for the Halton population. They also have a role in monitoring how effective NHS Halton CCG is as a commissioning organisation, this is known as assurance.

As set out in *The NHS Belongs To The People: A Call to Action*[1], the NHS faces many challenges over the next five years and beyond. Every day the NHS in Halton helps people to stay healthy, recover from illness and live independent and fulfilling lives. Sometimes the NHS doesn't live up to the high expectations people have of it. We want a health and social care system that delivers excellence and a positive experience for those who need our services. We know that demand for health and social care services is rising and the financial resources we have to meet this demand are increasingly scarce and constrained. Unchecked, these pressures threaten to overwhelm the health and social care system. We need to find a new approach to how we deliver and use health and care services so that we can continue to provide high quality healthcare, and meet the future needs of the population. This 5 year strategic plan has been developed in collaboration with Halton Borough Council, Public Health, providers and the public and sets out this new approach for Halton. We have to make radical and far reaching changes – the status quo is not an option.

1.1 About NHS Halton CCG

NHS Halton CCG is responsible for commissioning health services for approximately 128,000 people who are registered with our 17 GP practices. We are also responsible for commissioning emergency care for other people from outside of Halton whilst they are in the borough.

Halton's resident population live in two main towns, Runcorn and Widnes, as well as a number of parishes and villages. The geographical area covered by NHS Halton CCG is coterminous with the local authority boundary of Halton Borough Council.

NHS Halton CCG is clinically led by GPs and other healthcare professionals. We are formed and built on a membership model, drawn from the 17 general practices

[1] http://www.england.nhs.uk/wp-content/uploads/2013/07/nhs-belongs.pdf

located within Halton. Each practice has nominated a GP as its lead for liaison with NHS Halton CCG. Each area of our commissioning work has a nominated clinical lead, usually a GP or a nurse. There are also regular meetings of Practice Managers and a Practice Nurses Forum has now been developed.

NHS Halton CCG has existed in shadow form since November 2011. We were established as a sub-committee of the Board of NHS Merseyside in January 2012. NHS Halton CCG became a statutory body on 1st April 2013.

2. System Vision & Values

2.1 Our Vision

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

Our vision is **'to involve everyone in improving the health and wellbeing of the people of Halton'**.

2.2 Our Purpose

Our ***purpose*** is to improve the health and wellbeing of the population of Halton by empowering and supporting local people from the start to the end of their lives by preventing ill-health, promoting self-care and independence, arranging local, community-based support whenever possible and ensuring high-quality hospital services for those who need them.

We want to support people to stay well in their homes, in particular to avoid crises of care that can result in hospital admission. General practices will support and empower individuals and communities by promoting prevention, self-care, independence and resilience.

We will work with local people and with partner organisations including Halton Borough Council, healthcare providers and the voluntary sector. This will ensure that the people of Halton experience smooth, co-ordinated, integrated and high-quality services to improve their health and wellbeing.

2.3 Our Values

The key values and behaviours at the heart of our work are:

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

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

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

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

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

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

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

3. Opportunities for Change

We want people to live longer, healthier and happier lives. We are acutely aware that we are working within scarce resources, it is a well known fact that over the next five years NHS Halton CCG, Halton Borough Council and our partners face significant financial challenges. These financial challenges are driving us to do things differently and transform all aspects of health, social care and wellbeing in Halton over the next five years, beginning with an ambitious 5-year strategy and robust 2 year operational delivery plan.

NHS Halton CCG commissioned two organisations, i5 Health and Capita, to provide a detailed analysis[2] [3] of where opportunities existed for the Health economy in Halton to change to provide services which provide better outcomes and better value for money and ensure that acute services are only used by people in acute need. The analysis highlighted that both A&E attendances and hospital admissions for certain conditions, most notably respiratory, were the significant areas where opportunities for change existed.

By redesigning primary care access we aim to enable 7 day GP access same day appointments. Integrating Acute and Community services we aim to align clinical

[2] I5 Health – Commissioning Opportunity – NHS Halton CCG – May 2014
[3] Capita End-to-end care assessment – NHS Halton, Knowsley, St Helens & Warrington CCG's – May 2014

pathways enabling a seamless approach to patient care. Focusing on the vulnerable through multi-disciplinary teams will allow for significant efficiencies.

Evidence gathered from our residents and Acute hospitals indicated that 23% of the A&E attendances did not warrant acute care and that almost half of patients required no medical care. In 2014/15 we plan to bolster our Urgent care centres in Widnes and Runcorn to provide real alternatives to A&E. Utilising GP and Consultant oversight will offer a central location for 7 day GP access, speedy diagnostics and one stop approach to minor illness and injury. Aligning this with the North West Ambulance Service NHS Trust (NWAS) pathfinder scheme will give a triage option to ambulances that would ordinarily be heading to an acute setting.

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

The overall NHS Halton CCG financial pressure is a gap in income and demand over five years of around £39m therefore additional tightening of contracts and better use resources will drive the 5 year plan.

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

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

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

The 5-year strategic plan is totally aligned with the Better Care Fund (BCF) and has been developed in collaboration with the Local Authority, Public Health, providers and the public. This integrated approach has identified 8 priority areas where the opportunities are greatest to transform our healthcare delivery, these are;

3.1 Maintain and improve quality standards

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

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

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

3.3 Proactive prevention, health promotion and identifying people at risk early

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

An example of how this can work in an integrated wa is Halton Borough Council's Mental Health Outreach team which is currently piloting work with GP surgeries in order to identify people who may benefit from this service and prevent relapse.

3.4 Harnessing transformational technologies

Strategically, NHS Halton CGG are working with NHS Warrington CCG on a whole system IT transformation, which will allow data to flow across all systems, this will reduce the need for bulky/expensive back office functions.

Technology will also be central to supporting people to improve and maintain their health and well-being, offering a range of platforms and sophistication dependent on intensity of need and desired outcomes.

3.5 Reducing health inequalities

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

3.6 Acute and specialist services will only be utilised by those with acute and specialist needs.

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

3.7 Enhancing practice based services around specialisms

NHS Halton CCG with NHS England will support member practices to deliver sustainable general practice services in Halton. To result in a reduction in variation, an increase in capacity, enable 7/7 working, increase patient choice and control and the development of specialist skills, knowledge and service delivery.

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

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

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

4. Prioritisation

Working with Health and Wellbeing partners, including the local authority public health team, specific actions underpinning the eight identified priority areas in Halton and the seven NHS outcome ambitions have been developed. These actions have been developed in line with the 'Commissioning for Prevention' 5 steps of:

4.1 Analysing key health problems

Using the resources available including the Joint Strategic Needs Assessment (JSNA), Public Health Intelligence unit, Atlas of Ambition and Commissioning for Value tools the most significant health issues facing the people of Halton have been identified. These include cancer, respiratory conditions, cardiovascular conditions, diabetes, mental health conditions and unplanned hospital attendances and admissions.

4.2 Prioritise and set common goals

The actions identified in the commissioning intentions have been reviewed, those with the greatest likely impact have been prioritised and targets set which all partners have signed up to. This is an on-going process and the commissioning intentions will be reviewed throught their lifespan to ensure that they are acheiveing their goals and providing value for money

4.3 Identify high impact programmes.

Using the 'Anytown health system' tool, 'high impact' programmes have been identified.

Two of the most high impact programmes identified to address the problems identified are

- The development of the Urgent Care Centres to reduce both the number of unnecessary attendances at A&E and unplanned hospital admissions.
- The development of the primary care strategy

In addition, work commissioned by NHS Halton CCG by i5 Health and Capita have provided detailed analysis into the areas of Acute care where significant savings can be made by sharing best practice across all GP practices and by implementing schemes to reduce activity within acute settings.

4.4 Plan resources

The financial impact of these commissioning intentions, both in terms of recurrent and non-recurrent expenditure has been calculated, as have potential levels of financial saving. Ambitious but realistic targets for savings have been agreed and resources have been allocated in the budget for the commissioning intentions

4.5 Measure and experiment

Where possible nationally proved metrics will be used to demonstrate the level of improvement made by the projects, however where national metrics are not appropriate locally developed ones will be used.

5. Delivering Transformational Change

Characteristics of a high quality and sustainable health and care system

In December 2013 NHS England published "Everyone Counts: Planning for patients 2014/15 to 2018/19. This document described the characteristics of a high quality and sustainable health care system and how this could be achieved through transformational change. The passage below describes the changes required by NHS England but these are also just as relevant to NHS Halton CCG.

'Fulfilling our long-term ambitions will require a change in the way health services are delivered. People are living longer, and our ability to treat and help to manage conditions that were previously life-threatening is improving all the time. With this has come a change in what can be delivered safely, effectively and efficiently in different settings. For example, patients can be cared for in their own homes, supported by experienced clinicians and technology which enables them to monitor their condition and get expert help to manage it. The result is that patients who would previously have needed hospital treatment can now stay at home.'[4]

[4] Everyone Counts Planning for patients 2014/15 to 2018/19: pg9 para17.

NHS England has identified that any high quality, sustainable health and care system in England will have the following six characteristics in five years:

The six characteristics of a high quality sustainable health and care system are:

1. Ensuring that citizens will be fully included in all aspects of service design and change, and that patients will be fully empowered in their own care

2. Wider primary care, provided at scale

3. A modern model of integrated care

4. Access to the highest quality urgent and emergency care

5. A step-change in the productivity of elective care

6. Specialised services concentrated in centres of excellence (as relevant to the locality)

NHS Halton CCG has developed eight priority areas after extensive consultation with all key stakeholders, these priorities meet the 6 characteristics of a high quality sustainable health and care system as below. Within these priority areas specific intentions have been identified. For further details of the specific intentions and the priority areas please see Appendix A.

5.1 Ensuring that citizens will be fully included in all aspects of service design and change, and that patients will be fully empowered in their own care

NHS HALTON CCG PRIORITY AREA 3 – Proactive prevention, health promotion and identifying people at risk early.

NHS HALTON CCG PRIORITY AREA 6 – Acute and specialist services will only be used by those with acute and specialist needs

NHS HALTON CCG PRIORITY AREA 4 – Harnessing Transformational Technologies

Specific intentions:

Continue to work with Healthwatch and making the best use of the Halton People's Health Forum events to fully include citizens in all aspects of service design.

Continue to work with people with learning disabilities to develop awareness and understanding of services available in Halton. i.e. Health checks, Cancer, mental health and lifestyle. Through innovative methods such as the SPARC (Supporting People Achieving Real Choice) comics. Current allocated budget for 14/15 is £50,000

ADD141502 – continue to develop mechanisms to ensure we listen to the whole population, including young people and BME communities

PC141508 – Review access to lifestyles service for patients with cancer, for example breast cancer, weight loss and exercise programme - Potential increase in costs in the short term, dependent on increased uptake, should enable longer term cost savings.

PCI141501 – Strengthen the GP's role at the heart of out of hospital care by identifying people at risk of hospital admission and introducing named accountable clinician. - This is one of the actions which will be funded in part through the £5 per head GP strategy of £646,000

PC141501 – Consider the use of technology to manage sleep apnoea in the community

PC141506 – Implement the EPACCs IT system – improve the use of special patient notes in the end of life care

PCI141510 – Develop an integrated Health & Social care IM&T Strategy and work plan to include the use of telehealth and telemedicine to improve patient care - £100,000 recurring expenditure has been allocated in both 14/15 and 15/16 with a non-recurring expenditure of £500,000 in 15/16. There are planned savings of £200,000 per year from 15/16 onwards.

5.2 Wider primary care, provided at scale

NHS HALTON CCG PRIORITY AREA 7 – NHS Halton CCG with NHS England will support member practices to deliver sustainable general practice services in Halton. To result in a reduction in variation, an increase in capacity, enable 7/7 working, increase patient choice and control and the development of specialist skills, knowledge and service delivery.

Specific Intentions:

PCI141505 – To support GP Practices to deliver services over and above their contractual responsibilities. – This is one of the actions which will be funded in part through the £5 per head GP strategy of £646,000

PCI141506 – Develop the strategy for sustainable General Practice in Halton – This will also form part of the recurring £646,000 expenditure linked to the £5 per head GP strategy, however there is also non-recurring expenditure allocated of £300,000 in 2015/16 for weekend and evening access which will also be part of the sustainable General Practice strategy.

5.3 A modern model of integrated care

NHS HALTON CCG PRIORITY AREA 2 – Fully integrated commissioning and delivery of services across Health & Social Care

Specific Intentions:

ADD141509 – Better Care Fund actions are implemented (recurring expenditure from 15/16 identified as £6,522,000)

ADD141508 – Further develop integrated services between the NHS and Local Authorities for people with complex needs (finance included in expenditure of ADD141509)

ADD141512 – Develop an integrated approach with Halton Borough Council with community pharmacies – financial impact not known yet

PCI141514 – Secure provision of community services from 2015, VfM contract to reflect the needs of the population supporting more integrated care – The expectation is that this will result in a reduction in the current community contract value, however this will be informed by the new service specifications

5.4 Access to the highest quality urgent and emergency care

NHS HALTON CCG PRIORITY AREA 1 – Maintain and improve quality standards

Specific intentions:

EA6 - Warrington & Halton Hospital Foundation Trust A&E department Friends and Family test results have been identified as an area for targeting for specific improvement, this is being written into the quality schedule and has been chosen as a Quality Premium measure for NHS Halton CCG for 2014/15. With a planned improvement from a baseline of 35 (Dec 13) to 57 by 2015/16

ADD141505 – CQUINS developed with the providers to implement the commissioning outcomes of both the Francis report and the government response. This will be supported by evidence of duty of candour, quality strategy, and training programmes including mandatory training.

ADD141506 – Quality standards improved in the acute sector providers by appropriate use of SHMI and HSMR mortality figures to identify areas for further investigation and evidence of improvement actions where appropriate

MHUC141502 – Review the AED liaison psychiatry model, ensuring that acute and emergency care for people in mental health crisis is as accessible and high quality as for physical health emergencies.

5.5 A step-change in the productivity of elective care

NHS HALTON CCG PRIORITY AREA 8 – Providers working together across interdependencies to achieve real improvements in the health and wellbeing of our population

Specific intentions:

PC141509 – Review pathways for patients with cancer attending hospital to explore alternative models of follow up. i.e. telephone follow up or GP led – this will initial look at the prostate cancer pathway and should result in financial savings for hospital follow ups.

PCI141503 – Review the design of community services to focus on outcome based services – the desired outcome is for there to be increased integration, improved outcomes for patients and a reduction in inappropriate hospital admissions for conditions normally managed in the community.

5.6 Specialised services concentrated in centres of excellence (as relevant to the locality)

NHS Halton CCG is aware of the plans by NHS England to concentrate specialised services in centres of excellence, linked to Academic Health Science Networks. Whilst NHS Halton CCG is not the co-ordinating commissioner for any of the specialised service providers we are conscious of the potential impact that the concentration of services in centres of excellence could have on Halton residents and will be fully involved partners with NHS E in the implementation of these changes.

There is an intention locally to create centres of excellence based around practice based services

NHS HALTON CCG PRIORITY AREA 7 – Enhancing practice based services around specialisms

Specific Intentions:

PCI141505 – To support GP Practices to deliver services over and above their contractual responsibilities. – This is one of the actions which will be funded in part through the £5 per head GP strategy of £646,000

PCI141506 – Develop the strategy for sustainable General Practice in Halton – This will also form part of the recurring £646,000 expenditure linked to the £5 per head GP strategy, however there is also non-recurring expenditure allocated of £300,000 in 2015/16 for weekend and evening access which will also be part of the sustainable General Practice strategy.

6. Integration & Innovation

NHS Halton CCG is currently moving towards a fully integrated commissioning unit. Focusing on commissioning, contracting & quality. This commissioning for outcomes approach will bring full system / operational delivery. NHS Halton CCG and Halton Borough Council have harnessed the recent reforms in health and social care to create the platform for a fully integrated approach to commissioning. This whole system ensures we meet the political directions whilst providing services that are affordable, sustainable and meet the needs, wants and aspirations of our community.

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

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

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

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

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

The culture within and between organisations is focused on achieving real improvements in the health and well-being of our population through the delivery of high quality, effective and safe care. This approach recognises both the centrality of

supporting people to have control over their health and well-being and the inter-dependency across the systems and organisations to achieve this. This is facilitated through existing and developing mechanisms to incentivise and performance manage providers of services. This is underpinned by a letter of intent which informally binds the organisations to joint working. A formal Section 75 agreement is being developed to take this process to the next stage and drive structural, patient-centred, fully integrated service change.

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

The strategic aims of the plan are:

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

6.1 Integrated Commissioning Function

NHS Halton CCG is co-located alongside Halton Borough Council Social Care and Public Health and we have already seen the positive impact this has had on breaking down organisational, professional and cultural barriers. Halton's approach to urgent care, via the establishment of the urgent care partnership board, demonstrates the shared commitment to improving outcomes for service users/patients and their carers whilst making the most efficient use of public resources.

6.2 Health and Wellbeing of individuals in our community

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

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

6.3 Supporting Independence

There are a range of integrated services which focus on promoting recovery from illness, preventing unnecessary hospital admissions or premature admissions to

residential care, supporting timely discharge from hospital and maximising opportunities for independent living.

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

6.4 Managing Complex Care and Care Closer to Home

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

6.5 Innovation in Mental Health Practice

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

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

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

6.6 Research

NHS Halton CCG are linking with the North West Coast Academic Health Science Network (NWCAHSN) to build up an overview of innovations that we can quickly roll out. We will be working with the NWCAHSN through the commissioning cycle. We have a shared objective in ensuring that we deliver the best treatment, care, pharmaceutical products and technologies for patients and residents at the lowest cost. We particularly want a relationship with NWCAHSN in regard to stroke, neurological conditions and child and maternal health.

7. Clinical Priority Areas

These clinical areas have been identified as key to improving the health and wellbing of the people of Halton, this strategic and operational plan has been delevoped with these clinical areas making a significant contribution. The Clinical Lead areas are:

7.1 Cancer & End of Life

Current position

Prevalence of cancer remains high[5] and mortality worse in Halton[6]. Halton are good at referring and getting tests done quickly but patients still present late and social factors (smoking, obesity, lack of exercise etc) need improving. Screening uptake could be better. Halton has good access to tests compared with other areas of Merseyside and Cheshire but we are not complacent.

Our Aims

For End of Life care the aim is to maintain the current quality of service taking into account increasing demand. We will also look to increase GP education in this area.

For cancer prevention the aims are focussed on lifestyle factors and are covered more completely in the Health & Wellbeing strategy. We want to see quicker and more local access to diagnostics, eg. Local ultrasound and X-ray. We are undertaking the primary care cancer audit to assess where cancer diagnosis delays are and then address these issues. We are looking at the wellbeing of cancer pateints particularly regarding exercise and also looking at bringing follow up treatment closer to home eg. patients with prostate cancer having blood tests done locally and then either seeing the GP or the specialist as appropriate.

Performance

Screening statistics – a comprehensive breakdown of cancer screening statistics for Halton can be found on the Halton Public Health website:
http://www3.halton.gov.uk/healthandsocialcare/318895/318907/

Selected cancer screening statistics have been reproduced here.

[5] Halton Borough has the 11th highest incidence of cancer (all cancers) 2010-2012 of 326 Local Authorities, Source: Halton Borough Cancer Profile Series No1 – All cancers Jan 2014

[6] The Standardised Mortality Ratio (SMR) for Halton 2008-10 was 136, compared with 110 for the North West and 100 for England – Source – Halton Public Health Annual Report 2012 - http://www3.halton.gov.uk/lgnl/policyandresources/318448/318454/Public_Health_Annual_Report_2012.pdf

Bowel Screening

Bowel screening uptake and coverage (indicators), 60-74 year old, all persons, 2012 - *Figures from HSCIC*

Area	England	North West	Halton
Screened within 6 months of invitation	1,969,711 (55.37%)	279,919 (52.67%)	4,765 (48.00%)
Screened in previous 30 months	4,139,129 (52.14%)	548,592 (49.99%)	9,222 (48.91%)

According to HSCIC figures (GP level data), 48.00% of people aged 60-74, who were invited for screening (uptake), were actually screened within six months of their invite. This is lower than the proportions of 52.67% and 55.34% witnessed in the North West and England respectively.[7]

Breast Cancer Screening

Breast cancer screening coverage for 53-70 year old females in Halton was below that of England for the years 2010 to 2012. There has been an increase of breast screening coverage in Halton across the three years, which is in direct contrast to the North West, which has seen a reduction in coverage from 2010 to 2012.

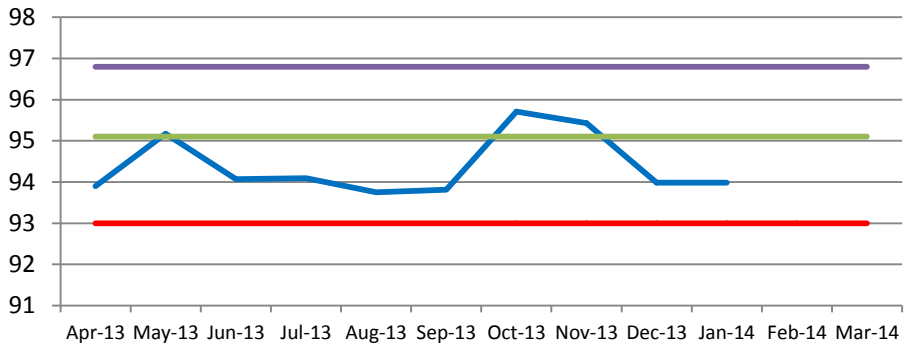
Coverage in Halton during 2012 was at just below 76%, compared to just below 75% in the North West and just below 77% in England.[8]

[7] Halton Borough: Cancer Profile Series 4 Bowel Cancer – Jan 2014: http://www3.halton.gov.uk/lgnl/policyandresources/318448/318454/Bowel_Cancer_Profile_2013

[8] Halton Borough Cancer Profile Series 3 Breast Cancer, January 2014 - http://www3.halton.gov.uk/lgnl/policyandresources/318448/318454/Breast_Cancer_Profile_2013

Maximum 2 week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP[9]

Percentage of patients waiting 2 weeks or less for outpatient appointment from urgent GP referral for suspected cancer



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
NHS Halton CCG	93.9	95.17	94.07	94.09	93.75	93.81	95.71	95.43	93.98	93.98		
NHS Constitution Standard	93	93	93	93	93	93	93	93	93	93	93	93
Median value	95.1	95.1	95.1	95.1	95.1	95.1	95.1	95.1	95.1	95.1	95.1	95.1
Top Quintile (National)	96.8	96.8	96.8	96.8	96.8	96.8	96.8	96.8	96.8	96.8	96.8	96.8

NHS Halton CCG performs well against the NHS Constitution measure standard, however there is room for improvement. Current performance places NHS Halton CCG in the lowest quintile when compared nationally and for most months below the national median value.

Commissioning Intentions

PC141505 – Review pathway around cancer presentations – this will look at the evidence across all pathways, and will include examining the evidence to introduce a targeted screening programme to increase early detection rates of lung cancer

PC141506 – Implement tools to improve the sharing of information at the end of life – Work towards implementing the EPACCs IT system – Improve the use of special patient notes in end of life care.

PC141507 – Implement the replacement for the Liverpool care pathway

PC141508 – To review access to lifestyles services for patients with cancer, for example breast cancer weight loss and exercise programme in line with the priorities of the National Cancer Survivorship Initiative

PC141509 – Review pathways for patients with cancer attending hospital to explore alternative models of follow up eg. Telephone follow up or GP led.

[9] Data from NHS Operational Planning Atlas as of 14/04/2014 – Median value and Top quintile value taken as most recent value available Q2 2013/14

7.2 Mental Health

Clinical Measures

Reducing Hospital admissions for people with Mental Health problems

Increasing number of people with mental health problems treated in their own home

Decreasing waiting times for appointments

Increasing access to appointments

Reducing the amount of Mental Health medication prescribed.

Current position

There are good examples of mental health services already commissioned by the CCG, including 'Operation Emblem' where a CPN accompanies police calls where a mental health issue is suspected. A pilot of this scheme has demonstrated a significant reduction in the number of S136 issued and a consequent saving in both police and social worker time and improved outcomes for the patient. The work done in developing a joint specification for a Tier 2 CAMHS service with the local authority is an excellent example of joint commissioning which provides an improved and equitable service. Work done around developing Psychological Therapies services for Halton residents will soon begin to show benefits with a single provider now overseeing all IAPT services for Halton residents.

Waiting times for secondary care outpatients is reducing and the psychiatric liaison service at Whiston is performing well

Our aims

To build on the psychiatric liaison service at Whiston by developing the service further at Warrington and Halton Hospitals Foundation Trust

To implement the actions within the Halton suicide prevention strategy

To building on the good work done around the tier 2 CAMHS service by reviewing the Tier 3 service.

To review the number of admissions to hospital for people with mental health problems.

To look at the shared care model of prescribing of anti-psychotic medication between primary and secondary care, with a view to increasing the numbers of patients under shared care.

To review the number and appropriateness of patients with dementia being prescribed anti-psychotic medication

To review the ADHD pathway with or without other mental health problems, to include new presentations as adults in collaboration with other CCG's

7.3 Ambulance Service

Paramedic Emergency Service (PES)

Commissioning Intentions for the Paramedic Emergency Service (PES) have been produced by the lead commissioner (NHS Blackpool CCG) on behalf of the 33 CCGs in the North West (NW). The Blackpool Ambulance Commissioning Team (BACT) utilised the agreed governance framework within the Memorandum of Understanding between them and the NW CCGs to produce commissioning intentions for 2014/15, and high level strategic intentions for 2014 to 2019, Consultation and engagement was carried out with each group within this governance framework, and NHS Halton CCG attended a planning workshop held in December 2013 and contributed to this process, as well as attending the Merseyside Area Ambulance Commissioning Group, working with the BACT and contributing to the final document.

The PES commissioning intentions document recognises the need for whole system transformation in order to move towards the healthcare system described by both the House of Commons Health Committee 'Urgent and Emergency Services' report (July 2013), and the Keogh 'Urgent and Emergency Care Review' (November 2013). Both reports describe PES as having a changed role within an enhanced system of urgent care; a role where conveyance to hospital will be one of a range of clinical options open to ambulance services and allow PES to become "mobile urgent treatment centres" (Keogh, 2013). One of these key required changes is to achieve a reduction in conveyance to hospital and the PES contract for 2014/15 has been designed to encourage this by incentivising this through CQUIN. This will allow the provider, North West Ambulance Service (NWAS), to build on the progress they have already made with commissioners over recent years; developing and implementing initiatives such as the Urgent Care Desk, Paramedic Pathfinder, Referral Schemes into Primary Care, Targeting Frequent Callers, and increasing the percentages of patients that are treated by 'See and Treat' and 'Hear and Treat'. All of these schemes support the achievement of 'Safe Care Closer to Home', which is a strategic goal of NWAS, as well as supporting NHS Halton CCG's plans for integration.

In NHS Halton CCG we have been working closely with NWAS in the development of the two Urgent Care Centres being developed in Halton, as part of this development NWAS sits on the Urgent Care Working Group the Urgent Care Centre development board and the Clinical Pathways Group.

The governance framework includes an 'Ambulance Strategic Partnership Board' (SPB), and each county area has a representative. In Halton, our ambulance commissioning lead feeds back from the SPB to our Merseyside Ambulance Commissioning Group, where NHS Halton CCG has representation. The SPB

maintains the strategic oversight of all county area reconfigurations, both at county and CCG level; acting as 'Change Management Board' and seeking assurance that county and local changes, translate into a North West level. A work shop has been arrange for June 2014, to begin this work. NHS Halton CCG will continue to ensure local plans align with the SPB via the Merseyside Area Commissioning Group.

Patient Transport Services (PTS)

Five PTS contracts are in place across the NW, which were awarded following a procurement exercise. Each are three year contracts, which began on 1 April 2013. There is one provider for each of the county areas; the provider for Halton is NWAS although the two acute trusts St Helens & Knowsley NHS Trust and Warrington & Halton NHS Foundation Trust also have separate contracts to provide Patient Transport Services.

The current service specification contains increased operating hours, and higher quality standards than the previous one. The service is provided for eligible patients. Planning for the next tender will begin during 2014/15, which will include reviewing the current service specification against new and emerging policy and guidance, such as 24/7 working. NHS Halton CGG will engage in this process via the Merseyside Ambulance Commissioning Group, and the wider governance as described above.

7.4 Womens Health

Clinical measures

Teenage Pregnancies – measured as Under 18 conception rate per 1000 females aged 15-17 (crude rate) 2009-2011 – 51.8 Halton, 34.0 England Average, 58.5 England Worst.(from public health profiles Sept 2013)

Chlamydia rates – July to Sept 2013. Halton 2303 per 100,000. Compared with 1736 for Cheshire & Merseyside area and 1785 for England as a whole. (from public health England Table 1.3 chlamydia testing data for 15-24 year olds)

Chlamydia screening – July to Sept 2013. Halton 7% tested, compared with 5.4% for Cheshire & Merseyside area, and 5.8% for England as a whole. (from public health England Table 1.3 chlamydia testing data for 15-24 year olds)

Cervical cytology – (NHS Cervical screening programme – Target age group 25-64, % less than 5 years since last adequate test) 2012-2013 Halton & St Helens PCT 78.1%, North-West 78.1%, England Average 78.6%) – from HSCIC Cervical screening programme 2012/13 Table 13

Current Position

Teenage pregnancies are high, significantly higher than the England average

Chlamydia screening is good, with a high rate of screening (7%) compared with both the Cheshire and Merseyside area (5.4%) and England as a whole (5.8%)

However the diagnosis rate of people with chlamydia is high in Halton, with a rate of 2,303 per 100,000, compared with 1,785 per 100,000 for England as a whole

Our Aims

Teenage pregnancies in Halton are too high, this should be an area to focus on over the next 2-5 years by greater use of long lasting contraception.

Prescribing of long lasting contraception across practices will be investigated, with focus on variation between practices. Improved training of Nurses in General Practice will be developed to improve rates of use of long lasting contraception, this should also reduce the number of terminations.

7.5 Dementia

Measures

Admissions to hospital for people with dementia (aiming for a reduction)

Dementia diagnosis rate (aiming for an increase)

Current Position

NHS Halton CCG is improving services in most areas for people with dementia, with an improving dementia diagnosis rate which is already one of the highest in the region with plans to improve this further. Support for people with dementia to live in their own homes needs to be increased by improving services which are already in place such as the dementia care advisors.

Our Aims

NHS Halton CCG aims to increase the diagnosis rate for people early on in the disease, avoid the need for hospital admissions and provide more support at home, including improving the psychological and social support that is available to enable people with dementia to live life to the full.

7.6 Integration, Adult safeguarding & complex care

7.6.1 Integration

Current Position

There is room for improvement in integration between primary care and community services and integration with social services is not as good as it should be, especially in relation to front line integration between nurses and social workers. Working practice between these workers needs to improve to obtain the benefits of integration.

Our Aims

To improve the links between staff in primary and community care settings.

7.6.2 Safeguarding Adults

Measures

Number of people referred to safeguarding team

Current Position

The current service is performing well although it is very busy. It is expected that the number of referrals will plateau as saturation is reached.

Our Aims

To maintain the current level of service with a similar volume of referrals

7.6.3 Care Homes Programme

Measures

Reduction in admissions to hospital from care homes

Current Position

Current admission figures are very good, reductions have been seen in both the number of admissions to hospital relating to UTI's and falls. Services in place are having an impact.

Our Aims

To continue the work already being done in minimising the number of admissions to hospital from care homes

7.7 Falls

Measures

Acute admission rate due to falls (aiming for a reduction)

Current Position

The clinical pathway for falls is not fully developed and not promoted. The current falls service has capacity issues.

Our Aims

The pathway needs to be fully developed. There is a need to develop services that will keep older people active and therefore less likely to fall. There needs to be a greater use of medical prevention treatments and appropriate medication management, this would reduce the number and/or severity of fractures following a fall.

7.8 Respiratory

Current position

Respiratory disease is one of the key contributing factors to reduced life expectancy in Halton and is the third leading cause of death after circulatory disease and cancer. There are significant health inequality issues in Halton concerning respiratory diseases where the mortality rate in our most deprived areas is double that of Halton as a whole, and historically, COPD detection rates have been lower in these more deprived areas.

Headline Facts

- It is estimated about 3,916 people aged 16+ living in Halton had Chronic Obstructive Pulmonary disease (COPD) in 2010. By 2020 this figure may be as much as 4,420.

- Estimations have also been calculated for the number of people predicted to have a longstanding health condition caused by bronchitis and emphysema. It was estimated that 328 people over the age of 65 were affected by this in 2012, and that the number will rise to 406 by 2020.

- There have been improvements in case finding since 2009/10 closing the gap between the modelled estimated number of people with COPD and those of GP disease registers. However, the number of people on the asthma register remains lower than the expected number.

- There is significant ward level variation in emergency hospital admission rates and at GP practice level. There is also a relationship with temperature, with a greater percentage of admissions seen in the winter months.

- Death rates for COPD have been falling but are above the North West and England rates. Death rates from respiratory causes in those aged under 75 years and pneumonia are also higher than England but similar to the North West.

- Prescribing of respiratory drugs accounts for 15.7% of Halton CCG prescribing spend and there is significant variation in prescribing across the 17 GP practices

Our Aims

We are developing a plan to improve respiratory health in the Borough encompassing prevention through to end of life care. In the short term our focus will be on;

- Adopting unified personalised action plans across both primary and secondary care for patients with COPD & Asthma

- Adopting a unified template in Asthma and COPD across all Primary care practices .

- Improved recognition, recording and follow up of acute exacerbations for both asthma and COPD

- Supporting patients and their carers to better manage their own care

- Implementing a learning and development programme to support professionals, patients and carers to improve their knowledge, skills and understanding of respiratory health care.

In the longer term we aim to

Ensure patients and their carers experience integrated care along the respiratory pathway

Provide support to GP practices that have been identified as outliers with regards to emergency hospital admissions and/or prescribing respiratory medication

Ensure patients have appropriate inhaler medication and know how to use them correctly

Provide quality assured spirometry with robust interpretation

7.9 Primary Care

Current Position

Current GP services are of a high standard and most parameters are at par with national average and some areas exceeding it. The Primary Care Group has the prime function of improving quality among all the member practices. As part of its work it has identified four areas where further improvements could be made, these are;

- Prevalence rates (identifying the unidentified patient) in respect to CVD, Stroke, Cancer, COPD etc.
- Access to GP
- Flu Immunisation rates
- Cervical Screening

Our Aims

Greater collaborative working between practices beginning with the areas highlighted above, identifying and sharing good ideas in other practices. Especially focussing on Flu immunisation performance as there is a large variation in performance between practices and with our neighbouring areas.

To support individual practices in bidding for enhanced services.

GP Development, there is an increase in workload and expectations, the current way of working is not sustainable, a considerable number of Halton GP's are approaching retirement and there is a national issue regarding recruitment, with General Practice not being considered as desirable a career.

Performance

Primary care dashboard is currently in development, this should be completed within 2014/15

7.10 Stroke

Clinical Measures

The early death rate from heart disease and stroke in Halton has fallen but remains worse than the England average.

NHS Halton CCG is not consistently achieving targets around the percentage of people who spend 90% of their time on a stroke unit and the percentage of people with a high risk of stroke who have a TIA and are assessed and treated in 24 hours.

Current Position

A Stroke Board had been established and is meeting regularly.

Some changes have already been made, for example both trusts have increased the number of beds ring-fenced for people who have had a stroke

St Helens & Knowsley NHS Trust are noted as doing well on initial assessment and treatment of Stroke but not on rehabilitation and the opposite is true at Warrington & Halton Hospitals NHS Foundation Trust.

A contract query was issued to Warrington & Halton Hospitals NHS Foundation Trust and an action plan established as a result which is being managed through the Stroke Board.

Discussions are taking place about options for models for stroke services – there is national pressure to opt for a model based on Hyperacute Units but that there is little support for this with the local Networks.

Aims

To achieve consistently high standards of delivery in stroke services

To develop and implement a stroke strategy setting out a clear vision for the future of stroke services

8. Quality Improvement

NHS Halton CCG has a Quality Committee as an intergral part of the governance arrangements, the committee has representation from across the health economy, including commissioners and providers and is a vital part of Halton's strategy to ensuring quality improvement across the whole system. The Early Warning Dashboard performance report and regular deep dives provide assurance when things are going right and early warnings when interventions may be required.

The NHS outcomes framework consists of five domains and seven outcome ambitions, the five domains are:

1. Prevent people from dying prematurely
2. Improved quality of life for people with long term conditions
3. Quick recovery from episodes of ill health or injury
4. Improved patient experience
5. Improved patient safety

These domains are served by the seven outcome ambitions. NHS Halton CCG has the following services and improvement programmes in place.

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

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

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

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

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

NHS Halton CCG has one of the best dementia diagnosis rates in the country (currently 62%), however, we are not complacent and are committed to reaching the target of 67% by 2014/15.

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

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

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

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

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

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

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

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

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

8.6 Increasing the number of people with mental and physical conditions having a positive experience of care outside hospital, in General Practice and in the community

NHS Halton CCG will work towards improving the patient experience of their GP surgery with the aim of increasing the percentage of people answering ‘good’ or ‘very good’ in the GP Patient survey with regards to their experience of the GP surgery to exceed the national average.

5 Boroughs Partnership NHS Foundation Trust has already begun a local Friends and Family test as part of commissioning for quality and innovation payment which will provide focus around improving a person’s experience of care.

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

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

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

8.8 Quality in Mental Health

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

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

- Reduce stigma and discrimination
- Reduce waiting times and ensure parity across services that will in turn support an integrated provision across cluster pathways
- Improve access
- Increase the level of involvement of service users in the quality agenda within the Trust, such as Serious Untoward Incident (SUI) panels
- Sustaining and supporting 5 Boroughs Partnership NHS Foundation Trust to be a pilot area for the Mental Health Friend and Family Test and continuing to support the Trust in the advancing quality agenda.

9. Sustainability

NHS Halton CCG faces a 'do nothing' 5 year finance gap of £39 Million. For the health economy to be sustainable the goals are;

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

9.1 Demographics

The population structure of Halton is projected to change in the next 5 years to 2018. Office for National Statistics predict that there will be an increase of 6.8% in the population aged 0-15 and 23.8% in those aged 65+. Conversely, it is estimated that there will be a decrease in those aged 16-24 by 13.6% and in 25-64 year olds by 2.3%. When looking at this change in the demographic profile of Halton over five years and taking into account the age profile of people using health services the following table has been created to give a baseline for population related growth in the health economy. This has been taken into account for all planning calculations for services in the acute sector.

	2014/15	2015/16	2016/17	2017/18	2018/19
0-64 popn change*	-100	100	-500	200	-100
65+ popn change*	500	800	300	1000	200
Overall change*	400	900	-200	1200	100
% Change*	0.32%	0.71%	-0.16%	0.94%	0.08%
% Weighted change**	0.74%	1.16%	0%	1.55%	0.17%

** ONS Interim 2011-based Subnational Population Projections*

*** From ONS report on Hospital admissions by age & sex 2007/08: NHS Information Centre for Health & Social care, Halton UA hospital admissions were split 70 / 30 between 0-64's and 65+*

9.2 Activity

The Halton Public Health team have identified that it is likely that there will be more demand on unplanned hospital care over the next five years from those living and registered with GPs in Halton, particularly in relation to these younger and older age groups.

Areas identified with a potential for increased demand, due to population changes, are;[10]

Emergency admissions for:

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

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

A&E attendances in those aged 65+

Analysis of activity demands on Halton Health economy

Older people 65+[11]	2012	2014	2016	2018	2020
With a limiting long-term illness	10782	11419	12185	12675	13300
Predicted to have dementia	1229	1256	1314	1421	1518
Predicted to have a longstanding health condition caused by a heart attack	948	1018	1073	1116	1166
Predicted to have a longstanding health condition caused by a stroke	444	473	501	528	551
Predicted to have severe depression	523	554	591	606	636
Predicted to have a fall	5048	5363	5665	5921	6206
With a BMI of 30 or more	5191	5585	5906	6127	6359
Predicted to have diabetes	2430	2605	2755	2895	3017
Adults 18-64[13]	**2012**	**2014**	**2016**	**2018**	**2020**
Predicted to have a learning disability	1901	1878	1858	1841	1824
Predicted to have a common mental disorder	12608	12499	12365	12269	12172
Predicted to have a moderate physical disability	6267	6190	6154	6136	6109
Predicted to have a serious physical disability	1878	1852	1842	1844	1845
Predicted to have diabetes	2625	2603	2584	2594	2585

[10] Future impact of demographic changes on unplanned hospital care in Halton
[11] http://www.poppi.org.uk
[13] http://www.pansi.org.uk

Contribution of Health and Wellbeing priority areas to emergency admissions in 2011/12[14]

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

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

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

	2009/10	2010/11	2011/12	% change 2009/10 to 2011/12	
Number of admissions for falls[15]	740	872	934	26.2%	↑

- Left unchecked this increase is likely to continue, as the number of falls in people aged 65+ is projected to rise from 5048 in 2012 to 5665 in 2016[16]

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

9.3 Finance

9.3.1 Introduction

The guidance "Everyone Counts: Planning for patients 2014/15 to 2018/19" sets out the aims for the NHS – meeting the promises of the NHS Constitution, empowering clinical commissioning through assumed autonomy whilst at the same time ensuring that services are safe and responsive to patients. The planning guidance also set out the requirements for CCG financial plans to 2018/19:

- They deliver 1% surplus at year end
- A minimum ½% non-recurrent contingency reserve is created
- For 2014/15 use 2.5% non-recurrently, dropping to 1% in the remaining years.

In developing the longer term strategy only the allocations for 2014/15 and 2015/16 are set – assumptions have had to be used for the remaining 3 years. Although the guidance does suggest that current levels of funding should continue the impact of potential alternative scenarios for future funding have also been considered.

9.3.2 Key prinicples and assumptions

In looking ahead to the future a degree of estimation and assumption will be required. Although NHSE has confirmed the next 2 years allocations there is no such certainty about funding beyond 2015/16. Clearly the General Election in 2015 and the relative state of the Public Finances could have a major impact on the level of resources available to the NHS. In looking at the future scenarios although Government borrowing is still very high constraining spending, the current economic down-turn does appear to be ending. This more positive view is therefore reflected in the scenario planning undertaken as part of the Financial Strategy.

Whilst NHS Halton CCG has benefitted from the inequalities component of the allocation this has been offset by the impact of the relatively low registered population growth estimates compared to the national average over the next 2 years. For 2014/15 and 2015/16 they set out a minimum uplift of 2.14% and 1.7% respectively.

The Planning guidance recently released suggests that for longer term strategic plans that the CCG should assume a continutation of the NHSE's current allocation policy although no decisions on allocation beyond 2015/16 have yet been taken. *"Commissioners should assume that income growth increases in line with the GDP deflator"* (1.8% for 2016/17 and 1.7% for the remaining 2 years)

The Running Cost Allowance (RCA) – the management costs of the CCG - have been redcued in 2014/15 from £25 per head of population to £24.78. In line with the announcement in the Comprehensive Spending Review (CSR), NHS administration costs are to be reduced by 10% in 2015/16. If the NHSE continue a policy of not increasing the total RCA nationally (even to reflect pension and pay award cost

increases) then the projected drop in ONS population forecast for NHS Halton CCG will mean that over the two years the CCG will have to cope with a 19% real terms cut in its RCA.

In developing the Financial strategy no attempt has been made to try and second guess the outcome of the Stenvens review of specialist and primary care commissioning and the potential that it may change the balance of commissioning responsibilities between the CCG and NHSE.

In terms of the strategy the key issue will be how far the CCG can control the costs of the services it commissions. These can vary due to inflationary price changes set nationally by Monitor in conjunction with the NHSE from 2014/15 and a re therefore out of the CCG's control. In recent years the inflationary uplift (of 2.2% - 2.5%) has been more than offset by the -4% efficiency built into NHS tariff inflation so that commissioners have benefitted from negative price rises. The planning guidance suggests that CCGs should assume that this continues over the 5 years to 2015/19

The other area of cost increase will be due to changes in activity – either in violume or in the type of treatment. Clearly the most important area is in acute Payment by Results (pbR) were activity multiplied by national tariff prices determine CCG costs. The model used to develop the financial strategy does build in some assumptions for activity growth. It should be noted that Monitor is consulting on new tariff currencies but it it still too early to assess the potential impact on commissioner costs and no allowance has been made in the strategy for such a change.

Although some cost increases may be as a direct consequence of CCG commissioning intentions, others will be driven by growth in patient demand which might be challenging to control, as payments cannot easily be stopped if patients continue to access services or prescriptions are written. This represents a potential risk to the CCG's financial viability and might prevent CCG commissioning decisions to invest to improve services being taken forward. Certainly the growing numbers of the elderly and the obese are longer term population trends which are expected to impact on the demand for NHS services.

The strategy maintains the Clinical Quality Incentives Scheme (CQUINS) at 2.5% over the 5 years

Some of the commissioning investments are due to national guidance. Within the strategy the largest example of this is the Better Care Fund in 2015/16. Although the CCG will receive an allocation of £2.292m in 2015-2016 towards the Better Care Fund it will need to find attiional sums either from growth or efficiencies to add new money to the Fund totalling £9.451m. There is likely to be recognition in the DH that significant mandate investement requirements cannot be made if the NHS finding increases are low.

The majority of the demand management will come from the impact of the beter Care Fund as well as the development of the CCG's Urgent care Centres. It should eb noted that the resources required setting up the Centres and the Fund in advance of the delivery of the associated QIPP efficiency savings will consume the bulk of NHS Halton CCG's available resources in 2015/16 and 2016/17. Clearly there are risks that failure to achieve the anticipated QIPP savings will put pressure on the CCG's finances.

9.3.3 Finanical Risks

- The Key risks to NHS Halton CCG achieveing its financial duties are;-
- The relative gap between annual allocation growth and national price or tariff uplifts net of the efficiey factor
- Activity growth for services subject to cost and volume payment systems e.g. PbR and CHC
- Increased costs due to PbR case mix changes or higher cost better practice tariffs
- National NHS Operating Framework "must do's" which require investment
- Failure to deliver the savings from the CCG's QIPP schemes

9.3.4 Financial risk management

The likelihood and impact of these risks can change over time NHS Halton CCG has various tools in place to mitigate or control these risks. These can be split into three types.

9.3.4.1 Financial Systems

NHS Halton CCG has a robust ledger and budget control system in place to enable actions to be taken quickly to address financial pressures.

NHS Halton CCG will keep back some of its allocation as a contingency reserve to deal with any in-year cost pressure

9.3.4.2 Governance arrangements

NHS Halton CCG has a robust internal governace arrangement which ensures that decisions are properly considered and approved and that all members can be assured that risks are being managed. Elements within this form of control include the work of the Audit Committee, performance and Finance Committee and meetings of the Governing Body and Membership. Other Key parts of this governance framework relate to the internal and external auditors of the CCG

9.3.4.3 Relationships and risk sharing

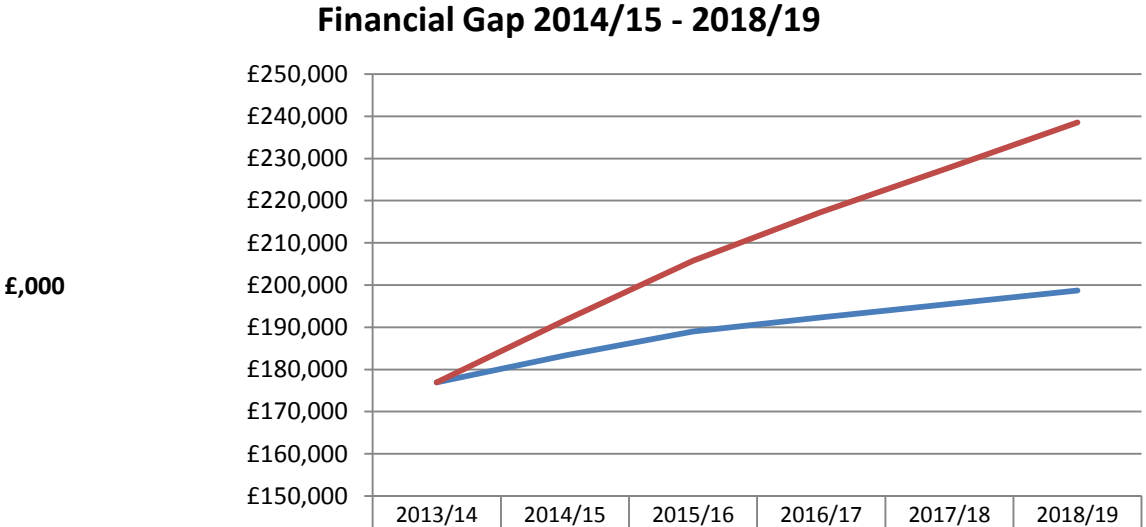
A third control mitigation is to try and share financial risk with other organisations. Examples of this include the risk share between NHS Halton , Knowsley and St Helens CCGs for the number of high cost patients with an acquired brain injury at Vancouver House in Liverpool. This arrangement seeks to reduce the risk of a disproportionate number of such cases falling on a single CCG in any one financial year through random chance. A similar arrangement applies to the creation of the £13.383m pooled budget between the NHS Halton CCG and Halton Borough Council for complex health and social care cases, with the risk of increased costs shared rather than trying to pass the cost on to the other party.

9.3.5 Financial Strategy

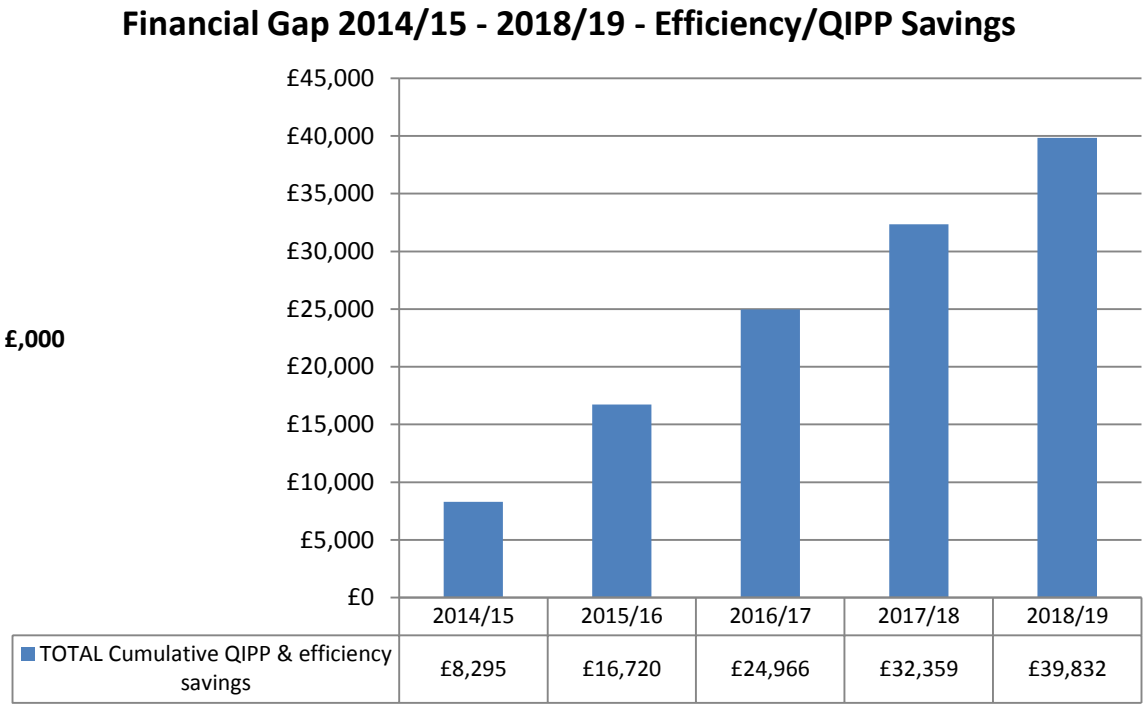
As part of the strategic financial modelling required by the NHSE NHS Halton CCG has completed a 5 year financial model, full details of this are available in the 5-year financial plan, A summary of the modelling used is described below.

The starting point is the 2014/15 annual budget already approved, figure 9.3.6 describes the financial gap facing the CCG between 2014/15 and 2018/19. This gap between the 'do nothing' position and the planned budget position is based on a series of a series of assumptions, to maintain a balanced budget, this 'gap' is filled by efficiency and QIPP savings.

9.3.6 Overall financial position & do nothing position



	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Planned Budget (excluding surplus)	£176,914	£183,321	£189,026	£192,343	£195,506	£198,711
Budget excluding efficiency & QIPP savings	£176,914	£191,616	£205,746	£217,309	£227,865	£238,543



The table and chart above show a summary of the overall financial position of NHS Halton CCG for the next five financial years. Taking anticipated growth into account £8.3M of savings need to be found in 2014/15. The cumulative effect of the 'do nothing position' would be a shortfall of £39.8m over the five year period. Savings are required to be found in each of the next five years with the largest gap being seen in 2015/16 where a saving of £8.4M will need to be found to achieve a balanced budget.

9.3.7 Financial Planning assumptions

Table 2 Planning Assumptions - Base Scenario 1						
Description	Type	2014/15	2015/16	2016/17	2017/18	2018/19
Allocation Growth (+%)	Programme	2.14%	1.70%	1.80%	1.70%	1.70%
	Running Costs	-0.58%	-10.51%	-0.51%	-0.55%	-0.51%
	Weighted Average	2.11%	1.49%	1.77%	1.67%	1.67%
Gross Provider Efficiency (-%)	Acute	-4.00%	-4.00%	-4.00%	-4.00%	-4.00%
	Non Acute	-4.00%	-4.00%	-4.00%	-4.00%	-4.00%
Provider Inflation (+%)	Acute	2.60%	2.90%	4.40%	3.40%	3.40%
	Non Acute	2.60%	2.90%	4.40%	3.40%	3.40%
Demographic Growth (+/- %)		0.32%	0.32%	0.31%	0.31%	0.23%
Non-Demographic Growth (+/- %) e.g. casemix	Acute	0.68%	0.68%	0.69%	0.69%	0.77%
	CHC	0.88%	1.88%	0.49%	0.49%	0.97%
	Prescribing	0.50%	0.50%	0.50%	0.50%	0.50%
	Other Non Acute	0.00%	1.88%	0.49%	0.49%	0.97%
Contingency (%)		0.50%	0.50%	0.50%	0.51%	0.53%
Non-Recurrent Headroom (%)		2.50%	1.02%	1.02%	1.02%	1.02%
Running Cost (spend per head (£)		0.024	0.021	0.021	0.021	0.020

The base case scenario 1 assumptions suggest that the CCG will stay in financial balance (delivering a 1% surplus) over the next 5 years – as limited allocation growth together with tariff efficiency and other CCG QIPP savings combine to give limited re-investment and development opportunities to the CCG over the period, the table below set out the forecast position to 2018/19 based on these assumptions

Table 3 Scenario 1 Base Case Summary	Year 1 - 2014/15			Year 5 - 2018/19		
	Recurrent Cashflows £000	Non Recurrent £000	Total Cashflows £000	Recurrent Cashflows £000	Non Recurrent £000	Total Cashflows £000
Total Expected Sources	181,551	1770	183,321	196,750	1,961	198,711
Total Planned Application of Sources	175,456	6,029	181,485	194,775	1,943	196,718
Planned Surplus / (Deficit)	6,095	-4,259	1,836	1,975	18	1,993
Percentage Surplus / (Deficit)	3.36%		1.00%	1.00%		1.00%

Two further scenarios have been developed, the first is that the Government will fund the proposed increase to employers NHS pension contributions in 2016/17. This has been estimated to add 0.7% to commissioner prices and tariff costs in that year.

Table 4 Scenario 2 Pension Cost Funded	Year 1 - 2014/15			Year 5 - 2018/19		
	Recurrent Cashflows £000	Non Recurrent £000	Total Cashflows £000	Recurrent Cashflows £000	Non Recurrent £000	Total Cashflows £000
Total Expected Sources	**181,551**	**1770**	**183,321**	**198,007**	**4,482**	**202,489**
Total Planned Application of Sources	**175,456**	**6,029**	**181,485**	**194,775**	**1,943**	**196,718**
Planned Surplus / (Deficit)	**6,095**	**-4,259**	**1,836**	**3,233**	**2,539**	**5,771**
Percentage Surplus / (Deficit)	3.36%		1.00%	1.63%		2.85%

The second scenario looks into an assumption that over target CCGs would receive a further 1% less than the current guidance about the base level of uplift. In effect a reduction in allocation growth by 1% after 2015/16

Table 5 Scenario 3 From 2016-17 Allocations 1% less	Year 1 - 2014/15			Year 5 - 2018/19		
	Recurrent Cashflows £000	Non Recurrent £000	Total Cashflows £000	Recurrent Cashflows £000	Non Recurrent £000	Total Cashflows £000
Total Expected Sources	**181,551**	**1770**	**183,321**	**191,004**	**-3,694**	**187,310**
Total Planned Application of Sources	**175,456**	**6,029**	**181,485**	**194,775**	**1,943**	**196,718**
Planned Surplus / (Deficit)	**6,095**	**-4,259**	**1,836**	**-3,771**	**-5,637**	**-9,408**
Percentage Surplus / (Deficit)	3.36%		1.00%	-1.97%		-5.02%

This reduced income would lead to the CCG posting a deficit from 2017/18 unless further corrective action is taken in addition to the efficiency and QIPP savings required in the base scenario. Further strategies needed to bridge this deficit are outlined below.

i) Request a reduction in surplus delivery target
ii) Reduce investments – in recurrent first, then the non-recurrent second
iii) Increase the CCG's QIPP plans to control activity growth in its health economy

It should be noted that whilst the downside scenario will present a significant challenge to the CCG, the continuation of the 4% tariff efficiency presents an even greater challenge to the providers of NHS services.

9.3.8 Investments in Urgent Care £000,s

Investments in Urgent Care	2014/15	2015/16	2016/17	2017/18	2018/19
Recurrent investments Urgent Care centre	300	500	900	490	130
Non Recurrent investment Urgent care centre	1,785	1,270	1,295	1,379	1,486
Total investment	2,085	1,770	2,195	1,869	1,616

9.3.8.1 Reduction on A&E Activity

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

9.3.8.2 Reduction on Non Elective Admissions

The aim is to reduce inappropriate non elective admissions into secondary care by moving emergency activity closer to home and increasing diagnostic activity in urgent care centres. This will impact non elective admission by 15% over 4 years. The financial impact of the reduction of secondary care non elective admissions amounts to

Year	Gross Saving
2014/15	£0.65m
2015/16	£1.35m
2016/17	£1.35m
2017/18	£0.65m
Total gross saving	£4.7m (across both A&E and non-elective admissions)
Total net saving	£2.07m

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

9.3.9 Planned Application of Funds – NHS Halton CCG

Appendix 3 Base Scenario 1 Source & Application of Funds	2014/15			2015/16			2016/17			2017/18			2018/19		
	Rec't £000	Non-Rec £000	Total £000	Rec't £000	Non-Rec £000	Total £000	Rec't £000	Non-Rec £000	Total £000	Rec't £000	Non-Rec £000	Total £000	Rec't £000	Non-Rec £000	Total £000
Allocation- Programme	**178,469**	**1,770**	**180,239**	**184,432**	**1,836**	**186,268**	**187,699**	**1,899**	**189,599**	**190,840**	**1,937**	**192,777**	**194,035**	**1,961**	**195,996**
Allocation- RCA	**3,082**		**3,082**	**2,758**		**2,758**	**2,744**		**2,744**	**2,729**		**2,729**	**2,715**		**2,715**
Total	**181,551**	**1,770**	**183,321**	**187,190**	**1,836**	**189,026**	**190,443**	**1,899**	**192,343**	**193,569**	**1,937**	**195,506**	**196,750**	**1,961**	**198,711**
Application of Funds															
Acute services	92,404	2340	94,744	92,238	-	92,238	93,689	-	93,689	93,911	-	93,911	94,087	-	94,087
MH services	16,276	120	16,396	16,298	300	16,598	17,009	-	17,009	17,043	-	17,043	17,144	-	17,144
Community services	18,029	409	18,438	17,154	-	17,154	17,890	-	17,890	18,375	-	18,375	18,485	-	18,485
Continuing Care services	10,856	682	11,538	19,882	-	19,882	20,939	-	20,939	21,816	-	21,816	23,829	-	23,829
Primary Care services	26,130	450	26,580	27,323	450	27,773	29,519	-	29,519	31,254	-	31,254	32,194	450	32,644
Other Programme services	8,680	1111	9,791	7,409	2,370	9,779	6,761	900	7,661	6,475	940	7,415	6,358	440	6,798
Total - Commissioning services	**172,374**	**5,112**	**177,486**	**180,304**	**3,120**	**183,424**	**185,806**	**900**	**186,706**	**188,874**	**940**	**189,814**	**192,098**	**890**	**192,988**
Running Costs	**3082**		3,082	2,756		2,756	2,736		2,736	2,727		2,727	2,677		2,677
Contingency		**917**	917		946	946		963	963		1,004	1,004		1,053	1,053
Total Application of Funds	**175,456**	**6,029**	**181,485**	**183,060**	**4,066**	**187,126**	**188,543**	**1,863**	**190,406**	**191,601**	**1,944**	**193,545**	**194,775**	**1,943**	**196,718**
Surplus/(Deficit)	6,095	- 4,259	1,836			1,899			1,937			1,961			1,993
% Surplus/(Deficit)			1.0%			1.0%			1.0%			1.0%			1.0%

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

9.3.10.1 Baseline QIPP savings £'000

Scenario 1 - Baseline Qipp Savings 2014/15 to 2018/19	2014/15 Recurrent £000	2014/15 Non Rec £000	2014/15 Total £000	2015/16 Recurrent £000	2015/16 Non Rec £000	2015/16 Total £000	2016/17 Recurrent £000	2016/17 Non Rec £000	2016/17 Total £000	2017/18 Recurrent £000	2017/18 Non Rec £000	2017/18 Total £000	2018/19 Recurrent £000	2018/19 Non Rec £000	2018/19 Total £000
Commissioning Schemes															
Opthalmology Procurement	**(280)**	**0**	(280)	**0**	**0**	0	**0**	**0**	0	**0**	**0**	0	**0**	**0**	0
Childrens Commissioning Procurement	**(40)**	**0**	(40)	**0**	**0**	0	**0**	**0**	0	**0**	**0**	0	**0**	**0**	0
Community MDT Redesign	**(75)**	**0**	(75)	**0**	**0**	0	**0**	**0**	0	**0**	**0**	0	**0**	**0**	0
Reduction in NEL activity 2.5% - 5%	**(678)**	**0**	(678)	(1,355)	**0**	(1,355)	(1,395)	**0**	(1,395)	(678)	**0**	(678)	**0**	**0**	0
Mental Health Capacity Claims	**(10)**	**0**	(10)	0	**0**	0	0	**0**	0	0	**0**	0	**0**	**0**	
Acute Other	**(300)**	**0**	(300)	0	**0**	0		**0**	0		**0**	0	**(1,000)**	**0**	(1,000)
Reduction in A&E Activity by 5%	**(240)**	**0**	(240)	(480)	**0**	(480)	(480)	**0**	(480)	(240)	**0**	(240)	**0**	**0**	
Telemedicine Impact	**0**	**0**	0	(200)	**0**	(200)	(200)	**0**	(200)	(100)	**0**	(100)	**0**	**0**	
Redesign of Community Nursing	**0**	**0**	0	(50)	**0**	(50)	(50)	**0**	(50)	(50)	**0**	(50)	**(50)**	**0**	(50)
Total - Commissioning services	**(1,623)**	**0**	**(1,623)**	**(1,835)**	**0**	**(1,835)**	**(1,875)**	**0**	**(1,875)**	**(918)**	**0**	**(918)**	**(1,000)**	**0**	**(1,000)**
Running Costs	(115)	0	(115)	(115)	0			0			0			0	
Total	**(1,738)**	**0**	**(1,738)**	**(1,950)**	**0**	**(1,835)**	**(1,875)**	**0**	**(1,875)**	**(918)**	**0**	**(918)**	**(1,000)**	**0**	**(1,000)**
Tariff/Price Efficency															
Acute Services	(3,879)	0	(3,879)	(3,666)	0	(3,666)	(3,690)	0	(3,690)	(3,748)	0	(3,748)	(3,756)	0	(3,756)
MH Services	(570)	0	(570)	(628)	0	(628)	(652)	0	(652)	(680)	0	(680)	(682)	0	(682)
Community Services	(750)	0	(750)	(672)	0	(672)	(686)	0	(686)	(716)	0	(716)	(735)	0	(735)
Continuing Care Services	(258)	0	(258)	(288)	0	(288)	0	0	0	0	0	0	0	0	0
Primary Care Services	(1,008)	0	(1,008)	(985)	0	(985)	(1,093)	0	(1,093)	(1,181)	0	(1,181)	(1,250)	0	(1,250)
Other Programme Services	0	0	0	245	0	245		0	0		0	0		0	0
Total - Commissioning services	**(6,465)**	**0**	**(6,465)**	**(5,994)**	**0**	**(5,994)**	**(6,121)**	**0**	**(6,121)**	**(6,325)**	**0**	**(6,325)**	**(6,423)**	**0**	**(6,423)**
Running Costs	(92)		(92)	(231)		(231)	0	0	0	0	0	0			
Total	**(6,557)**	**0**	**(6,557)**	**(6,225)**	**0**	**(6,225)**	**(6,121)**	**0**	**(6,121)**	**(6,325)**	**0**	**(6,325)**	**(6,423)**	**0**	**(6,423)**

9.3.10.2 Baseline Investments (£000,s)

Scenario 1 - Baseline Investments 2014/15 to 2018/19	2014/15			2015/16			2016/17			2017/18			2018/19		
	Recurrent £000	Non Rec £000	Total £000	Recurrent £000	Non Rec £000	Total £000	Recurrent £000	Non Rec £000	Total £000	Recurrent £000	Non Rec £000	Total £000	Recurrent £000	Non Rec £000	Total £000
1/2% Contingency	0	892	892	0	941	941	0	944	944	0	986	986	0	1,040	1,040
A&E Liason Whiston/Warrington	261	0	261	0	0	0	0	0	0	0	0	0	0	0	0
Care Home Project	200	0	200	0	0	0	0	0	0	0	0	0	0	0	0
GP Strategy £5 per Head of Population	646	0	646	0	0	0	0	0	0	0	0	0	0	0	0
Hospice Investment	47	0	47	0	0	0	0	0	0	0	0	0	0	0	0
UCC Centre Development (Inc 1% transformational funding)	300	1,785	2,085	500	1,270	1,770	100	1,295	1,395	100	1,379	1,479	100	1,486	1,586
Designated Safeguarding Doctor	100	0	100	0	0	0	0	0	0	0	0	0	0	0	0
MH 136 Triage Pilot	27	0	27	0	0	0	0	0	0	0	0	0	0	0	0
Innovation fund	200	450	650	0	450	450	200	450	650	200	450	650	200	450	650
Prescribing Efficiencies	500	0	500	500	0	500	500	0	500	500	0	500	500	0	500
Activity Management Reserves	1,251	0	1,251	1,163	0	1,163	1,069	0	1,069	1,048	0	1,048	1,042	0	1,042
CHC Restitution	0	682	682	0	0	0	0	0	0	0	0	0	0	0	0
IM &T Intergration	0	500	500	0	0	0	0	0	0	0	0	0	0	0	0
Other Savings	0	514	514	330	164	494	251	144	395	212	144	356	0	144	144
Vascular and 18 Week Backlog	0	550	550	0	0	0	0	0	0	0	0	0	0	0	0
Better Care Fund	0	0	0	9,451	0	9,451	0	0	0	0	0	0	0	0	0
Total - Commissioning services	**3,532**	**5,373**	**8,905**	**2,493**	**2,825**	**5,318**	**2,120**	**2,833**	**4,953**	**2,060**	**2,959**	**5,019**	**1,842**	**3,120**	**4,962**
Running Costs	0	0	0	0	0	0	0	0	0	0	0		0	0	0
Total	**3,532**	**5,373**	**8,905**	**2,493**	**2,825**	**5,318**	**2,120**	**2,833**	**4,953**	**2,060**	**2,959**	**5,019**	**1,842**	**3,120**	**4,962**
Inflation															
Acute Hospital Services	2,519		2,519	2,657		2,657	4,058		4,058	3,185		3,185	3,193		3,193
Mental Health Services	371		371	456		456	717		717	578		578	579		579
Community Services	488		488	487		487	755		755	608		608	625		625
Continuing Care Services	258		258	288		288	398		398	209		209	233		233
Primary Care Services	1,160		1,160	1,199		1,199	1,366		1,366	1,476		1,476	1,563		1,563
Other Programme Services	0		0	245		245	133		133	64		64	63		63
Total - Commissioning services	**4,797**	**0**	**4,797**	**5,332**	**0**	**5,332**	**7,427**	**0**	**7,427**	**6,120**	**0**	**6,120**	**6,256**	**0**	**6,256**
Running Costs	14		14	20		20	0	0	0	0	0	0			
Total	**4,811**	**0**	**4,811**	**5,352**	**0**	**5,352**	**7,427**	**0**	**7,427**	**6,120**	**0**	**6,120**	**6,256**	**0**	**6,256**

9.3.11 Running costs

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

9.4 Provider Sustainability

NHS Halton CCG commissioned Capita to provide an assessment of the retrospective current and future view of the health and social care activity, spend and patient flows across the Mid Mersey Area. As part of this project the impact of the modelled reduction in emergency admissions and emergency length of stay on St Helens & Knowsley Hospitals NHS Trust and Warrington & Halton NHS Foundation Trust was calculated. While recognising that NHS Halton CCG commissions services and not providers, this report provided 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, The bed shift associated with early supported discharge would offset this income reduction.

10. Improvement Interventions

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

10.1 – Maintain and improve quality standards.

- Specific targets have been written in the quality schedule of the Community healthcare provider to increase the rate of medication error reporting as this has been highlighted as below the national average.
- The quality of services will be reported at GP practice level at as near to real-time as possible. (ADD141503)
- The Friends and Family test will be piloted with GP practices and rolled out to the Mental Health and community care providers (ADD141504)
- CQUINs developed with the providers to implement the commissioning outcomes of both the Francis report and the government response. Reviewing performance against last year and against Cavendish review,

'patients first' government response and Berwick re patient safety collaborative. This will be supported by evidence of duty of candour, quality strategy and training programmes including mandatory training. (ADD141505)

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

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

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

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

- Examining the evidence to introduce a targeted screening programme to increase early detection rates of lung cancer (PC141505)
- To work with the NHS England Merseyside area team in the shared pursuit of improving uptake and early diagnosis of bowel, breast and cervical cancers (Public Health Commissioning Intentions 2014/15 – Merseyside Area Team)
- To review access to lifestyles service for patients with cancer, for example breast cancer weight loss and exercise programme (PC141508)
- Review provision of services for people with diabetes who have developed foot problems with the desired outcome of reducing the number of complications associated with foot problems in people with diabetes (PC141513)
- Securing 1 day service provision for people who have had a TIA (PC141510)

- Strengthen the GP's role at the heart of out of hospital care by identifying people at risk of hospital admission and introducing named accountable clinician (PCI141501)
- Explore the potential for introduction of a programme of care for Familial hypercholesterolemia. (PCI141512)
- Roll out learning disabilities physical health checks to under 16s (MHUC141510)
- Delivery of the Direct Enhanced Service for dementia within general practice, to increase awareness and screening for dementia (MHUC141511)
- Reduce the level of antibiotic prescribing (ADD141510)

10.4 – Harnessing transformational technologies

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

10.5 – Reducing health inequalities

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

- Develop alternative employment opportunities for vulnerable groups to improve the emotional wellbeing and support individual personal development (MHUC141508)
- Develop mechanisms to ensure we listen to the whole population, including young people and BME communities (ADD141502)

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

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

10.7 – Enhancing practice based services around specialisms

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

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

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

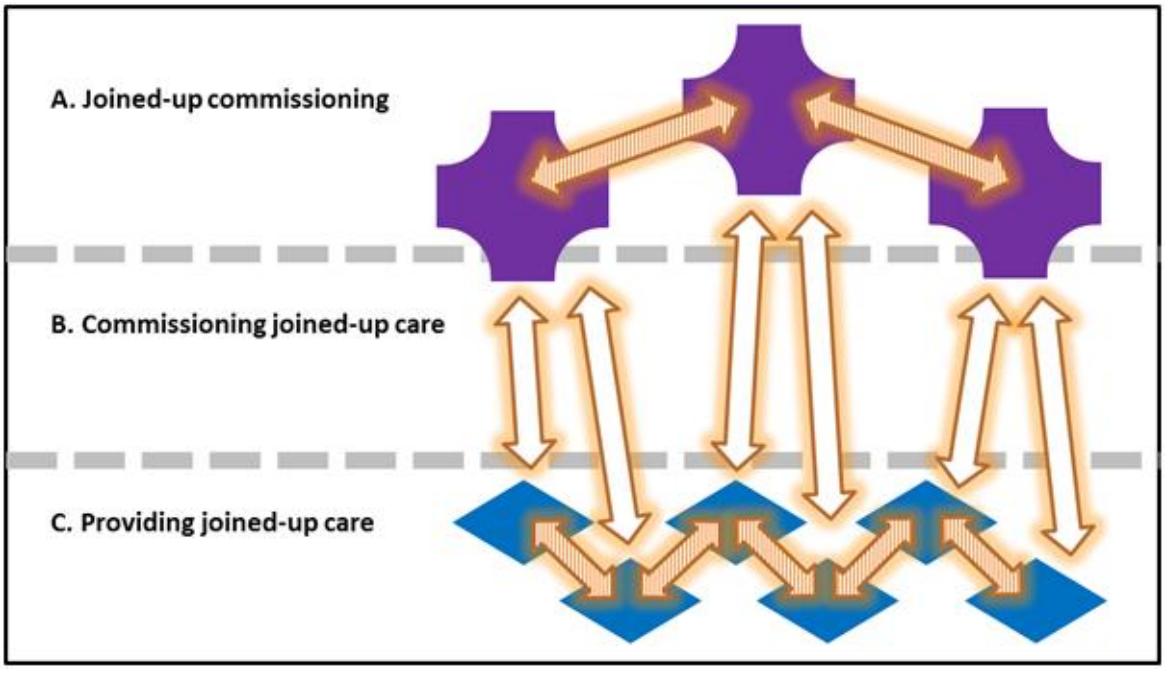
11. Contracting & Governance Overview

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

11.1 Contracting

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

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



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

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

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

11.2 Managing Performance

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

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

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

11.3 Risk Assessment & Mitigation

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

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

Controls to mitigate against these risks fall into three categories.

11.3.1 Financial systems

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

11.3.2 Internal governance

These arrangements are intended to ensure that decisions are properly considered and approved and that all the members of NHS Halton CCG can be assured that risks are being properly managed. These include the performance management arrangements described earlier. Other elements are the Audit Committee, Finance and Performance Committee and meetings of the Governing Body and membership; internal and external auditors will test the robustness of NHS Halton CCG's internal controls and systems. The Board Assurance Framework and Risk Register are well developed and highlight the controls and assurance in place for the identified risks.

11.3.3 Relationships and risk sharing

Examples of this include the creation of the pooled budget arrangements between NHS Halton CCG and Halton Borough Council for Continuing Health Care (CHC) adults and social care cases. Each party agrees to share the financial risk.

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

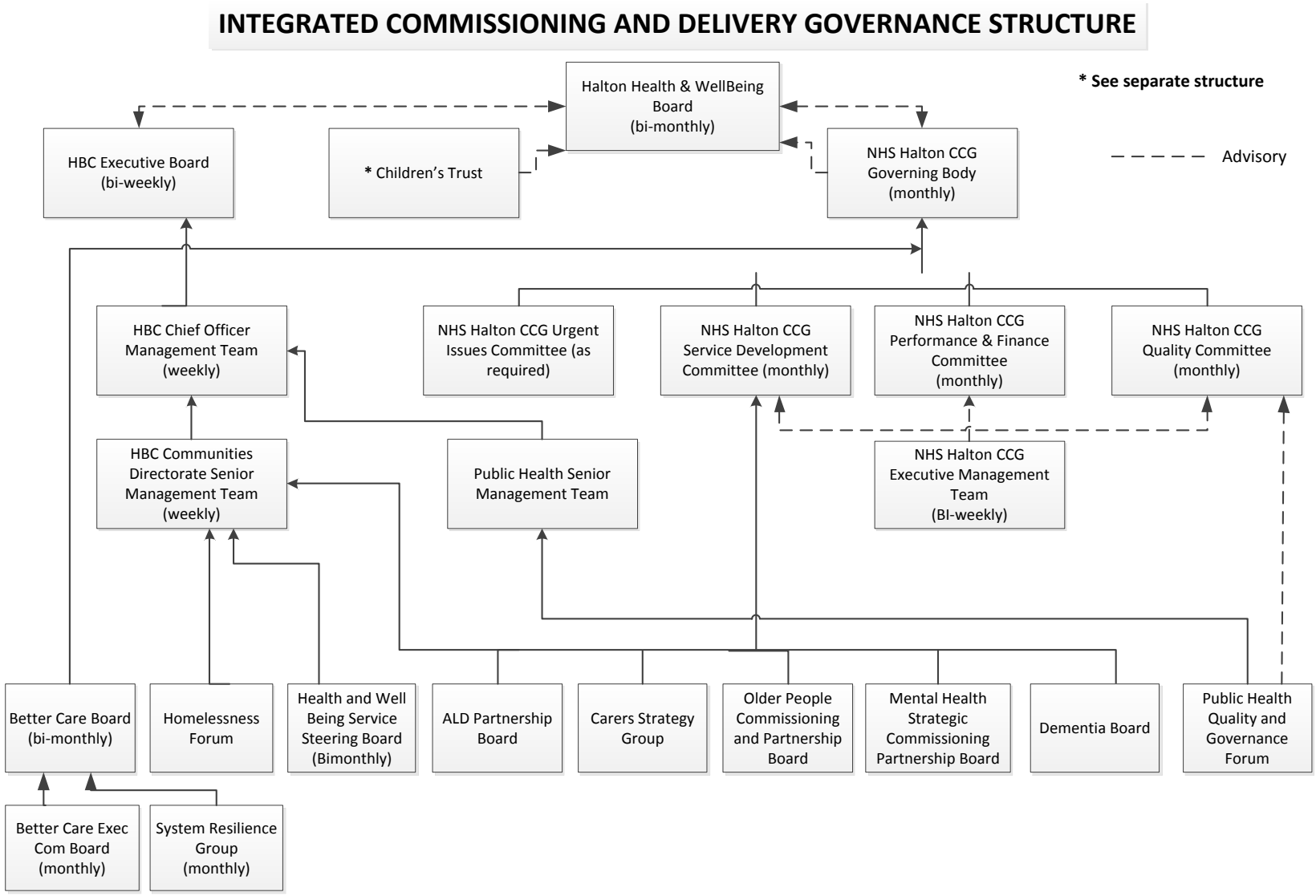
The close working between NHS Halton CCG and Halton Borough Council has led to the development of a list of shared risks to the delivery of the required changes

and the risk mitigations in place. The table below identifies a number of high level risks that we have identified as being the most significant.

Risk	Risk rating	Mitigating Actions
Improvements in the quality of care and in preventative services will fail to translate into the required reductions in the acute sector by 2015/16, impacting the overall funding available to support core services and future schemes.	High	Our integrated commissioning process is engaging a clinical lead and economist to work through the activity of all our provider trusts. This work will highlight further efficiencies by determining the activity that brings best value. Activity below the criteria of significant impact may need to stop to achieve this.
The introduction of the Care Bill 2013 will have implications in the cost of care provision, partnership working, policies, procedures and the skilled and informed workforce.	High	Strategic Group was established in October 2013 to begin to identify the implications of each element of the Care Bill.
Financial fragility	High	Work on-going to forecast financial situation and continue to identify efficiencies across both organisations.
Legal Challenge	High	Robust consultation processes in place, clear application of eligibility criteria, with policies and procedures in place to support decision-makers.
Failure to identify and deal with cultural issues across the HBC and NHS Halton CCG could result in staff feeling isolated; anxious and worried; and a reduction in job performance.	High	Building trust through effective communication, shared values, equal opportunities and effective leadership is crucial to the successful development of integrated teams.
Shifting of resources to fund new joint interventions and schemes will destabilise current service providers, particularly in the acute sector.	High	Our current plans are based on the strategies we have in place covering all service areas and linking in to the priorities of the Joint Health and Wellbeing Strategy and Joint Strategic Needs Assessment.
A lack of detailed baseline data and the need to rely on current assumptions means that our financial and performance targets for 2015/16 onwards are unachievable.	High	We are investing specifically in areas such as data management to ensure that we have up-to-date information around which we will adapt and tailor our plans throughout the next 2 years. This includes moving forward with data-sharing and developing a joint performance framework across all areas.
Operational pressures will restrict the ability of our workforce to deliver the required investment and associated schemes to make the vision of care outlined a reality.	High	Organisational development is an important factor in the successful delivery of the operational plan. On-going evaluation of the team and skill mix will ensure the infrastructure and capacity to deliver the schemes identified.
Communication	Medium	• Joint Local Authority and NHS Halton CCG commissioning team meetings take place on a bi-monthly basis communicating the vision and plans for the future and involving staff at the outset. • Communication and media tools have been identified as a future scheme to ensure the public are fully aware and involved in all aspects of the strategy and operational plan.

11.4 Whole System Governance

The governance structure within NHS Halton CCG fits within a wider system wide governance structure with the Halton Health and Wellbeing board at its head. This structure ensures that all parts of the Halton health economy are working towards the same goals and are aware of and contribute to the plans and actions of all parties in the wider health economy.



12. Reducing inequalities

The Halton Joint Strategic Needs Assessment (JSNA) identified 5 areas where outcomes could be improved, these are:

- People with cancer
- Child development
- Falls in adults
- Harm from Alcohol
- People with mental health conditions

Informed by the Joint Strategic Needs Assessment (JSNA) and in consultation with local residents, strategic partners and other stakeholders, the Halton Health & Wellbeing Strategy 2012-15 identified these as the five key priorities to help us to achieve our vision.

The Joint Health and Wellbeing Strategy sets the framework for the commissioning of health and wellbeing services in Halton with a particular emphasis on prevention and early intervention. This has been identified as an area of strategic focus for NHS Halton CCG.

The NHS E paper 'Promoting Equality and Tackling Health Inequalities' [17] highlighted the most cost-effective high impact interventions as recommended by the National Audit Office report into Health Inequalities, and the Public Accounts Committee Report into Tackling Inequalities in life expectancy, these are:

- Increased prescribing of drugs to control blood pressure;
- Increased prescribing of drugs to reduce cholesterol;
- Increase smoking cessation services;
- Increased anticoagulant therapy in atrial fibrillation;
- Improved blood sugar control in diabetes;

NHS Halton CCG with its partners in Public Health, Halton Borough Council and NHS England are developing a Cardiovascular strategy for Halton which will address some of the issues identified, including the prescribing of anti-hypertensives to patients at risk of or already diagnosed with cardiovascular disease, prescribing statins to patients at risk of or already diagnosed with cardiovascular disease. Working with colleagues in Public Health to review the support available for smoking cessation services.
NHS Halton CCG will work with the Mersey Diabetes Network to develop Merseyside pathways for diabetes as well as specific actions to review the provision of services for people with diabetes who have developed foot problems and reviewing the scope of the community diabetes provision with a desired outcome of reducing the amount of secondary care activity.

[17] http://www.england.nhs.uk/wp-content/uploads/2013/12/brd-dec-1.pdf

NHS Halton CCG will develop a new service specification for the Anticoagulation therapy service, Atrial Fibrillation is an integral part of the service specification for this service.

12.1 Equality Delivery System

The Equality Delivery System (EDS) was rolled out to the NHS in July 2011 and formally launched in November 2011. The EDS is currently being implemented by NHS Halton CCG.
The main purpose of the EDS was, and remains, to help local NHS organisations, in discussion with local partners including local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010. By using the EDS, NHS organisations can also be helped to deliver on the public sector Equality Duty (PSED). EDS2 is more streamlined and simpler to use compared with the original EDS. It is aligned to NHS England's commitment to an inclusive NHS that is fair and accessible to all.

12.1.1 Provider Equality Performance and EDS2

NHS Halton CCG has included the implementation of EDS 2 across its main providers and has stipulated this within the quality contract schedule for 2014/15. This performance measure requires Healthwatch Halton to play a quality assurance role on behalf of the CCG during 2014/15 EDS 2 self-assessments process. The key Providers include:

5 Boroughs Partnership NHS Foundation Trust
St Helens & Knowsely Hospitals NHS Trust
Warrington and Halton Hospitals NHS Foundation Trust
Bridgewater Community Healthcare NHS Trust

Other key trusts include
Liverpool Women's NHS Foundation Trust
Alder Hey Children's NHS Foundation Trust
Liverpool Heart and Chest NHS Foundation Trust

12.1.2 Halton CCG EDS2

Currently Halton CCG has assessed its self as developing across 18 outcomes. The CCG will formally report to the Integrated Governance Committee to formally approve a number of Stretch targets where the CCG intends to move from developing status to achieving status.
The CCG EDS2 self-assessment is a continuous evidence gathering process but CCG will formally self-assess and present its findings to Healthwatch Halton and other community representatives between January and March 2014/15.

To ensure Healthwatch Halton play a key quality assurance role the CCG will ensure their representatives receive training and briefings on EDS 2 and the Equality Act 2010 and monitor Healthwatch involvement in provider assessments. Furthermore Halton CCG will present its findings to the Healthwatch Management Committee between January and March 2015

Currently the CCG is graded at developing across all 18 outcomes.
The following stretch target has been identified to align with the actions contained within the Equality Objective Plan and CCG priorities for 2014/15. The outcomes highlighted for progression from developing status to achieving status are:

- Services are commissioned, procured, designed and delivered to meet the health needs of local communities

- 2.1 People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds

- Goal 3 -A representative and supported workforce- two targets to be proposed at Equality and HR meeting at Cheshire and Merseyside Commissioning Support Unit on the 7th February that align with the Equality Objective Plan and Wirral HR Business Manager who has the relevant links back into the HR and Remuneration Committee

- 4.1 Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations

- 4.2 Papers that come before the Board and other major committees identify equality-related impacts including risks, and say how these risks are to be managed

Grades will be agreed with Healthwatch Halton and other community representatives between January and March 2015. The measurement and grading is subject to CCG evidence and poof that

- People from most protected groups fare as well as people overall – Goals 1 and 2

- Staff members from most protected groups fare as well as the overall workforce- Goal 3

- Many of the examples show a strong and sustained commitment – Goal 4
    - This would include speeches given by Board members and senior leaders to various audiences; reports presented by Board members and senior leaders to various audiences; participation in Board Leadership Programmes for equality; and active promotion of equality-based initiatives for service

12.2 Parity of Esteem

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

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

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

13. Citizen Participation

NHS Halton has a Comprehensive communication and engagement strategy which is reported via the quality committee to Governing Body. Communication and engagement was part of this year's internal audit annual assurance review, and communication and engagement was rated as "significant assurance" from audit. There are regular Board to Board meetings with providers, these are reported quarterly in the chief officers report to governing body. The health and wellbeing board is also keyed into this process and key issues / reports are included in Governing body.

The service development committee and membership forum a linked in the constitution, they are key stakeholders when making plans that fit with the strategy.

Healthwatch are a voting member of the quality committee and are also in attendance at governing body and the health and wellbeing board. Halton Healthwatch is a member of the NHS-E Quality surveillance group.

NHS Halton CCG chose to have a formal relationship with Halton Healthwatch, as part of this relationship there are four 'Halton Peoples Forum' events a year held at either the stadium or the town hall.

In association with Halton Healthwatch the Halton People's Forum have had several engagement events during the planning process both in developing commissioning intentions as part of the 'call to action' but also including development sessions with

respect to specific aspects of the plan such as the urgent care centres with feedback sessions built into the events as demonstrated in the image below.

In addition The Commissioning Intentions document clearly demonstrates which intentions were developed as part of the various engagement events which have taken place

14. NHS England Commissioning Intentions

NHS Halton CCG's commissioning Intentions do not operate in a vaccum, within the wider Halton health economy services are provided at many levels, in various settings by many different providers, some very specialised health care services are commissioned and funded by NHS England through 'Specilaised Commissoining' GP's are funded and commissioned through NHS England Primary Care.

14.1 NHS England Specialised Services Commissioning Intentions

NHS Halton CCG is aware of the plans by NHS England to concentrate specialised services in centres of excellence, linked to Academic Health Science Networks, Whilst NHS Halton CCG is not the co-ordinating commissioner for any of the specialised service providers we are conscious of the potential impact that the concentration of services in centres of excellence could have on Halton residents and will be fully involved partners with NHS E in the implementation of these changes.

14.2 NHS England Primary Care Commissioning Intentions

NHS Halton CCG is working with NHS England Primary Care Commissioning and has aligned its strategic intentions with some of the specific actions highlighted in "Primary care Commissioning Intentions 2014/15 – 2015/16 Merseyside"

Specific Service Issues raised by NHS England Primary Care Commissioning include;

- Personal Medical Services

NHS England seeks to align PMS contracts with local emerging primary care strategies. Locally in Merseyside this means a review of all PMS contracts for size and volume to align to national process in relation to equitable funding. The preferred model is for larger / federated PMS contractors to bring benefit and economies of scale. This should be linked to CCG and LA quality strategies where appropriate.

NHS Halton CCG are in the process of developing a Primary Care Strategy which will be led by the practice membership the aim of which is to agree a delivery model for primary care which will seek to support the governments drive to bring care closer to home, strengthen integration between services,; specifically community and social care whilst retaining the GP relationship that we know our patients value. The strategy will be developed with all key delivery partners and work will commence in May 2014 with a series of workshops to help facilitate delivery.

- APMS Contracts

NHS England will be engaging with APMS practices and their representatives to seek to agree the best way forward for APMS contracts, NHS England will be mindful of the impact of closures of these centres on patients and on choice and competitions. The Merseyside Area Team will systematically review its time limited APMS contract portfolio. For Halton this will include the Windmill Hill Practice in Runcorn. Any significant changes to services, both in terms of access and services provided will be subject to appropriate consultation and engagement of key local stakeholders and Equality Impact Assessment. The Area team will collaborate with CCG Primary Care colleagues in the development of local APMS service specifications.

NHS Halton CCG will work with NHS England to ensure the best possible outcome for the residents of Halton

- Local Enhanced Services

Any outstanding Local Enhanced Service (LESs) carried over by NHS England through transition will cease from 31 March 2014. Any remaining LESs will be migrated across to CCGs for future commissioning.

During transition, as directed by NHS England, NHS Halton undertook a full review of all Local Enhanced Services (LES) to ascertain whether they are clinically relevant in terms of supporting our commissioning intentions, review clinical outcomes and assess value for money. All LES' were evaluated against agreed criteria in line with national guidance and several including Anti-coagulation monitoring, Near Patient Testing, Palliative Care Drugs and Care at the Chemist will continue. The CCG have committed to reviewing all service specifications relating to these LES' to ensure they reflect latest clinical guidance and the appropriate procurement routes agreed. In addition, the CCG will continue to work with NHS England to support the implementation and monitoring of Directed Enhanced Services that are delegated to CCGs.

- GP IT Services and Care.Data

CCGs will continue to have delegated management for the delivery of GP IT Services and to set local strategies for strategic systems and technology.
By the summer of 2014 NHS England (Merseyside) anticipates that at least 5 per cent of GP practices will be linked to hospital data. By the end of March 2015 this will have increased to 90 per cent.
NHS Halton CCG is working closely with the Local Authority and other delivery partners to review its IM&T Strategy with the intention of developing a joint Health & Social Care Informatics Strategy that will be delivered across the Local Health Economy. We will continue to build on the good work we have progressed to date with 100% of practices receiving e-Discharge letters and A&E activity data and will continue to look at ways to promote ways to increase the uptake of Choose & Book which will support e-Referral when it becomes live. Currently over 60% of practices are using the Summary Care Record and the CCG has a work programme in place to ensure 100% uptake by December 2014.

NHS
Halton Clinical Commissioning Group

NHS Halton CCG
2 Year Operational Plan
Measures & Targets
2014/15 – 2015/16

15. Operational Plan Outcome Measures & Targets

This section goes into some detail about current and expected levels of performance across a range of different performance measures. Some statistical terminology is used to describe where performance is good or bad in relation to benchmarks.

It is useful to have an understanding of some of the commonly used terms to help interpret the data. Appendix D lists some of the common terms used, how they are calculated and what they mean.

The 5 year strategy and 2 year operational plan detail both the vision for where the Health economy in Halton needs to be in five years and the methods and schemes that need to be in place to achieve that vision. This section of the plan gives some detail on the metrics that will be used to demonstrate that the schemes are having the desired effect, the level of ambition for those metrics and how Haltons performance compares over time, with both national and regional comparitors.

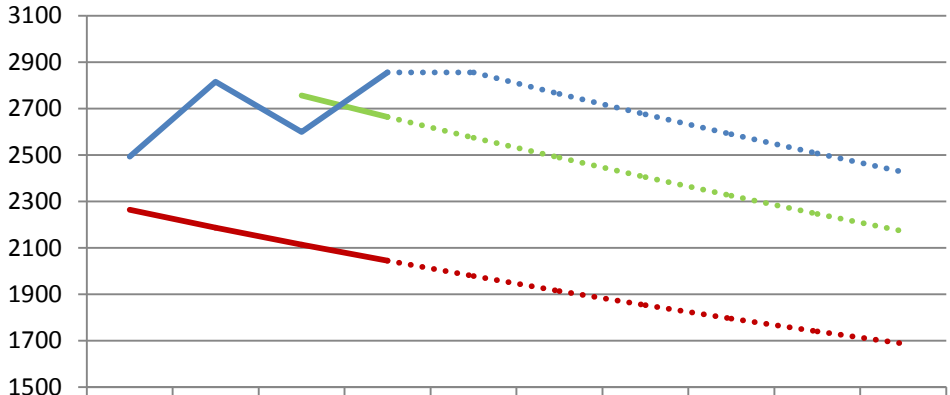
15.1 Securing additional years of life for the people of Halton with treatable mental and physical health conditions

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

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

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

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



	Actual 2009	Actual 2010	Actual 2011	Actual 2012	Plan 2013	Plan 2014	Plan 2015	Plan 2016	Plan 2017	Plan 2018
National*	2264.3	2187.7	2115	2045	1979	1915	1854	1796	1741	1688
Local Trajectory*			2757	2665	2576	2489	2406	2325	2247	2172
Halton CCG	2493	2816	2600	2856	2856	2765	2676	2591	2508	2427

Source Data: http://ccgtools.england.nhs.uk/opa/flash/atlas.html on 16/06/2014

** Taken from Potential years of Life lost from causes considered amenable to healthcare - A Public Health tool to facilitate comaprison of CCG plans against relavent trends*

This measure has been selected as a 2014/15 Quality Premium Measure with a nationally set target for the calendar year 2014 of a 3.2% reduction based on the directly standardised rate from a 2013 baseline. NHS Halton CCG has worked closely with the Halton Public Health team to model the elements within PYLL to determine where the greatest gains can be made to achieve a real reduction in the number of years of life lost by Halton residents.

The table below shows the areas identified by Public Health Halton. Those sections in red show where improvements can be made, with dark red showing the areas of greatest potential gain.

The table shows that the greatest gain can be made in Cardio Vascular Disaease (CVD) and Nesoplasms, especially in age ranges of 50-69.

CVD has been recognised as an area for improvement in Halton, and alongside long term ambitions of improving the lifestyle factors associated with CVD (smoking, obesity, exercise) there are also some short-term measures identified that could have an impact, these are centred around early identification, optimising medication and ensuring a concordance between patient and practice around the medication regime.

Years of life lost 2013

Area identified where years of life lost

Area identified where greatest number of years of life lost

	Age Group	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74
Infections	Tuberculosis										
	Selected invasive bacterial and protozoal infections										
	Hepatitis C										
	HIV/AIDs										
Neoplasms	Malignant neoplasm of colon and rectum										
	Malignant melanoma of skin										
	Malignant neoplasm of breast										
	Malignant neoplasm of cervix uteri										
	Malignant neoplasm of bladder										
	Malignant neoplasm of thyroid gland										
	Hodgkin's disease										
	Leukaemia										
	Benign neoplasms										
Nutritional, endocrine & metabolic	Diabetes mellitus										
Neurological disorders	Epilepsy and status epilepticus										
CVD	Rheumatic and other valvular heart disease										
	Hypertensive diseases										
	Ischaemic heart disease										
	Cerebrovascular diseases										
Respiratory diseases	Influenza (including swine flu)										
	Pneumonia										
	Asthma										
Digestive disorders	Gastric and duodenal ulcer										
	Acute abdomen, appendicitis, intestinal obstruction, cholecystitis / lithiasis, pancreatitis, hernia										
Genitourinary disorders	Nephritis and nephrosis										
	Obstructive uropathy & prostatic hyperplasia										
Maternal & infant	Complications of perinatal period										
	Congenital malformations, deformations and chromosomal anomalies										
Injuries	Misadventures to patients during surgical and medical care										

For Diabetes mellitus and Leukaemia the Potential Years of Life Lost (PYLL) is not included for deaths after the ages of 50 and 45 respectively

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

By continuing a year on year reduction of 3.2% on the potential years of life lost (PYLL) this would bring NHS Halton CCG's figure for PYLL from causes amenable to health care to the 4th Quintile nationally from the 5th currently (based on 2012 quintile boundaries). It should however be noted that as this measure is a quality premium measure with a target attached to it of 3.2% most CCG's will be aiming for a smililar level of improvement.

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

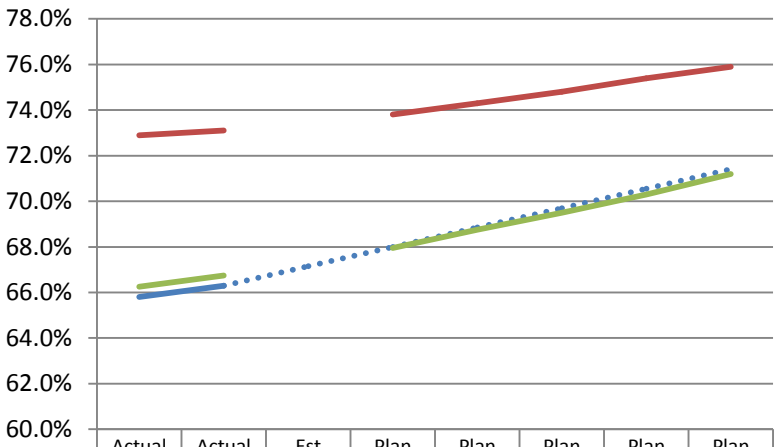
Based on national and local intelligence NHS Halton CCG has developed a number of schemes for implementation over the next 2 years which have the intention of improving the health related quality of life of the people of Halton with one or more long term conditions.

The schemes identified are;

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

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

C2.1 Enhancing quality of life for people with long-term conditions (Average EQ5D score)



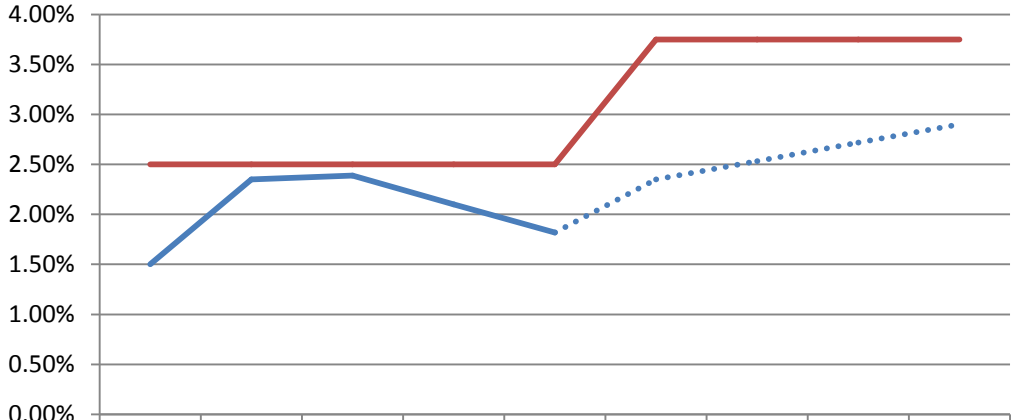
	Actual 11/12	Actual 12/13	Est 13/14	Plan 14/15	Plan 15/16	Plan 16/17	Plan 17/18	Plan 18/19
Halton average health status score	65.8%	66.3%	67.2%	68.0%	68.9%	69.7%	70.6%	71.4%
England Average	72.9%	73.1%		73.8%	74.3%	74.8%	75.4%	75.9%
NHS Merseyside Area (median)	66.3%	66.8%		68.0%	68.8%	69.5%	70.3%	71.2%

Source Data: http://ccgtools.england.nhs.uk/opa/flash/atlas.html on 16/06/2014

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

A 0.5% increase has been seen in the average health status score between 2011 and 2012 in Halton. This places Halton in the lowest 20% of CCG's nationally and slightly below average when looking at CCG's in Merseyside. Given the rate of improvement needed to reach the England 2012 average score by 2015/16 this looks unrealistic. A more realistic target of a 0.8% Year on Year improvement is both stretching, given historical rates of improvement, and achievable, given the improvement schemes being put into place. This level of improvement would place NHS Halton CCG slightly above average in the Merseyside Area team by 2015/16 This would represent a statistically significant level of improvement on the 2012/13 figure regardless of regional or national improvements.

C2.2 IAPT roll out - Proportion of people that enter treatment against the level of need in the general population



	2012/13 Q4 Actual	2013/14 Q1 Actual	2013/14 Q2 Actual	2013/14 Q3 Actual	2013/14 Q4 Actual	2014/15 Q1 Plan	2014/15 Q2 Plan	2014/15 Q3 Plan	2014/15 Q4 Plan
Halton	1.50%	2.35%	2.39%	2.10%	1.82%	2.35%	2.53%	2.72%	2.90%
England	2.50%	2.50%	2.50%	2.50%	2.50%	3.75%	3.75%	3.75%	3.75%

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

The 2012/13 Q4 actual performance is based on the Halton & St Helens PCT figure, There are two IAPT providers in Halton, Self Help and Bridgwater Community Health Care Trust. This is due to change shortly and the IAPT service will be provided through 5 Boroughs Partnership.
To achieve the 2014/15 Quality Premium NHS Halton CCG will need to achieve an Improving Access to Psychological Therapies (IAPT) annual access level of at least 15% by 31/03/2015

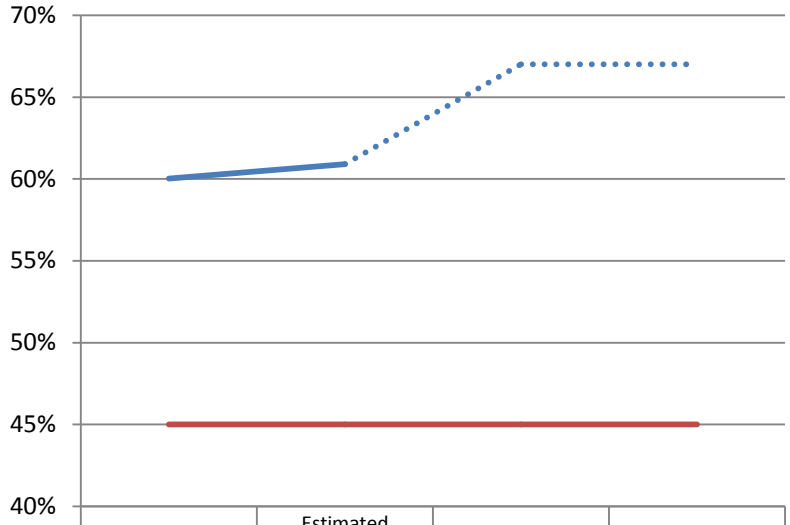
Halton's historical performance with St Helens as a PCT and NHS Halton CCG's performance in 2013/14 (8.66%) is below the England average. Plans highlighted in the table above and in Appendix A will have a positive impact on the number of people accessing IAPT services

The current estimated performance for 2013/14 is 8.66%

The trajectory set in chart C2.2 above demonstrates the quarterly planned figures to achieve a 10.5% annual figure for 2014/15 this is below the National Quality Premium target, however it is not thought possible that given the current levels of performance that a near doubling of the number of people accessing the service during 2014/15 was realistic.

For 2015/16 the intention is to increase performance and ultimately achieve the 15% IAPT access level. This is equal to 2460 people based on a Halton prevalence of 16401.

C2.13 Estimated diagnosis rate for people with dementia

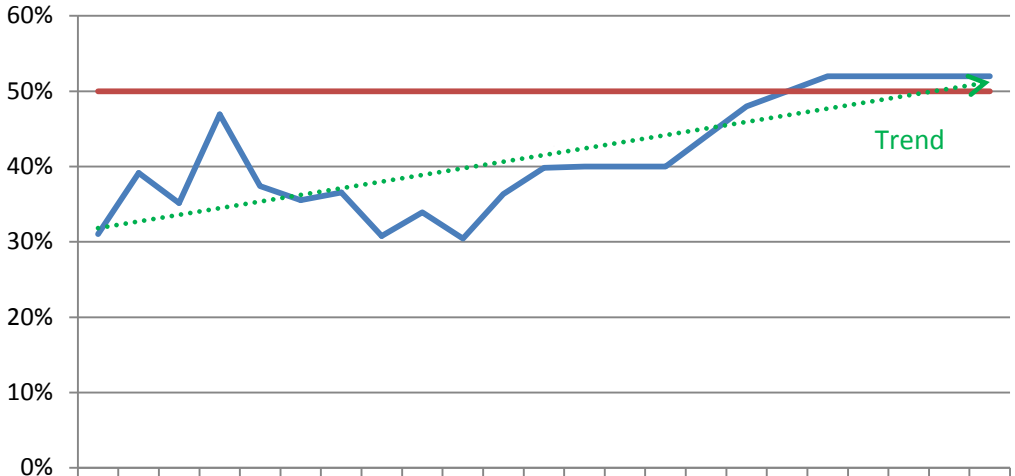


	Actual 2012/13	Estimated 2013/14	Plan 2014/15	Plan 2015/16
Halton Estimated diagnosis rate	60%	61%	67%	67%
England CCG Ave.	45%	45%	45%	45%

Source Data – Halton CCG: http://dementiapartnerships.com/diagnosis/dementia-prevalence-calculator// on 17/06/2014
England CCG Ave: https://www.gov.uk/government/policies/improving-care-for-people-with-dementia
Halton CCG Target: http://www.england.nhs.uk/wp-content/uploads/2013/12/every-count-tech-def.pdf

The NHS Halton CCG estimated diagnosis rate for 2012/13 was 60.02% this is the 16th highest rate in the country (out of 210 CCG's). The provisional 2013/14 results showed a further improvement and an estimated final year position of 60.9%. The plan is to reach the regionally set target of 67% by 31 March 2015 and to at least maintain that level of performance for 2015/16.

C2.11 Recovery following talking therapies for people of all ages



	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May 14 plan	Jun 14 Plan	July 14 Plan	Aug 14 Plan	Sept 14 plan	Oct 14 Plan	Nov 14 Plan	Dec 14 Plan	Jan 15 Plan	Feb 15 Plan	Mar 15 Plan
Actuals	31%	39%	35%	47%	37%	36%	37%	31%	34%	30%	36%	40%	40%	40%	40%	44%	48%	50%	52%	52%	52%	52%	52%
Plan	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%

A major restructure of how IAPT services are offered from August 2014 onwards will have a significant impact on the recovery rates recorded. Based on historical trend performance and the move to a single provider to enable best practice across the whole population, the expectation is that NHS Halton CCG will achieve the 50% IAPT recovery rate by the end of March 2015.

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

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

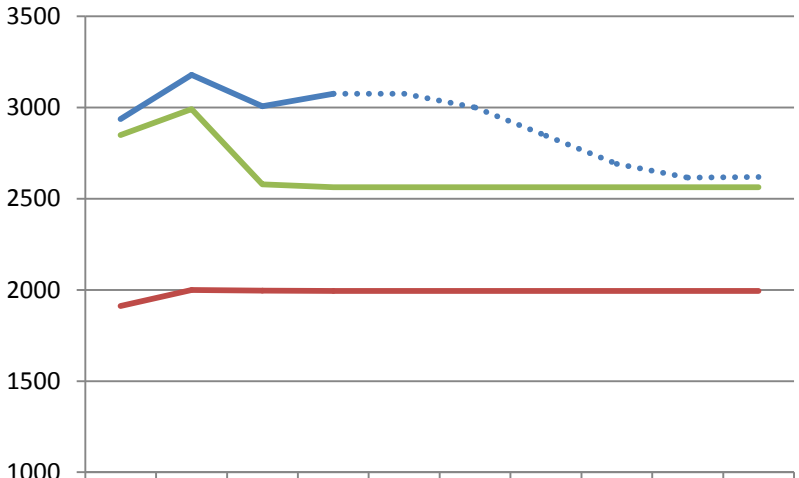
The schemes identified are;

Reference	Description
PC141501	Develop a respiratory strategy for Halton and implement actions from the strategy. To include: 1) reviewing the pathway for people with sleep apnoea. This will include the possibility of using technology to manage sleep apnoea in the community, and considering whether weight management is part of the pathway 2) Reviewing the provision of spirometry services in Halton
PC141506	Implement tools to improve the sharing of information at the end of life: - Work towards implementing the EPACCs IT system - Improve the use of special patient notes in end of life care
PCI141501	Strengthen the GPs role at the heart of out of hospital care and supporting people to stay healthy by identifying people at risk of hospital admission including the introduction of a named accountable clinician
PCI141505	To support GP practices and other providers where appropriate to deliver services over and above their core contractual responsibilities (Local Commissioning Schemes – previously known as Enhanced Services)
PCI141506	A strategy for sustainable general practice services in Halton
PCI141508	Support NHS England in ensuring quality in primary care
PCI141510	Develop an Integration Health & Social Care IM&T Strategy & work plan to include; 1) exploring ways for clinicians and carers to have access to the same information regardless of setting, 2) explore opportunities for OOH providers to have access to primary care record OOH, 3) use of Telehealth and telemedicine to improve patient care, 4) identify the benefits and possibly introduction of Map of Medicine and 5) extending the uptake and use of Choose & Book to improve pathways to hospital and patient choice
PCI141514	Secure provision of community services from 2015
WCF141504	Continue to review with possible procurement community midwifery service
WCF141510	Evaluate the Mersey QIPP pilot for children's community nursing service.
WCF141512	Amend existing care provision for children to build on work done currently to divert emergency admissions and A&E presentations to the new Urgent care centre
MHUC141514	Implement the Urgent Care redesign preferred model

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

15.3.1 Annual Composite Measure

Composite measure of avoidable emergency admissions



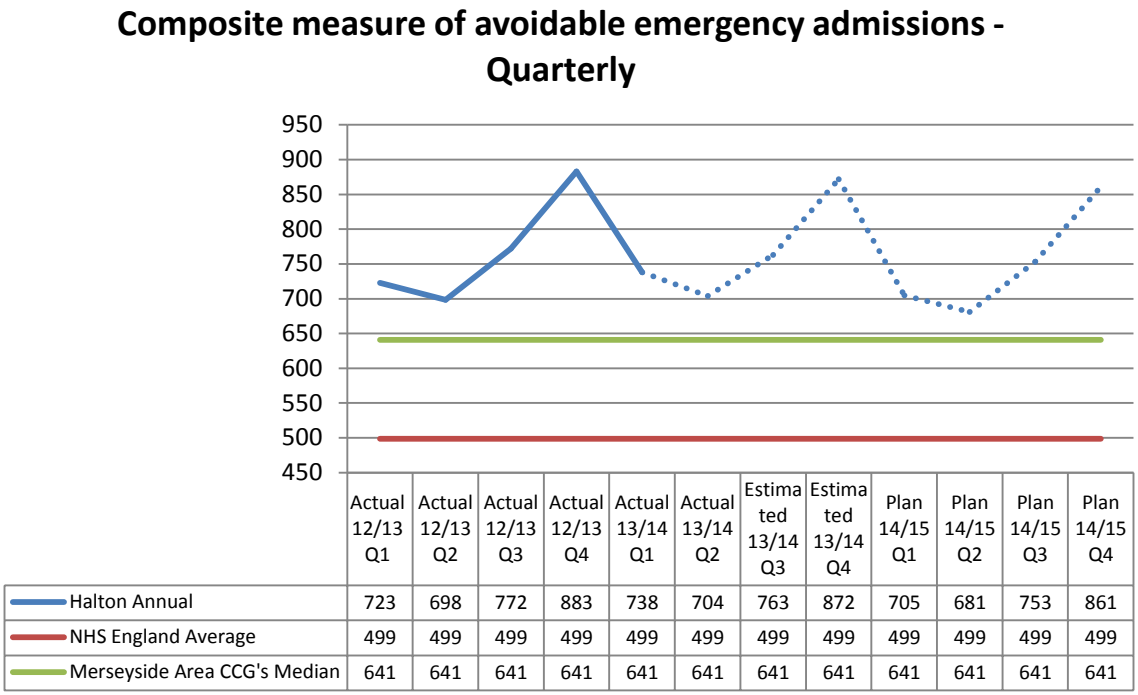
	Actual 09/10	Actual 10/11	Actual 11/12	Actual 12/13	Est. 13/14	Plan 14/15	Plan 15/16	Plan 16/17	Plan 17/18	Plan 18/19
Halton Annual	2936	3179	3007	3076	3076	2999	2845	2692	2615	2619
NHS England Average	1912	2000	1996	1994	1994	1994	1994	1994	1994	1994
Merseyside Area CCG's Median	2848	2991	2579	2563	2563	2563	2563	2563	2563	2563

Source data: http://ccgtools.england.nhs.uk/loa/flash/atlas.html on 17/06/2014

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

There is an expectation for NHS Halton CCG to achieve 15% of savings over the next five years. The schemes identified in the table above will contribute towards this saving and have been assessed as a realistic level by two independent economic reports by i5 Health and Capita. The plan is to reduce the number of avoidable emergency admissions by 15% over four years. This will be achieved in part by the development of the urgent care centre however this will only become fully operational part way through 2014/15. A 2.5% reduction is planned (from the revised 2012/13 figure) for 2014/15, this would reduce the number of emergency admissions per 100,000 to 2999; Further 5% reductions (on the 12/13 baseline) are expected to be seen in both 15/16 and 16/17. Beyond 16/17 the current expectation is that there will be continued innovation and development of the service and a further 2.5% reduction is anticipated. Beyond 2017/18 an age standardised demographic increase of 0.17% is forecast, however development in services over the next four years may impact on this.
The 14/15 Quality premium is based on a reduction being seen between 13/14 and 14/15 or a rate below 1,000 per 100,000. The Baseline data for 2013/14 will not be available until summer 2014 the figures above are based on the 2012/13 actual

15.3.2 Quarterly composite measure



	Actual 12/13 Q1	Actual 12/13 Q2	Actual 12/13 Q3	Actual 12/13 Q4	Actual 13/14 Q1	Actual 13/14 Q2	Estimated 13/14 Q3	Estimated 13/14 Q4	Plan 14/15 Q1	Plan 14/15 Q2	Plan 14/15 Q3	Plan 14/15 Q4
Halton Annual	723	698	772	883	738	704	763	872	705	681	753	861
NHS England Average	499	499	499	499	499	499	499	499	499	499	499	499
Merseyside Area CCG's Median	641	641	641	641	641	641	641	641	641	641	641	641

Source Data: http://ccgtools.england.nhs.uk/opa/flash/atlas.html on 17/06/2014

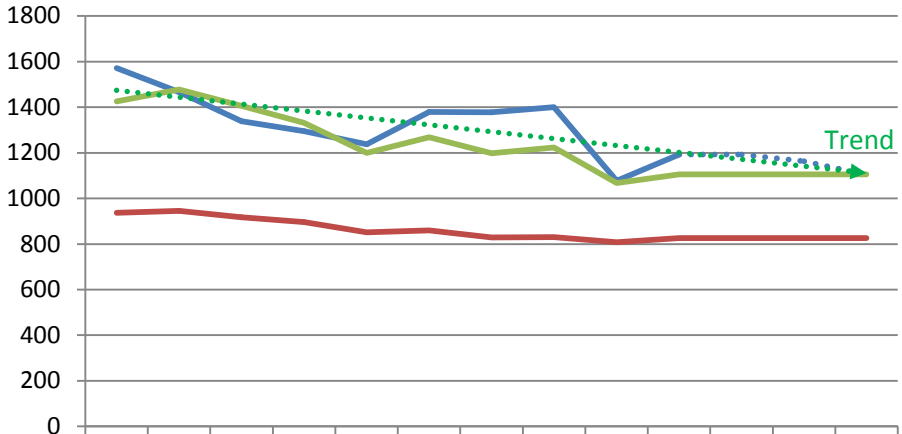
This measure is a composite of four separate measures. These are;

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

Separate plans have been made of each of these measures. For the composite measure quarterly plans are required for 14/15, the figures based in the chart above are based on the 2.5% reduction on the 12/13 baseline. This have been split across the year based on the seasonal pattern seen in both 12/13 and 13/14 YTD

15.3.3 Unplanned hospitalisation for chronic ambulatory care conditions

C2.6 Unplanned hospitalisation for chronic ambulatory care (ACS) conditions (adults)



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

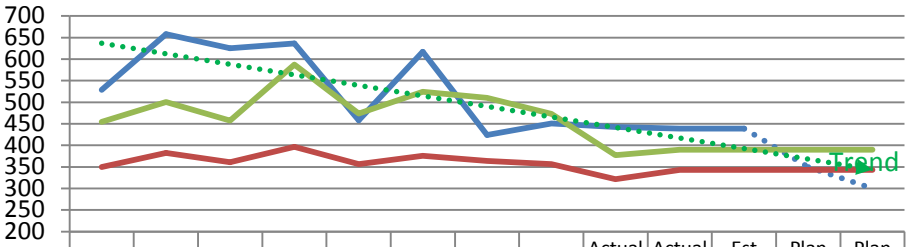
Source data: http://ccgtools.england.nhs.uk/loa/flash/atlas.html on 10/01/2014

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

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

15.3.4 Unplanned hospitalisation for asthma, diabetes and epilepsy

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



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

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

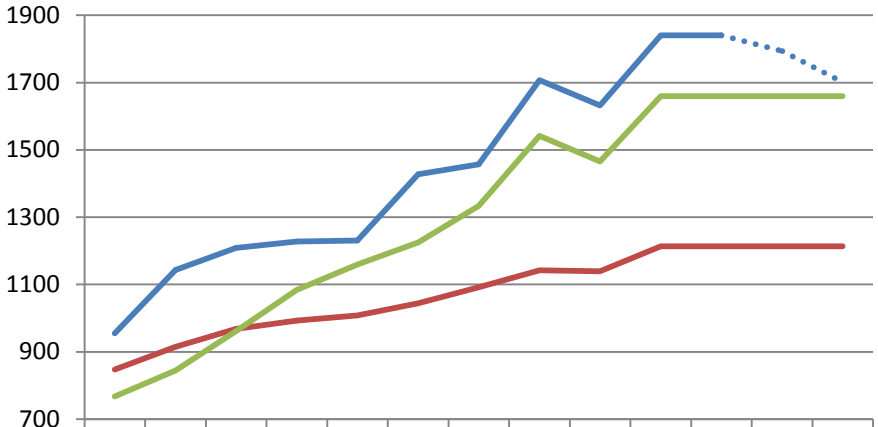
This is one of the measures included in the composite measure on emergency admissions

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

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

15.3.5 Emergency admissions for acute conditions that should not usually require hospital admission

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



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

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

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

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

15.3.6 Emergency admissions for children with lower respiratory tract infections (LRTI's)

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

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

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

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

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

The 410 per 100,000 target has been chosen as slightly higher level of improvement than other types of emergency admissions as schemes planned over the next two years are expected to have a larger impact including 'Paediatric attendance at A&E'

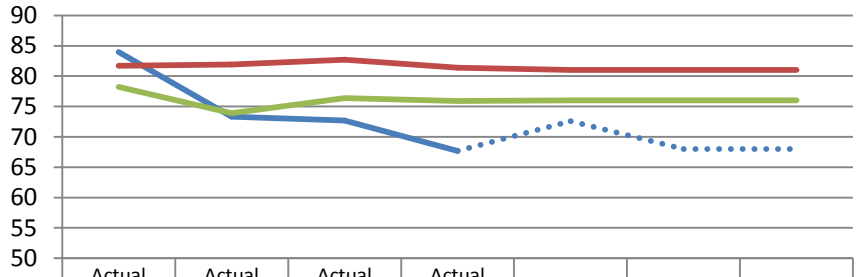
NHS Halton CCG aim to reduce the utilisation of A&E by children by 16% over 2 years by ensuring that there are paediatric specific services, using agreed care pathways available within the community at the two Urgent Care centres to be established within Halton, for the most common conditions which cause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

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

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

Although estimated performance for 13/14 is 72.6% the BCF requires 2 year plan figures based on the 2012/13 actual, for Halton this was 68%, this level of performance is planned to be maintained to 2015/16.

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

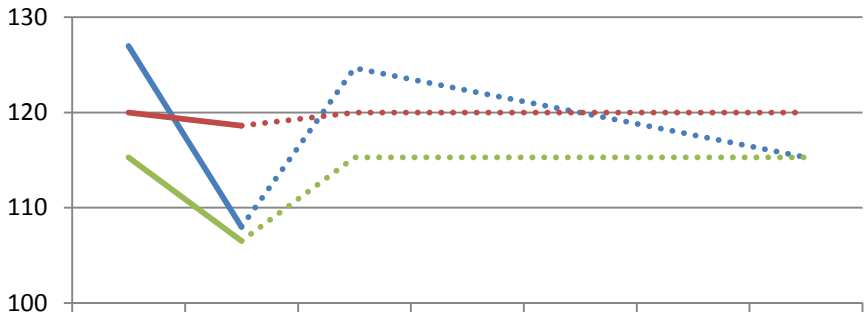


	Actual 09/10	Actual 10/11	Actual 11/12	Actual 12/13	Est 13/14	Plan 14/15	Plan 15/16
Halton	84	73	73	68	73	68	68
England	82	82	83	81	81	81	81
North West 2nd Quintile	78	74	76	76	76	76	76

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

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

C4.2.1 Patient experience of hospital care - number of 'poor' responses per 100 patients



	2012 Actual	2013 Actual	2014 Plan	2015 Plan	2016 Plan	2017 Plan	2018 Plan
Halton	127	108	124.66	122.32	119.98	117.64	115.3
NHS England 2012 Ave.	120	118.6	120	120	120	120	120
Merseyside 2012 Median	115.3	106.5	115.3	115.3	115.3	115.3	115.3

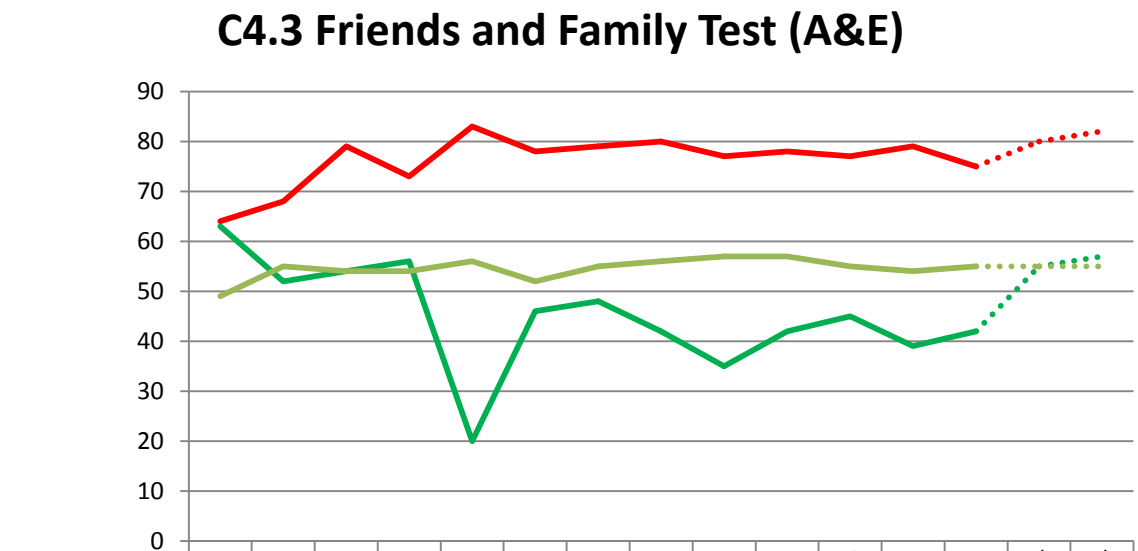
Source Data: http://ccgtools.england.nhs.uk/loa/flash/atlas.html on 17/06/2014

Data is available for 2012 and 2013 however following guidance from NHS England Merseyside Area Team. Only the 2012 figure has been used for benchmarking purposes. This shows NHS Halton CCG with a performance of 127 'poor' responses per 100 patients (a person can have a 'poor' response to more than one question in the survey).

By working together with the Acute Trusts, regularly reviewing performance through the Quality committee and by providing more streamlined & reduced care pathways to reduce lengths of stay and prevent delayed discharge this should provide a better experience for a patient receiveing hospital care and this will be reflected in these survey results.

Taking into account the very good improvement in survey responses in 2013 but using 2012 as the benchmark a target has been set to achieve the Merseyside 2012 median value by 2018 this would improve NHS Halton CCG's performance from worse than the national average to better than average.

15.5.1 Friends and Family Test A&E.



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	14/15 Plan	15/16 Plan
Warrington	63	52	54	56	20	46	48	42	35	42	45	39	42	55	57
St Helens	64	68	79	73	83	78	79	80	77	78	77	79	75	80	82
England	49	55	54	54	56	52	55	56	57	57	55	54	55	55	55

Source[18]

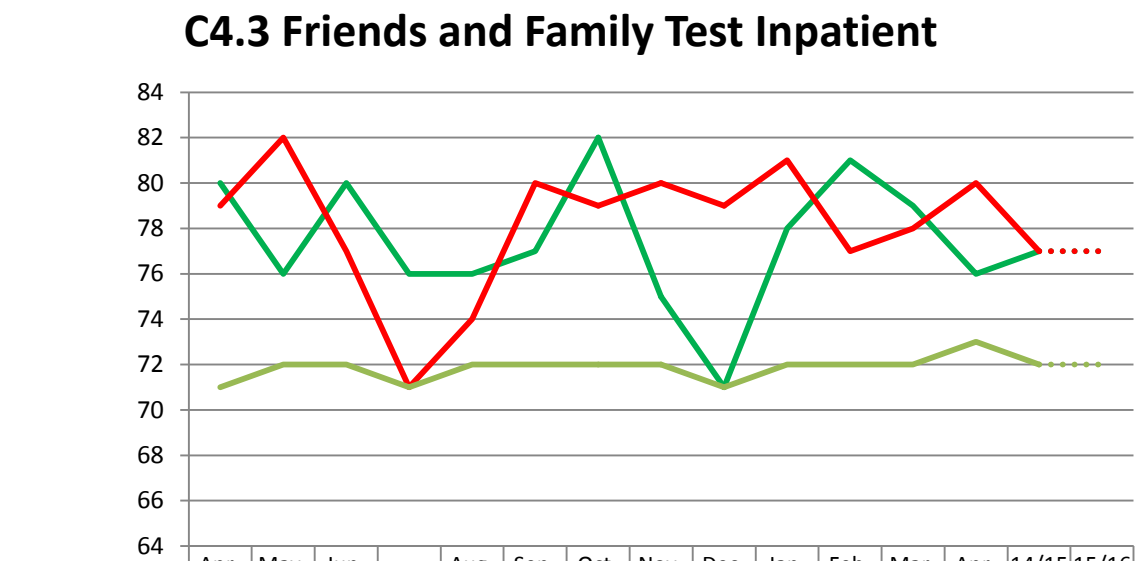
There are significant differences in performance in the Friends and Family test (A&E) between St Helens & Knowsley NHS Trust and Warrington & Halton Hospitals NHS Foundation Trust.

By working together with the Acute Trusts, regularly reviewing performance through the Quality committee and by providing more streamlined services with genuine alternatives to A&E this should have an impact on waiting times and only patients with genuine acute needs attending the Type 1 A&E centres. This should provide a better experience for a patient receiveing Accident and Emergency care and this will be reflected in these survey results.

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

[18] http://www.england.nhs.uk/statistics/statistical-work-areas/friends-and-family-test/friends-and-family-test-data/

15.5.3 Friends and Family Test - Inpatient.



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	14/15 Plan	15/16 Plan
Warrington	80	76	80	76	76	77	82	75	71	78	81	79	76	77	77
St Helens	79	82	77	71	74	80	79	80	79	81	77	78	80	77	77
England	71	72	72	71	72	72	72	72	71	72	72	72	73	72	72

Source[19]

With regards to the Friends and Family Test (Inpatient) both Warrington & Halton Hospitals NHS Foundation Trust and St Helens & Knowsley NHS Trust perform much higher than the England average. The plan for 14/15 and 15/16 are to maintain this excellent level of performance at the average of the period April 13 to April 14, 77% compared with the England averge of 72% over the same period

[19] http://www.england.nhs.uk/statistics/statistical-work-areas/friends-and-family-test/friends-and-family-test-data/

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

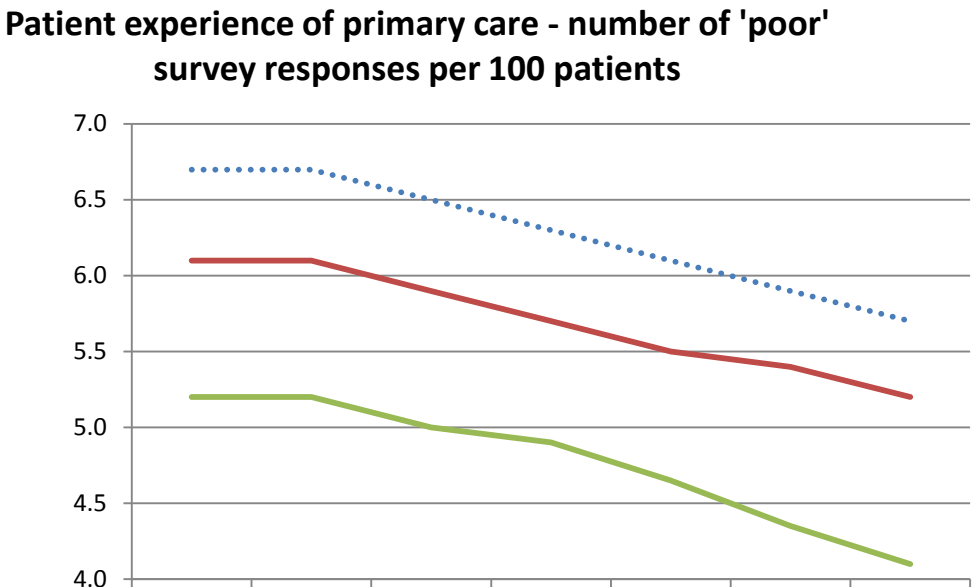
Based on national and local intelligence NHS Halton CCG has developed a number of schemes for implementation over the next two years which have the intention of increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general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

The schemes identified are;

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

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

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



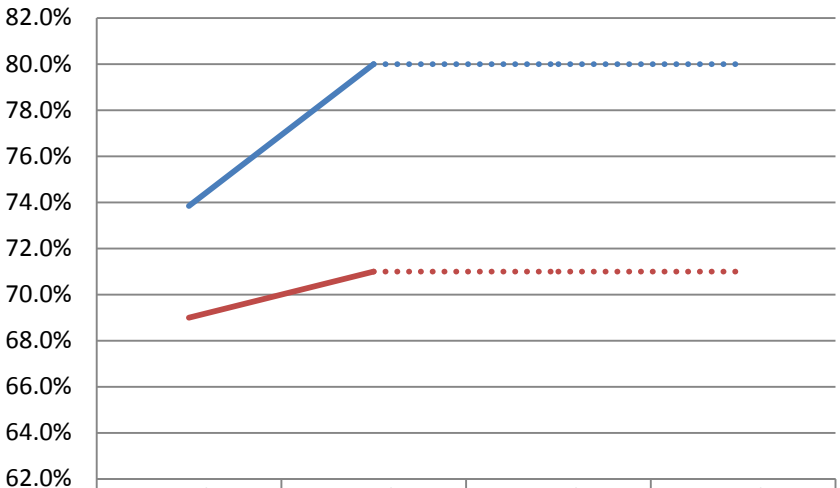
	2012 Actual	2013 Est	2014 Plan	2015 Plan	2016 Plan	2017 Plan	2018 Plan
Halton	6.7	6.7	6.5	6.3	6.1	5.9	5.7
NHS England	6.1	6.1	5.9	5.7	5.5	5.4	5.2
NHS Merseyside	5.2	5.2	5.0	4.9	4.7	4.4	4.1

Source Data: http://ccgtools.england.nhs.uk/loa/flash/atlas.html on 16/06/2014

The data above is a composite indicator of results from both GP services and GP out of hours services. In 2012 Halton's performance of 6.7 'poor' survey responses per 100 patients was higher than both the England and Merseyside average, Improvements are expected in this performance measure both nationally and locally. NHS Halton CCG's targeted improvement is realistic in terms of relecting the level of ambition both regionally and nationally however NHS Halton is starting from a slightly worse position. It is anticipated that by 2016 NHS Halton CCG's performance in terms of GP patient experience will be better than the levels currently experienced nationally.

15.6.2 Patient Experience - GP Out of Hours

(C4.1) Patient experience of GP out of hours services

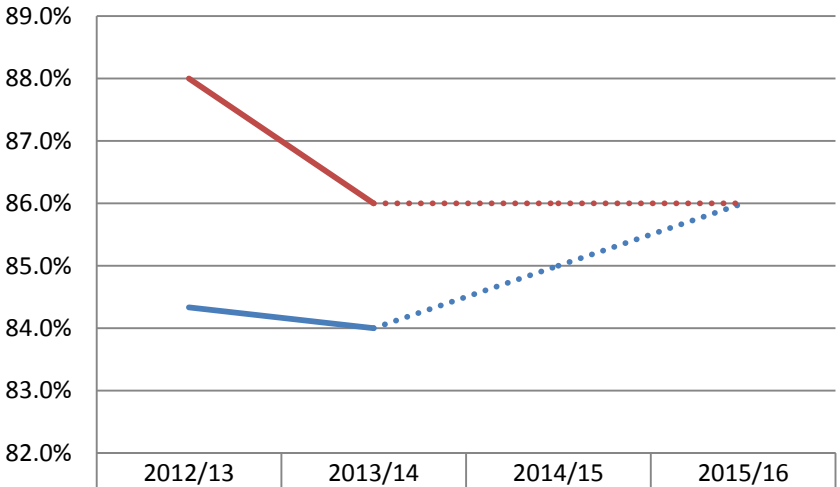


	2012/13	2013/14	2014/15	2015/16
% of people answering 'good' or 'very good' in the GPPS survey	73.8%	80.0%	80.0%	80.0%
England average	69.0%	71%	71.0%	71.0%

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

15.6.3 Patient Expereince – GP Overall Experience

GPPS Survey Q28 'Overall, how would you describe your experience of your GP Surgery



	2012/13	2013/14	2014/15	2015/16
% of people answering 'good' or 'very good' in the GPPS survey	84.3%	84.0%	85.0%	86.0%
England Average	88.0%	86.0%	86.0%	86.0%

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

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

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

The schemes identified are;

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

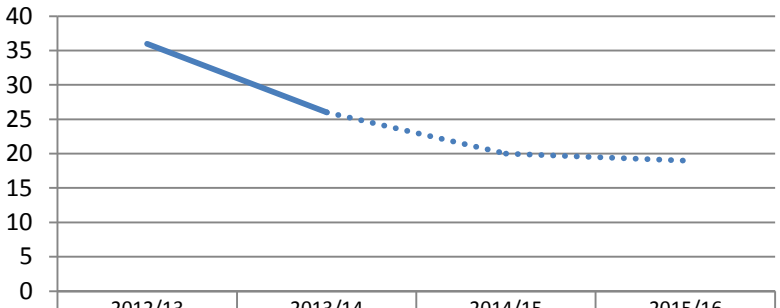
15.7.1 MRSA Zero tolerance

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

15.7.2 Clostridium Difficile

NHS Halton CCG had a very good year in 2013/14 in terms of the number of people reported with HCAI Clostidium Difficile, the Acutal (26) was much lower than the target set for the CCG of 33. In light of this NHS E have set the NHS Halton CCG a challenging target for 2014/15 of just 20 cases, with a further reduction expected to be seen in 2015/16.

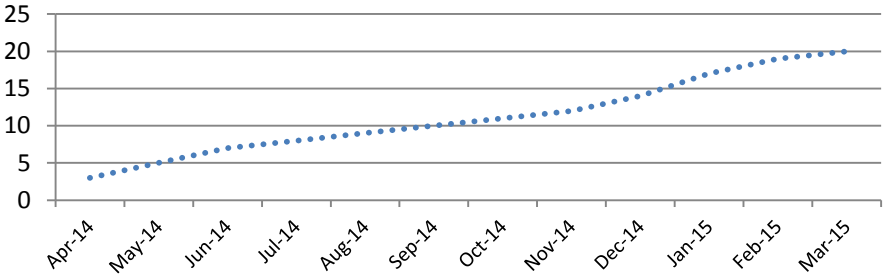
(C5.4) Incidence of healthcare associated infection (HCAI) Clostridium Difficile (c.difficile)



	2012/13 Actual	2013/14 Actual	2014/15 Plan	2015/16 Plan
The number of C.difficile infections reported in people aged 2 and over	36	26	20	19

15.7.3 Clostridium Difficile monthly plan

(C5.4) Incidence of healthcare associated infection (HCAI) Clostridium Difficile



	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
C-diff cases (cumulative)	3	5	7	8	9	10	11	12	14	17	19	20

The seasonal variation of C-Difficile infections has been taken into account when planning monthly figures for 2014/15.The percentages applied are 33% of cases expected between Jan to March, with the peak for infections being in January, 27% for April to June, 20% for July to September and 20% for October to December. These estimates were taken from 'English voluntary surveillance scheme for C. Difficile infections'[20]

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

16. Operational Plan NHS Constitution measures

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

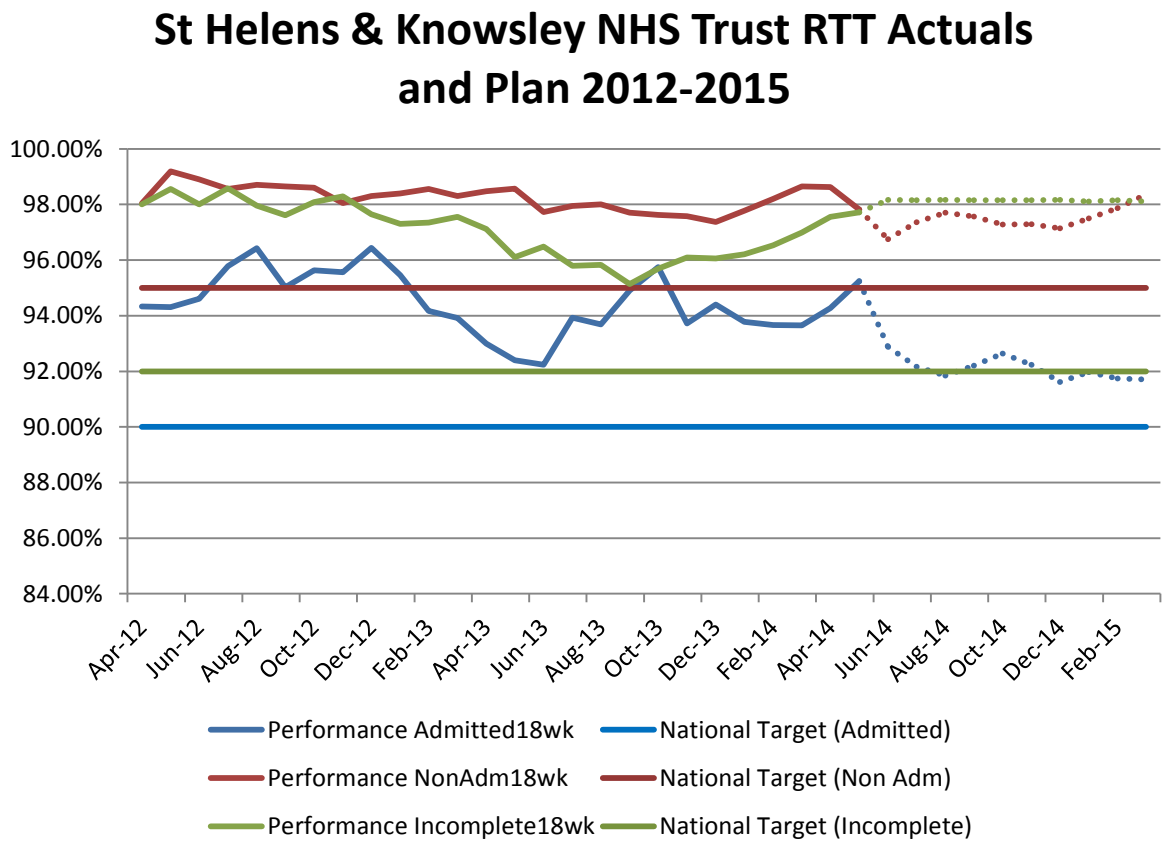
Description	Standard	Halton 14/15 Target	Halton 15/16 Target
Referral to Treatment waiting times for non-urgent consultant–led treatment			
Admitted patients to start treatment within a maximum of 18 weeks from referral	90%	90%	90%
Non-admitted patients to start treatment within a maximum of 18 weeks from referral	95%	95%	95%
Patients of incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral	92%	92%	92%
Diagnostic test waiting times			
Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral	99%	99%	99%
A&E Waits			
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department	95%	95%	95%
Cancer waits – 2 week wait			
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93%	93%	93%
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer not initially suspected)	93%	93%	93%
Cancer waits – 31 days			
Maximum one month (31 day) wait from diagnosis to first definitive treatment for all cancers	96%	96%	96%
Maximum 31-day wait for subsequent treatment where that treatment is surgery	94%	94%	94%
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	98%	98%	98%
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	94%	94%	94%
Cancer waits – 62 days			
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer	85%	85%	85%
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	90%	90%	90%
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set	n/a	90%	90%
Category A ambulance calls			
Category A calls resulting in an emergency response arriving within 8 minutes (Red 1)	75%	75%	75%
Category A calls resulting in an emergency response arriving within 8 minutes (Red 2)	75%	75%	75%
Category A calls resulting in an ambulance arriving at the scene within 19 minutes	96%	95%	95%

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

16.1 RTT (Referral to Treatment)

NHS Halton CCG has acknowledged that there is significant pressure across the health economy in achieving the 18-week referral to treatement timescale, especially within the Acute providers. In Halton, Bridgewater Community NHS Trust has provided assurance that it will continue to meet its 18-week timescales for the small amount of consultant led services which it provides.

St Helens & Knowsley NHS Trust has also provided Trust level figures of the expected level of RTT performance



Against all three RTT measures St Helens & Knowsely NHS Trust plans to exceed the national target.

NHS Halton CCG has planned for growth in the activity in each of the providers, both acute and community, a contingency has been put aside to deal with overperformance, however where this occurs providers will be held to account and access will be requested to the patient tracking lists, consultant productivity and Theatre utilisation.

16.2 NHS Constitution support measures

Description	Standard	Halton 14/15 Target	Halton 15/16 Target
Mixed Sex Accommodation Breaches[21]			
Minimise breaches (rate per 1,000 FCEs)	0.1	0.1	0.1
Cancelled Operations			
All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patients treatment to be funded at the time and hospital of the patient's choice	100%	100%	100%
Mental Health			
Care Programme Approach (CPA): the proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period	95%	95%	95%
Referral to Treatment waiting times for non-urgent consultant-led treatment			
Zero tolerance of over 52 week waiters	0	0	0
A&E waits			
No waits from decision to admit to admission (trolley waits) over 12 hours	0	0	0
Cancelled Operations			
No urgent operation to be cancelled for a 2nd time	0	0	0
Ambulance Handovers			
All handovers between ambulance and A&E must take place within 15 minutes and crews should be ready to accept new calls within a further 15 minutes. Financial penalties, in both cases, for delays over 30 minutes and over an hour.	0	0	0

16.2.1 Mixed Sex Accommodation

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

16.2.2 Ambulance Handovers

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

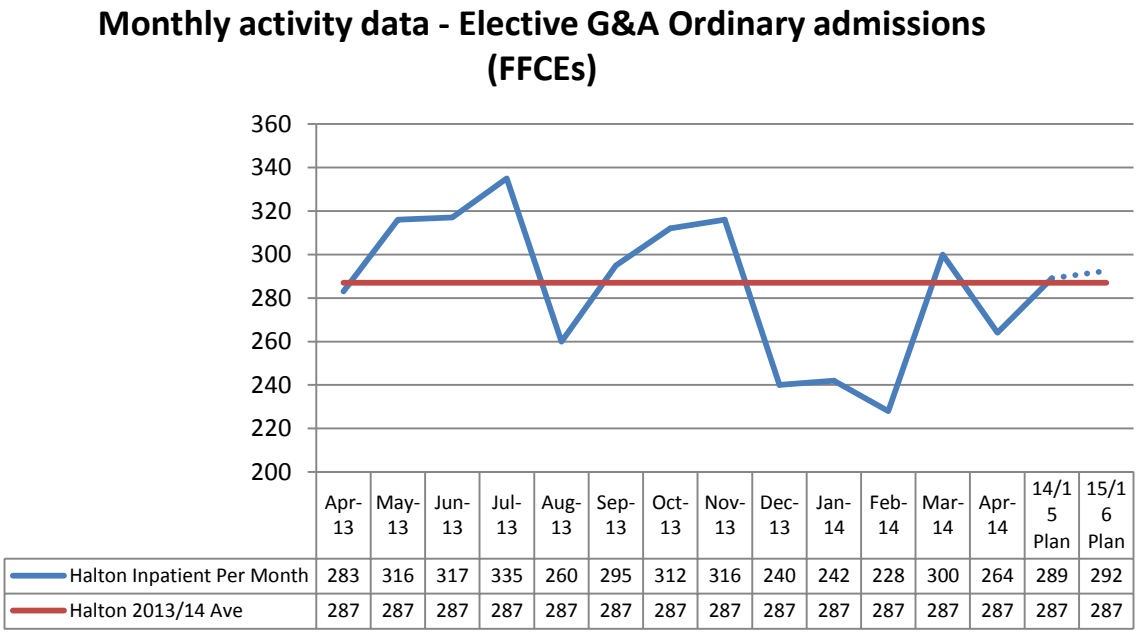
[21] http://www.england.nhs.uk/statistics/statistical-work-areas/mixed-sex-accommodation/msa-data/

17. Operational Plan Activity

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

17.1 Elective[22]

17.1.1 Elective G&A Ordinary Admissions (FFCEs)



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	14/15 Plan	15/16 Plan
Halton Inpatient Per Month	283	316	317	335	260	295	312	316	240	242	228	300	264	289	292
Halton 2013/14 Ave	287	287	287	287	287	287	287	287	287	287	287	287	287	287	287

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

Growth has been calculated using the growth table as discussed in section 9.1

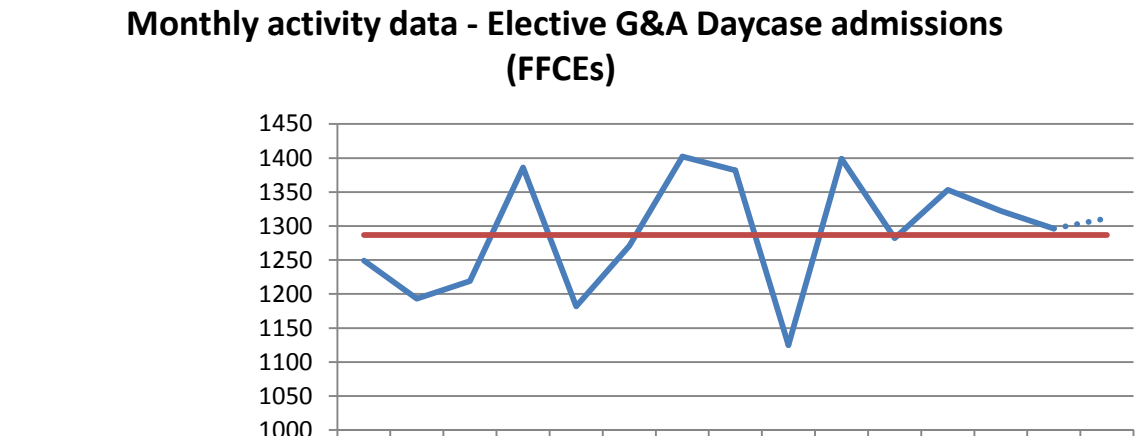
0.74% (age standardised activity increase for 2014/15)
1.16% (age standardised increase for 2015/16)

The average number of G&A ordinary admissions per month in 2013/14 is estimated to be 287; by 14/15 this is expected to have increased to 289 and by 2015/16 to 292 per month.

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

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

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



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	14/15 Plan	15/16 Plan
Halton Daycase Per Month	1249	1193	1219	1386	1182	1271	1402	1382	1125	1399	1282	1353	1322	1296	1311
Halton 2013/14 Ave	1287	1287	1287	1287	1287	1287	1287	1287	1287	1287	1287	1287	1287	1287	1287

A small amount of increased activity is expected due to the changes in the population of Halton, the calculations behind how this has been done are described in section 9.1

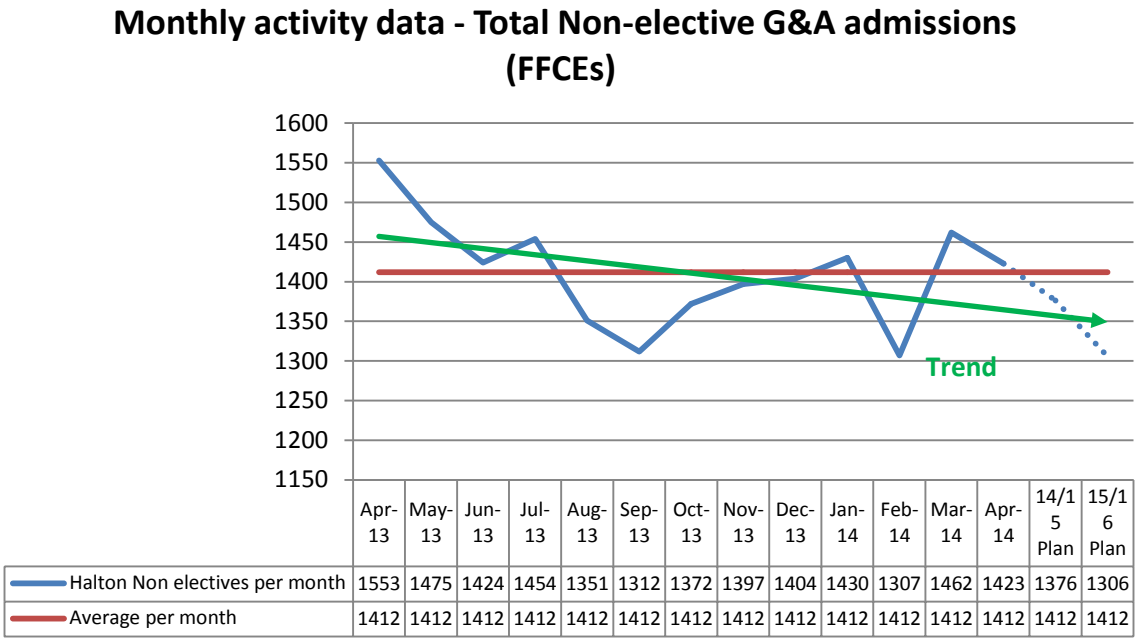
0.74% (age standardised activity increase for 2014/15)
1.16% (age standardised increase for 2015/16)

For the number of elective G&A day case admissions the average number of admissions per month in 2013/14 is expected to be 1287, for 14/15 this is expected to have increased to 1296 and for 2015/16 an increase to 1311 per month.

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

17.2 Non Elective Admissions

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



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	14/15 Plan	15/16 Plan
Halton Non electives per month	1553	1475	1424	1454	1351	1312	1372	1397	1404	1430	1307	1462	1423	1376	1306
Average per month	1412	1412	1412	1412	1412	1412	1412	1412	1412	1412	1412	1412	1412	1412	1412

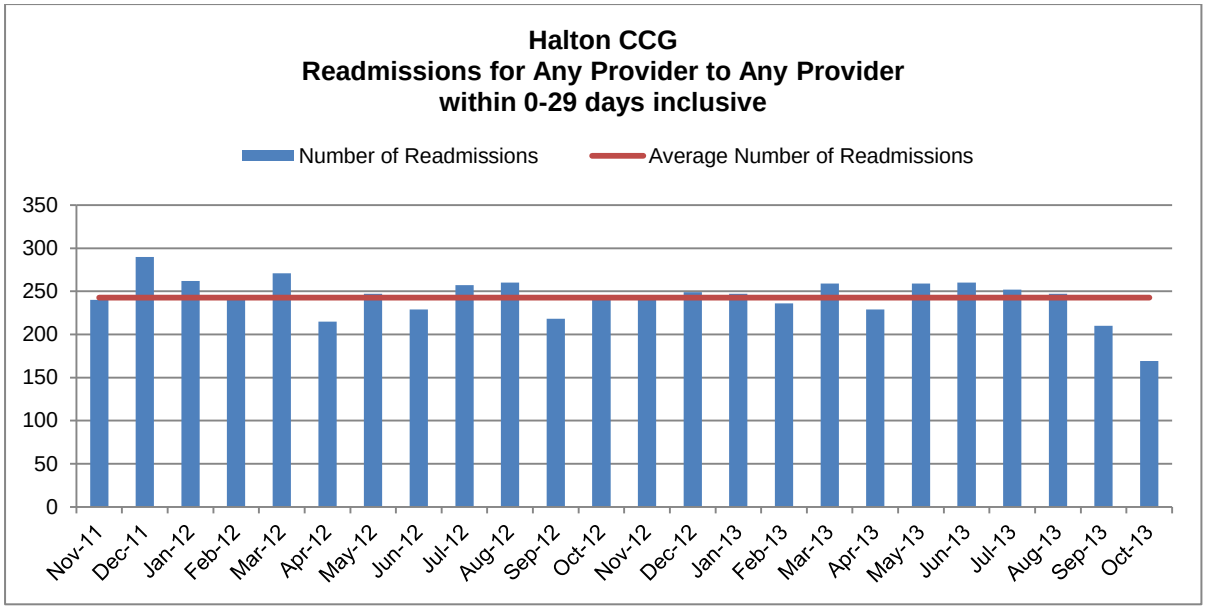
The actions being put into place as part of the 5-year strategy and 2-year operational plan are forecast to have the impact of reducing the number of non-elective admissions by 2.5% (based on 13/14 estimate) for 2014/15 then a further 5% in 2015/16 and 2016/17.

For 2013/14 the estimate has been calculated as the April to November average of 1412. A 2.5% reduction equates to 35 cases per month. The 14/15 plan is 1376 per month and 15/16 plan of 1306 per month.

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

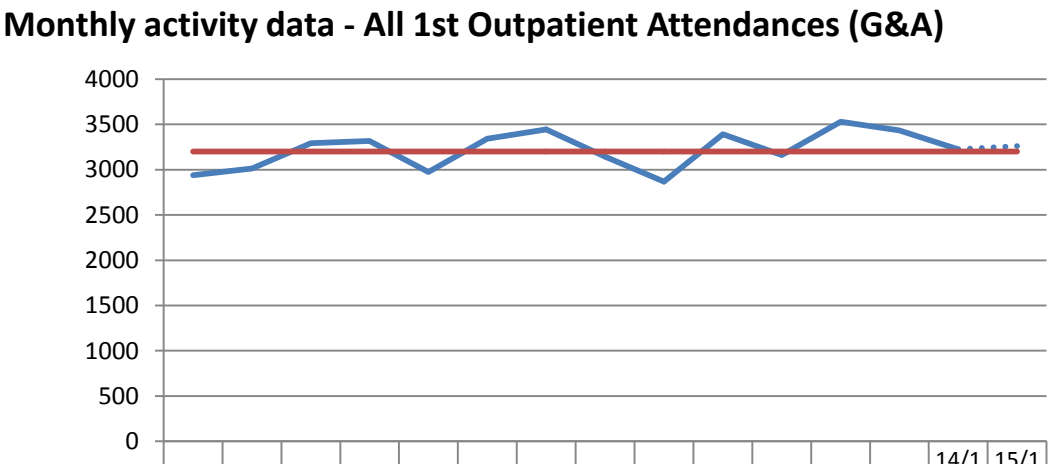
17.2.2 Readmissions 0-28 days

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



17.3 Outpatient Attendances

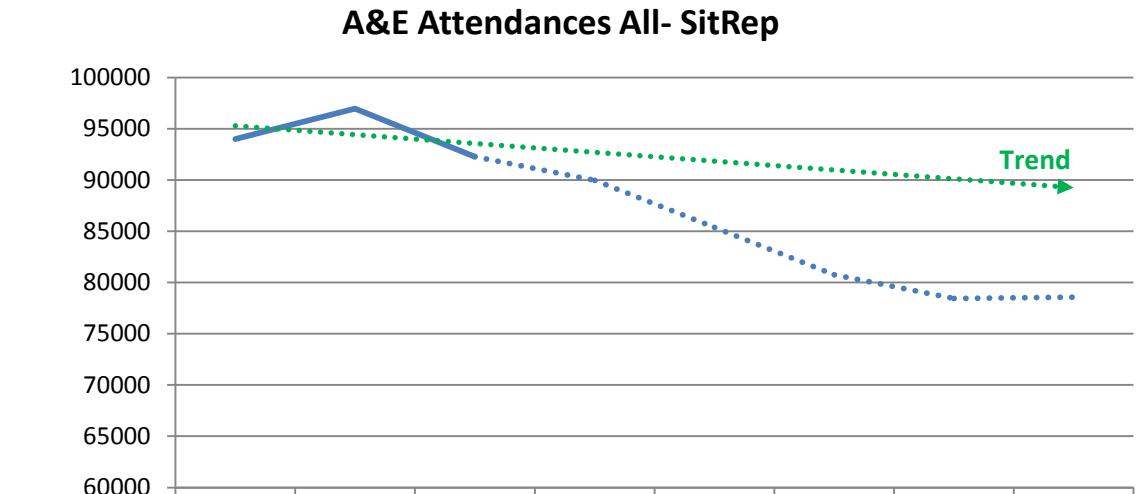
17.3.1 All first outpatient attendances in general & acute specialties



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	14/15 Plan	15/16 Plan
Halton per month	2938	3015	3293	3319	2973	3341	3445	3145	2867	3392	3162	3529	3435	3225	3262
Ave	3202	3202	3202	3202	3202	3202	3202	3202	3202	3202	3202	3202	3202	3202	3202

Increases in the number of outpatient attendances recorded at the general and acute trusts are expected in both 2014/15 and 15/16. These increases have been calculated in line with the different rates of demographic change differing age groups and the proportion of activity that is made up from those age groups. This equates to a small increase of 0.74% in the overall total number of outpatient admissions for 14/15 and a slightly larger increase of 1.16% for 2015/16

17.4 A&E Attendances[23]



	2011/12	2012/13	2013/14 Forecast	14/15 Plan	15/16 Plan	16/17 Plan	17/18 Plan	18/19 Plan
Halton CCG	94016	96959	92293	89985	85371	80756	78449	78582
Trend	94016	96959	92293					

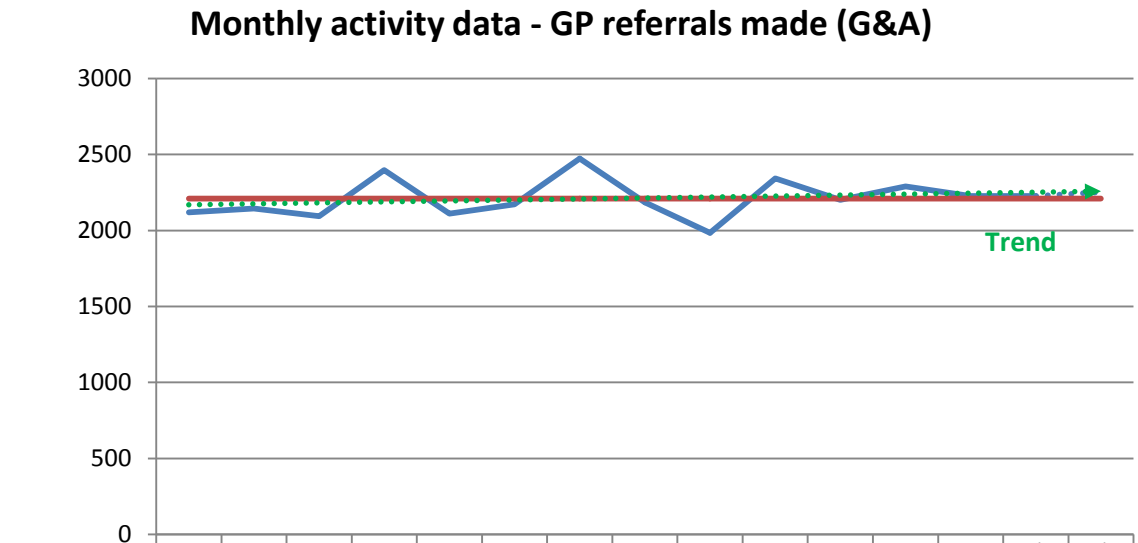
By implementing the commissioning intentions, including developing the Urgent Care Centres in Widnes and Runcorn the plan is to reduce A&E attendances by 2.5% in 14/15, 5% in both 15/16 and 16/17 and 2.5% in 17/18. This is significantly lower than would be expected by looking at the trend over the last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

This is a challenging but achievable goal. Independent economic analysis by i5 Health and Capita confirm that the scale of the ambition is achieveable.

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

17.5 Referrals

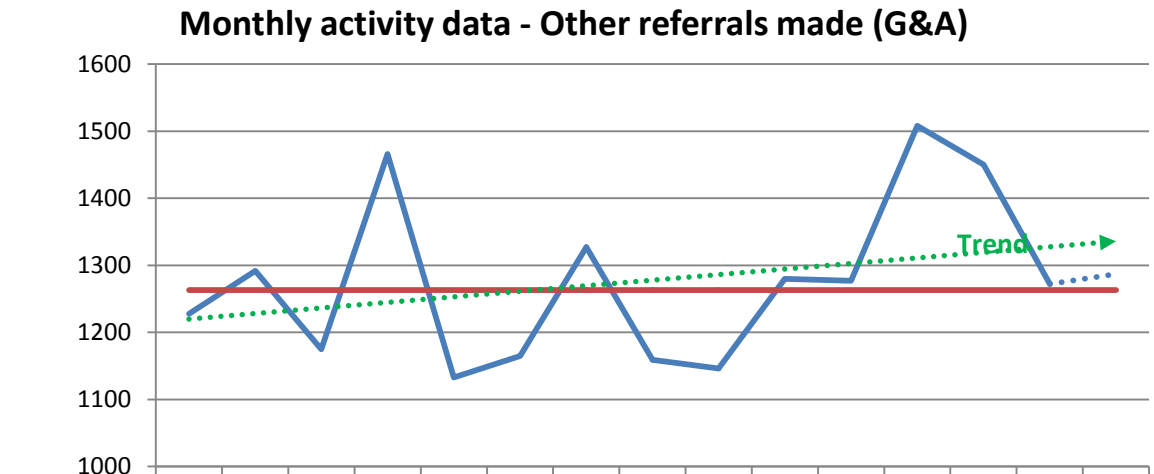
17.5.1 GP Referrals made (G&A)



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	14/15 Plan	15/16 Plan
Actual	2119	2144	2094	2397	2110	2173	2473	2184	1985	2343	2202	2289	2227	2226	2252
Average	2209	2209	2209	2209	2209	2209	2209	2209	2209	2209	2209	2209	2209	2209	2209

Small increases in activity have been planned for 14/15 and 15/16, these have been calculated based on demographic changes and the age breakdown in service use. This has been calculated as a 0.74% increase in 2014/15 and a further 1.16% increase in 15/16. This increase in activity is below the trend since April 2013 but follows the same trajectory.

17.5.2 Other referrals made (G&A)



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	14/15 Plan	15/16 Plan
Actual	1228	1292	1175	1466	1133	1165	1327	1159	1146	1280	1277	1508	1450	1272	1287
Average	1263	1263	1263	1263	1263	1263	1263	1263	1263	1263	1263	1263	1263	1263	1263

There have been large variations in the monthly figures available for Halton from April 2013. Over the last seven moths the average is 1263 per month and the trend is for an increasing number of other referrals

Small increases are planned for 2014/15 and 2015/16 based on anticipated increase in demand from demographic changes and the age profile of service users. This has been calculated as 0.74% for 2014/15 and 1.16% for 2015/16. The figures reported in the chart for these two years are the average number of 'other referrals' per month in that year.

18. Better Care Fund Plan

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

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

Metrics		Current Baseline (as at….)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	439.7		816.2 (target)
	Numerator	82		N/A
	Denominator	18,648		N/A
		(April 2012 - March 2013)		(April 2014 - March 2015)

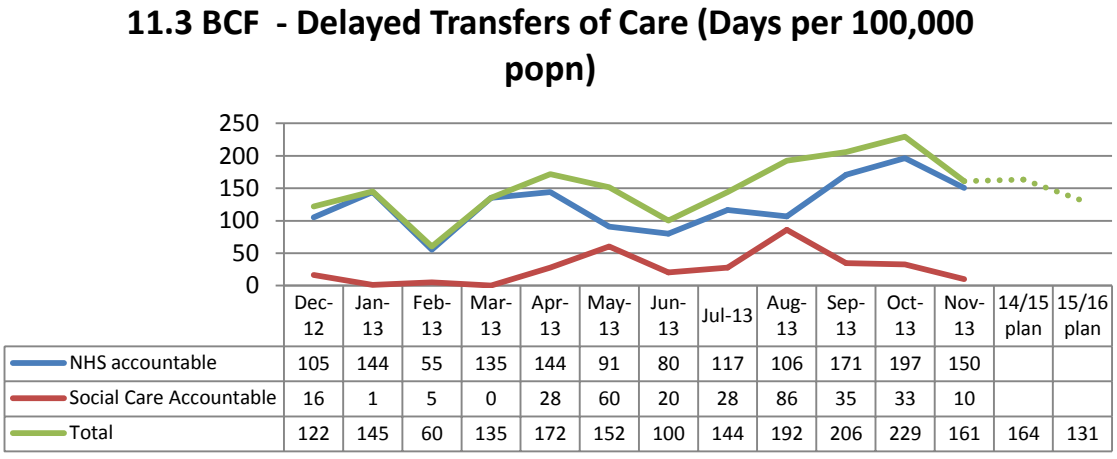
As a part of this scheme, there is a strong focus on assessing and intervening with people with complex needs, and their carers, at an earlier stage, providing care and support in the community for as long as possible. Expected outcomes and benefits include a reduction in the proportion of people requiring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

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

Metrics		Current Baseline (as at….)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	72.63%	N/A	68% (target)
	Numerator	69		N/A
	Denominator	95		N/A
		(April 2012 - March 2013)		(April 2014 - March 2015)

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

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



	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	14/15 plan	15/16 plan
NHS accountable	105	144	55	135	144	91	80	117	106	171	197	150		
Social Care Accountable	16	1	5	0	28	60	20	28	86	35	33	10		
Total	122	145	60	135	172	152	100	144	192	206	229	161	164	131

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

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

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

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

18.4 Avoidable emergency admissions (composite measure)

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

This measure is a composite of 4 emergency admission measures. The data has been taken from the Operational Planning Atlas tool[24]

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

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

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

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

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

18.5 Patient / service user experience

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

18.6 Local Measure

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

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

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

Appendix A - Operational Plan Schemes

A1 Planned Care

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A2 Women Children & Families

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A3 Primary & Community care

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

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

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

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

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

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

<table>
<tr><td colspan="2">Project Description</td><td colspan="4">A strategy for sustainable general practice services in Halton</td></tr>
<tr><td>Ref</td><td>PCI141506</td><td>Commissioning Area</td><td>Primary & Community</td><td>Programme / Project</td><td>Primary</td></tr>
<tr><td colspan="4" rowspan="6">Desired Outcome</td><td>Oversight Group</td><td>To be agreed</td></tr>
<tr><td colspan="4" rowspan="5">The problem is that general practice services in Halton are not sustainable and there is no agreed strategy to address this. NHS Halton CCG, with NHS England, will support member practices to develop and agree a strategy to deliver sustainable general practice services in Halton. Sustainable general practice services are required to:
• Reduction in variation
• Increase capacity in general practice and the reconfiguration of urgent in hours primary care to reduce unnecessary admissions
• Enable 7/7 working
• Improve long term condition management, particularly for frail and/or elderly people
• Reduce health inequalities
• Increase patient choice and access
• Develop specialist skills, knowledge and service delivery amongst the local workforce providing general practice services
• Provide local service alternatives in straight forward planned care
• Develop a plan for managing the changing age and skill profiles of the local general practice workforce</td><td>Commissioning Lead</td><td>Jo O'Brien</td></tr>
<tr><td>Clinical Lead</td><td>Dr Gary O'Hare, Dr Salil Veedu, Dr Cliff Richards</td></tr>
<tr><td>Integrated Commissioning Partners</td><td>NHSE as the commissioner and principal contractor for general practice services in Halton.
17 general practices in Halton as small/medium businesses and independent contractors within the NHS</td></tr>
<tr><td>Better Care Fund Plan</td><td>No</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td colspan="2">Financial Impact</td><td colspan="2">Tbc, however whilst contractual responsibility sits with NHSE may require considerable CCG staff input which may put pressures on existing core work</td><td>Strategic Objectives supported</td><td>CCGICS3</td></tr>
</table>

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

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

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

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

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

Project Description		Explore the potential for introduction of a programme of care for Familial hypercholesterolemia			
Ref	PCI141512	Commissioning Area	Primary & Community	Programme / Project	Primary
				Oversight Group	None
Desired Outcome		Reduction in people dying prematurely, enhanced quality of life and experience of care for people with long-term conditions		Commissioning Lead	Julie Holmes
				Clinical Lead	Not applicable
				Integrated Commissioning Partners	PH
				Better Care Fund Plan	No
Financial Impact				Strategic Objectives supported	CCGICS3, NHSOF1, NHSOF2

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

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

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

A4 Mental Health & Unplanned care

Project Description		Develop local services to reduce suicide attempts			
Ref	MHUC141 501	Commissioning Area	Mental Health & Unplanned Care	Programme / Project	Mental Health
				Oversight Group	5BP Contract Board Mental Health strategic commissioning board
Desired Outcome		Reduce excess mortality in people with mental health problems known to services and from suicide		Commissioning Lead	Jennifer Owen/ Simon Bell
				Clinical Lead	Dr Anne Burke, Dr Elspeth Anwar
				Integrated Commissioning Partners	PH, LA
				Better Care Fund Plan	Yes
Financial Impact		Cost of CPN would be at least £50k. there would be potential savings across the whole health economy but not all of these would be aligned to CCG budgets		Strategic Objectives supported	NHSOF1, NHSOF2, CCGICS1
Milestones					
2014/15				2015/16	
Q1	Suicide prevention strategy development, Pilot around A&E Liaison				
Q2	Implement actions from suicide prevention strategy. Pilot CPN with police across Warrington & Halton				
Q3	As above				
Q4					
Supporting measures	Reduction in suicide attempts				

Project Description		Review the AED liaison psychiatry model across Mid Mersey CCGs			
Ref	MHUC141 502	Commissioning Area	Mental Health & Unplanned Care	Programme / Project	Mental Health
				Oversight Group	5BP contract Board Bridgewater Oohs contract Board-WCCG WHHFT contract board STH&K contract Board Mental Health strategic commissioning board
Desired Outcome		Acute and emergency care for people in mental health crisis is as accessible and high-quality as for physical health emergencies. Ensure equitable liaison psychiatry services to support effective crisis care – Linked to MHUC141501		Commissioning Lead	Jennifer Owen
				Clinical Lead	Dr Anne Burke
				Integrated Commissioning Partners	Other CCGs
				Better Care Fund Plan	No
Financial Impact				Strategic Objectives supported	NHSOF2, NHSOF3, NHSOF4, NHSOF5, HHWS 5, CCGOIS1
Milestones					
2014/15				2015/16	
Q1					
Q2					
Q3					
Q4					
Supporting measures		No variation in 4-hour A&E waits between providers for people in mental health crisis			

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A5.1 Communication

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

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

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

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

A5.2 Quality

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

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

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

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

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

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

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

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

A5.3 Process & Policy

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

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

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

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

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

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

A5.4 Medicines Optimisation

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

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

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

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

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

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

Appendix B: What has influenced our Plans?

B1 National Drivers

B1.1 NHS Mandate[25]

In November 2013 the Department of Health issued the refreshed NHS Mandate.

The objectives in the Mandate focus on the areas identified as being of greatest importance to people, these include

- Preventing ill health
- Managing on-going physical and mental health conditions such as dementia
- Helping people recover from episodes of ill health such as stoke or following injury
- Better care not just better treatment
- Providing safe care – people are treated in a clean and safe environment

The updated mandate reflects the Government's priority to transform the way in which the NHS provides care for older people and those with complex needs – from a system which is reactive, responding when something goes wrong to a proactive service, which is centred around the needs of each individual patient.

This is something which is already being addressed in Halton but has been identified as one of our areas for strategic focus over the next five years.

The Mandate also sets out the ambition for GPs to be responsible for co-ordinating this patient-centred care.

A significant element of NHS Halton CCG's 5 year strategic plan is to review and enhance how GPs and their practices work together and with providers to achieve the best outcomes for patients.

B1.2 The NHS Belongs To The People: A Call To Action[26]

The NHS faces an unprecedented level of future pressure. This is the definitive conclusion of *The NHS Belongs To The People: A Call To Action,* published by NHS England in July 2013.

This report highlighted a number of future pressures that threaten to overwhelm the NHS.

- An ageing population.
- A significant increase in the number of people with long-term conditions – for example, heart disease, diabetes and hypertension.

[25] https://www.gov.uk/government/publications/nhs-mandate-2014-to-2015
[26] http://www.england.nhs.uk/2013/07/11/call-to-action/

- Lifestyle risk factors in the young.
- Greater public expectations.
- Rising costs and constrained financial resources.

The resulting increase in demand combined with rising costs mean that fundamental changes will need to be made to how we deliver and use health care services.

The NHS Belongs To The People: A Call To Action highlights that these changes are about finding ways to do things differently, such as using technology to improve productivity, putting people in charge of their own health and care, integrating health and care services and more.

Some of the changes identified in *The NHS Belongs To The People: A Call To Action* are already underway in Halton. Integrated commissioning has already begun between NHS Halton CCG and Halton Borough Council but we intend to do more, there are opportunities to provide more care outside of hospitals, refocusing on prevention, matching services more closely to individuals' risks, harnessing new technology and making better use of data between organisations.

These opportunities in Halton have been described in more detail in the integrated transformation plan completed in partnership with Halton Borough Council and the two year CCG operational delivery plan.

The strategic directions identified by the CCG 5 year plan are closely aligned to the requirements identified in the NHS Call to Action.

B1.3 NHS Call to Action – Commissioning for Prevention[27]

The NHS Call to Action – Commissioning for prevention document highlighted some of the national statistics highlighting the benefits of prevention, both in terms of financial cost and patient outcomes.
Smoking cessation, suicide prevention and Atrial Fibrillation diagnosis and early treatment have all been shown to have significant short term benefits as well as long term improved outcomes. NHS Halton CCG is committed to improve services in all these areas both now and in the future.
'Commissioning for prevention' also highlighted 5 steps in the planning process

- Analyse Key Health problems
- Prioritise and set common goals
- Identify high-impact programmes
- Plan resources
- Measure and experiment

Proactive prevention has been highlighted as an area of strategic priority for NHS Halton CCG over the next five years.

[27] http://www.england.nhs.uk/wp-content/uploads/2013/11/call-to-action-com-prev.pdf

B1.4 NHS Outcomes Framework[28]

In November 2013 the Department of health published the NHS Outcomes Framework for 2014/15 this is to be read alongside The Mandate from the Government to NHS England.

The domains for 2014/15 remain the same as those for 2013/14 however it was announced that there would be a refresh for 2015/16. The domains are:

Domain 1	Preventing people from dying prematurely
Domain 2	Enhancing quality of life for people with long-term conditions
Domain 3	Helping people to recover from episodes of ill health or following injury
Domain 4	Ensuring that people have a positive experience of care
Domain 5	Treating and caring for people in a safe environment and protecting them from avoidable harm

NHS Halton CCG has aligned this 5 year strategy and delivery plans to the NHS Outcomes Framework, with each project being measured using one or more of the domains.

B1.5 Mid Staffordshire NHS Public Enquiry (Francis Report)[29]

Following an extensive inquiry into failings at Mid-Staffordshire NHS Foundation Trust, Robert Francis QC published his final report on 6th February 2013.

It told a story of appalling suffering of many patients within a culture of secrecy and defensiveness. The inquiry highlighted a whole system failure. A system which should have had checks and balances in place, and working, to ensure that patients were treated with dignity, and suffered no harm.

The 1,782 page report had 290 recommendations with major implications for all levels of the health service across England. It called for a whole service, patient centred focus. The detailed recommendations did not call for a reorganisation of the system, but for a re-emphasis on what is important, to ensure that this does not happen again.

The essential aims identified are to

[28] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/256456/NHS_outcomes.pdf
[29] http://www.midstaffspublicinquiry.com/report

- Foster a common culture shared by all in the service of putting the patient first;
- Develop a set of fundamental standards, easily understood and accepted by patients, the public and healthcare staff, the breach of which should not be tolerated;
- Provide professionally endorsed and evidence-based means of compliance with these fundamental standards which can be understood and adopted by the staff who have to provide the service;
- Ensure openness, transparency and candour throughout the system about matters of concern;
- Ensure that the relentless focus of the healthcare regulator is on policing compliance with these standards;
- Make all those who provide care for patients – individuals and organisations – properly accountable for what they do and to ensure that the public is protected from those not fit to provide such a service;
- Provide for a proper degree of accountability for senior managers and leaders to place all with responsibility for protecting the interests of patients on a level playing field;
- Enhance the recruitment, education, training and support of all the key contributors to the provision of healthcare, but in particular those in nursing and leadership positions, to integrate the essential shared values of the common culture into everything they do;
- Develop and share ever improving means of measuring and understanding the performance of individual professionals, teams, units and provider organisations for the patients, the public, and all other stakeholders in the system.

B1.6 Keogh Report[30]

On 6th February 2013, the Prime Minister announced that he had asked Professor Sir Bruce Keogh, NHS Medical Director for England, to review the quality of care and treatment provided by those NHS trusts and NHS foundation trusts that were persistent outliers on mortality indicators. A total of 14 hospital trusts were investigated as part of this review. The review of all 14 trusts has been completed. At both a local and national level, key findings have been collated and examined and recommendations have been made.

The ambitions below have been identified in the report as being common challenges facing the wider NHS, NHS Halton CCG will be reviewing its position in relation to these ambitions and taking any necessary action to ensure that we meet the highest standards.

Ambition 1

We will have made demonstrable progress towards reducing avoidable deaths in our hospitals, rather than debating what mortality statistics can and can't tell us about the quality of care hospitals are providing.

[30] http://www.nhs.uk/NHSEngland/bruce-keogh-review/Pages/published-reports.aspx

Ambition 2

The boards and leadership of provider and commissioning organisations will be confidently and competently using data and other intelligence for the forensic pursuit of quality improvement. They, along with patients and the public, will have rapid access to accurate, insightful and easy to use data about quality at service line level.

Ambition 3

Patients, carers and members of the public will increasingly feel like they are being treated as vital and equal partners in the design and assessment of their local NHS. They should also be confident that their feedback is being listened to and see how this is impacting on their own care and the care of others.

Ambition 4

Patients and clinicians will have confidence in the quality assessments made by the Care Quality Commission, not least because they will have been active participants in inspections.

Ambition 5

No hospital, however big, small or remote, will be an island unto itself. Professional, academic and managerial isolation will be a thing of the past.

Ambition 6

Nurse staffing levels and skill mix will appropriately reflect the caseload and the severity of illness of the patients they are caring for and be transparently reported by trust boards.

Ambition 7

Junior doctors in specialist training will not just be seen as the clinical leaders of tomorrow, but clinical leaders of today. The NHS will join the best organisations in the world by harnessing the energy and creativity of its 50,000 young doctors.

Ambition 8

All NHS organisations will understand the positive impact that happy and engaged staff have on patient outcomes, including mortality rates, and will be making this a key part of their quality improvement strategy.

B1.7 National Audit Office Report – Maternity services in England[31]

In November 2013 the National Audit Office published its report into maternity services in England.

Overall the report was generally positive about maternity services nationally, but it did highlight that the variation across the country should be addressed.

"NHS maternity services provide good outcomes and positive experiences for most women during a very important time in their lives. Since the Department of Health's 2007 strategy, there have been improvements in maternity services, but the variation in performance across the country, and our findings on how services are being managed, demonstrate there is substantial scope for further improvement. The Department's implementation of its strategy has not matched its ambition."[32]

In terms of the performance relating to Halton residents, this has been highlighted for three trusts where complications or interventions arose.

Liverpool Women's NHS Foundation Trust
Performance significantly worse than the national average for Injury to neonate, better than average for infection rates (neonate), lower emergency caesarean section rate, Higher induction of labour and instrumental delivery
St Helens & Knowsley NHS Foundation Trust
Performance significantly worse for emergency readmission rates (28 days), neonate, and infection rate neonate, higher induction of labour rates and lower instrumental delivery rates
Warrington & Halton NHS Foundation Trust
Performance was statistically better than average for 3rd and 4th degree perineal tears, but significantly worse than average for; Emergency readmission rates 28 days neonate, injury to neonate, emergency admission within 30 days (maternal), infection rates neonate and higher than average rates of induction of labour.

The Maternity, Children and Young People's Strategic Clinical Network will be supporting a review of maternity services across Cheshire and Merseyside. This review will involve providers, commissioners, professional bodies, local authorities (including public health), Healthwatch and people who access maternity services. The review programme is sponsored by NHS Halton CCG on behalf of Merseyside CCGs. It is due to commence in May 2014 and will have the objective of producing a strategy to deliver sustainable, high quality maternity services across Cheshire and Merseyside. The timescales for this review are still to be determined.

[31] https://www.nao.org.uk/report/maternity-services-england/
[32] Amyas Morse, head of the National Audit Office, 8 November 2013

B1.8 Housing Services[33]

A report by the National Housing Federation and endorsed by the NHS Alliance identified where GP Practices could serve their populations closer to home and more cost effectively through developing constructive collaborations with their local housing partners.
Supported housing services help older and vulnerable residents live healthier, more independent lives. Services can include simple adaptations like handrails and ramps, hospital discharge projects, or combined support and accommodation packages for people with mental health problems, adults with learning disabilities or people living with dementia.

B1.9 New approaches to commissioning

Prime Contractor
NHS Halton CCG will be investigating implementing 'Prime Contractor' arrangements for a whole pathway of care or model of care where tiers of care are closely networked, enabling alignment of incentives and accountability for quality improvement and capacity management.

B2 Local Drivers

B2.1 Finance

Taking anticipated growth into account the cumulative effect of the 'do nothing position' would be a shortfall of £39m over the next five years. Savings are required to be found in each of the next five years.

The Dr Foster Hospital Guide 2013[34] highlights NHS Halton CCG as one of just six CCGs in the country which were identified as an area of 'smart spending' between 2011 and 2013.
These are areas where money has been identified as being used more effectively with regard to avoidable emergency admissions and less effective procedures.
NHS Halton CCG showed a reduction of 6% in the number of avoidable emergency admissions, whilst at the same time there has been a reduction of 25% in the number of less effective procedures being carried out.

B2.1.1 Independent economic assessment

Independent Assurance of Financial and Operational plan QIPP savings

[33] http://www.housing.org.uk/media/press-releases/gps-unsure-how-to-commission-vital-support-services
[34] http://myhospitalguide.drfosterintelligence.co.uk/#/download-centre

Between October 2013 and June 2014 the commissioning intentions and associated financial impact have been developed and incorporated into the financial plan and the 5 and 2 year plans.

The financial savings allocated to some of the commissioning intentions have been calculated using the information available such as anticipated levels of change in activity and the expected unit costs attached to this activity.

In order to provider further, independent, assurance as to the feasibility of these commissioning intentions to achieve the necessary level of savings an independent health economics organisation ,i5 Health Ltd, was commissioned.

In addition, Capita, were commissioned to provide a retrospective, current and future view of health and social care activity, spend and patient flows across the Mid Mersey Area, covering NHS Halton, Knowsley, St Helens and Warrington CCG's. This additional investigation has also provided assurance that the current focus of commissioning is the correct one and that significant savings are possible in Acute care without destabilising the Acute care providers.

Methodology

Both i5 and Capita have used different methods to calculate the potential levels of benefit available in the health economy, however both paint a similar picture.

I5 reviewed actual Halton Acute 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 with and the costs associated with the attendance and/or admittance i5 have calculated the actual cost of activity which could have been treated elsewhere

Capita have used a more statistical approach in that whilst they looked at the same data they have also looked at the variations between General Practices and what the potential savings would be if some (but not all) of this variation could be removed. After taking into account variations in age and deprivation related heath there remain variations in activity such as A&E Attendance and Non-elective activity which are potential areas that savings could be made. Capita have calculated two levels of savings, one based on the reduction of the variation between practices to the best quartile of practices, the second level of savings is based on the schemes identified in the BCF and operational plans and in Capita's judgement would be the maximum amount of saving available.

Both i5 and Capita have assumed some growth in electives and Capita goes into some detail around the significant shift in elective activity towards daycase.

Neither i5 nor Capita have factored in the cost of the schemes needed in the community or elsewhere to achieve the savings in the Acute sector

Headline figures

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 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

Conclusion

Overall both the i5 and Capita assessments give assurance that the commissioning intentions are focussed in the right areas (Acute care, Older people),and that the level of savings identified in the financial and operational plan are broadly achievable, although at the top end of what is possible.

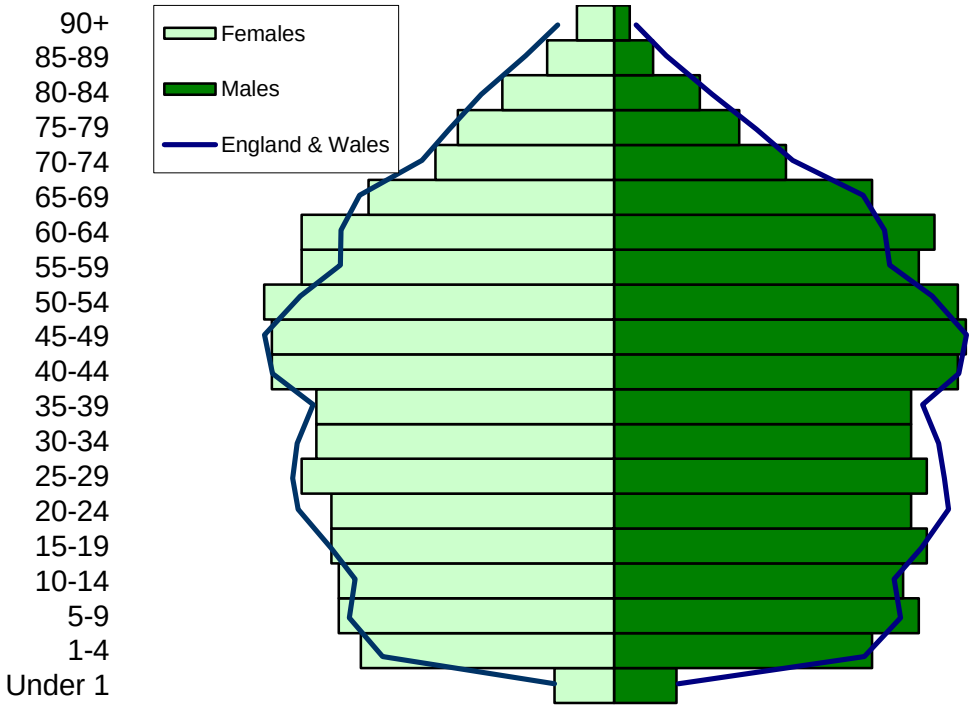
B2.2 Joint Strategic Needs Assessment[35]

The Joint Strategic Needs Assessment (JSNA) provides valuable data on the health and wellbeing of the population of Halton. The data within this document has been used to inform NHS Halton CCG when developing its vision for the next five years and its future commissioning intentions. The full document is available online, however selected data have been reproduced here.

B2.2.1 Demographics

As highlighted in the NHS Call to Action and the NHS mandate an ageing population presents a future pressure to the NHS. Halton is not immune to these pressures, the chart below shows the population profile for Halton for 2012

2012 population profile for Halton.



- **In the short term (2011 - 2014)** Halton's population is projected to grow by 1% from 125,700 to 126,800
- **In the medium term (2011 - 2017)** Halton's population is projected to grow by 2% from 125,700 to 128,000

[35] http://www3.halton.gov.uk/councilanddemocracy/statisticsandcensusinformation/318888/

- **In the long term (2011 - 2021)** Halton's population is projected to grow by 3% from 125,700 to 129,300. This is still lower than the North West region which is projected to grow by 4% and nationally, which is projected to grow by 9%
- **Younger people (0 - 15 year olds)** - population projected to grow by 10% (2011 - 2021)
- **Working age (16 - 64 year olds)** - population projected to decline by 5% (2011 - 2021)
- **Older people (65+)** - population projected to grow by 33% from 18,600 in 2011 to 24,700 in 2021

Following national and regional trends, Halton's population continues to age with older people making up an increasing proportion of the population. The growth in the numbers of older people will increase the demands for both formal and informal support. Small decreases in the working age population mean there are fewer people to provide and pay for this additional support.

Source: Halton JSNA

B2.2.2 Dementia

As highlighted in the NHS mandate, Dementia is one of the areas identified as an area of greatest importance to people.
Halton GP practices currently perform very well in relation to the early identification of people with dementia with an estimated diagnosis rate of 59.5%, this is the 2nd highest in the north west, and 12th highest CCG area nationally (out of 211)

The table below shows how the number of people predicted to have dementia is expected to increase to 2020

People aged 65 and over predicted to have dementia, by age, projected to 2020[36]					
	2012	2014	2016	2018	2020
People aged 65-69	81	92	99	92	90
People aged 70-74	126	137	142	173	189
People aged 75-79	218	223	228	235	252
People aged 80-84	312	312	335	345	359
People aged 85-89	283	283	300	339	361
People aged 90	209	209	209	237	268
Total population aged 65 and over predicted to have dementia	1,229	1,256	1,314	1,421	1,518

[36] Source: POPPI *Table produced on 05/12/13 16:44 from www.poppi.org.uk version 8.0 Figures may not sum due to rounding. Crown copyright 2012*

There is predicted to be a 23.5% increase in the number of people with dementia over the next 7 years, this is an additional 289 older people.

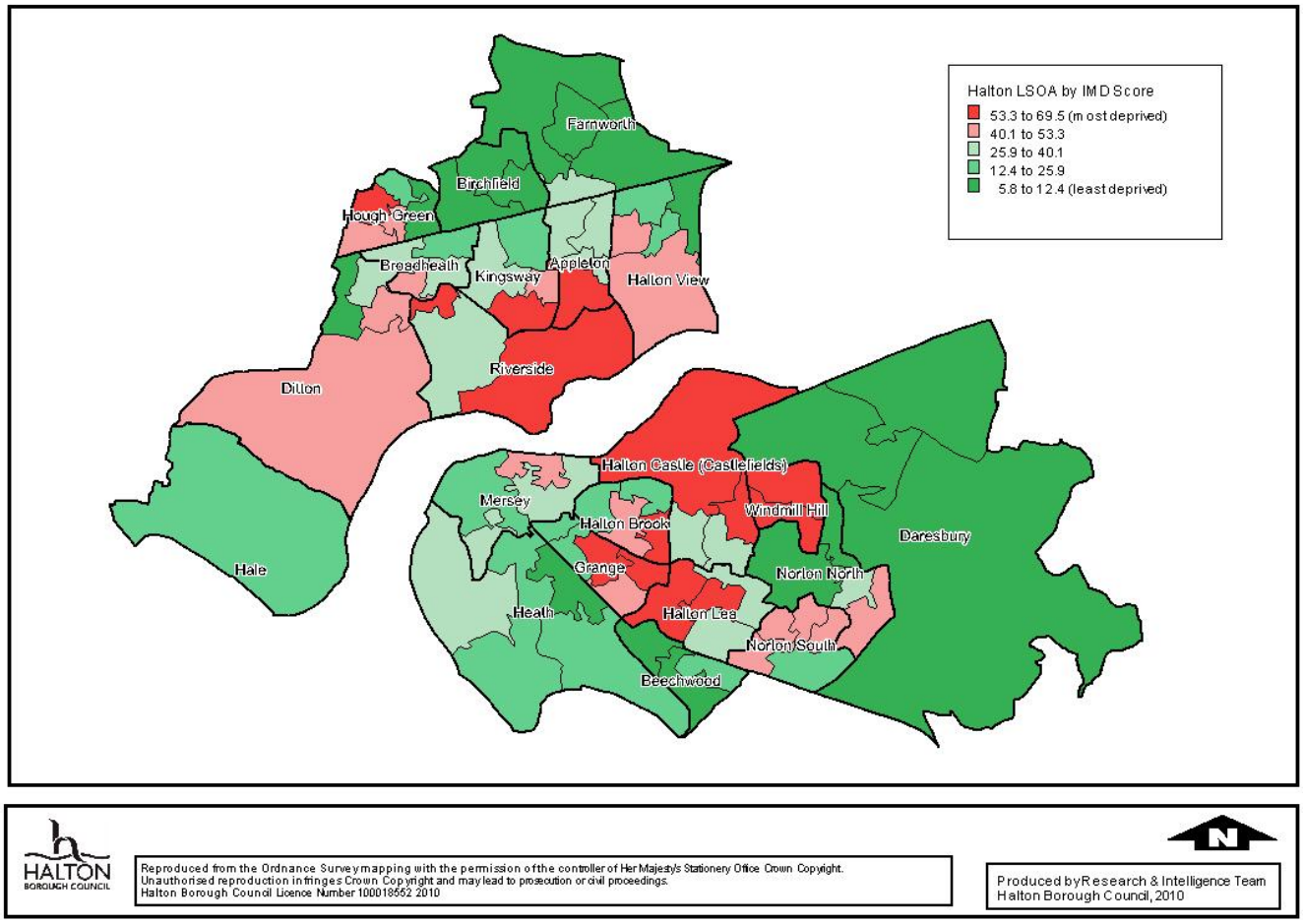
B2.2.3 Deprivation Profile

The JSNA identifies that Halton is a relatively deprived community, deprivation can have a significant impact of the health of communities and one of the areas highlighted as a strategic objective for the CCG over the next five years is to reduce the health impact of these inequalities.

B2.2.4 Index of Multiple Deprivation (IMD) 2010

- Halton is ranked as the 27th most deprived local authority in England (out of 326 local authorities). This is the 3rd worst out of the six local authorities which make up the Liverpool City Region, behind Liverpool and Knowsley.
- The ward with the highest average IMD score in 2010 and therefore the most deprived ward in Halton is Windmill Hill. The least deprived ward in Halton is Birchfield.
- The overall IMD is made up of seven domain measures. Daresbury ward does well across all of these whilst Windmill Hill has some of the highest scores.
- Deprivation scores at small area geography (known as Lower Super Output Areas) shows that the area with the highest deprivation is located in Kingsway ward.
- There are 21 LSOAs in Halton that fall in the top 10% most deprived nationally. Of these, 10 fall in the top 3% most deprived nationally and 2 fall in the top 1%.

Map 1: Overall IMD 2010 score at LSOA level in Halton[37]



Source: Halton JSNA

37 http://www3.halton.gov.uk/lgnl/policyandresources/policyplanningtransportation/researchandintelligence/pdfs/IMD2010report.pdf

B2.3 Health Profile[38]

The health of people in Halton is generally worse than the England average. Deprivation is higher than average and about 7,000 children live in poverty. Life expectancy for both men and women is lower than the England average.

Life expectancy is 11.1 years lower for men and 10.8 years lower for women in the most deprived areas of Halton than in the least deprived areas.

Over the last 10 years, all cause mortality rates have fallen. The early death rate from heart disease and stroke has fallen but is worse than the England average. The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.[39]

●	Significantly worse than England average
●	Not significantly different from England average
●	Significantly better than England average

[38] http://www3.halton.gov.uk/lgnl/policyandresources/318448/318454/HealthProfile2012Halton00ET.pdf

[39] *1 % people in this area living in 20% most deprived areas in England, 2010 2 % children (under 16) in families receiving means-tested benefits & low income, 2010 3 Crude rate per 1,000 households, 2011/12 4 % at Key Stage 4, 2011/12 5 Recorded violence against the person crimes, crude rate per 1,000 population, 2011/12 6 Crude rate per 1,000 population aged16-64, 2012 7 % mothers smoking in pregnancy where status is known, 2011/12 8 % mothers initiating breast feeding where status is known, 2011/12 9 % school children in Year 6 (age 10-11), 2011/12 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population, 2007/08 to 2009/10 (pooled) 11 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2009-2011 12 % adults aged 18 and over, 2011/12 13 % aged 16+ in the resident population, 2008-2009 14 % adults, modelled estimate using Health Survey for England 2006-2008 15 % adults achieving at least 150 mins physical activity per week, 20 12 16 % adults, modelled estimate using Health Survey for England 2006 -2008 17 Directly age standardised rate per 100,000 population, aged under 75, 2008-2010 18 Directly age sex standardised rate per 100,000 population, 201 1/12 19 Directly age sex standardised rate per 100,000 population, 2010/11 20 Estimated users of opiate and/or crack cocaine aged 15-64, crude rate per 1,000 population, 2010/11 21 % people on GP registers with a recorded diagnosis of diabetes 2011/12 22 Crude rate per 100,000 population, 2009-2011 23 Crude rate per 100,000 population, 2012 (chlamydia screening coverage may influence rate) 24 Directly age and sex standardised rate for emergency admissions, per 100,000 population aged 65 and over, 2011/12 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.08-31.07.11 26 At birth, 2009-2011 27 At birth, 2009-2011 28 Rate per 1,000 live births, 2009-2011 29 Directly age standardised rate per 100,000 population aged 35 and over, 2009-2011 30 Directly age standardised rate per 100,000 population aged under 75, 2009-2011 31 Directly age standardised rate per 100,000 population aged under 75, 2009-2011 32 Rate per 100,000 population, 2009-2011*

Halton Clinical Commissioning Group

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	**1** Deprivation	61431	48.9	20.3	83.7		0.0
	2 Proportion of children in poverty	6770	27.3	21.1	45.9		6.2
	3 Statutory homelessness	64	1.3	2.3	9.7		0.0
	4 GCSE achieved (5A*-C inc. Eng & Maths)	808	59.0	59.0	31.9		81.0
	5 Violent crime	1737	14.6	13.6	32.7		4.2
	6 Long term unemployment	1106	13.4	9.5	31.3		1.2
Children's and young people's health	**7** Smoking in pregnancy ‡	335	21.2	13.3	30.0		2.9
	8 Starting breast feeding ‡	812	51.3	74.8	41.8		96.0
	9 Obese Children (Year 6) ‡	242	19.4	19.2	28.5		10.3
	10 Alcohol-specific hospital stays (under 18)	42	153.9	61.8	154.9		12.5
	11 Teenage pregnancy (under 18) ‡	126	51.8	34.0	58.5		11.7
Adults' health and lifestyle	**12** Adults smoking	n/a	23.1	20.0	29.4		8.2
	13 Increasing and higher risk drinking	n/a	22.5	22.3	25.1		15.7
	14 Healthy eating adults	n/a	22.7	28.7	19.3		47.8
	15 Physically active adults	n/a	49.8	56.0	43.8		68.5
	16 Obese adults ‡	n/a	25.9	24.2	30.7		13.9
Disease and poor health	**17** Incidence of malignant melanoma	22	18.4	14.5	28.8		3.2
	18 Hospital stays for self-harm	500	416.4	207.9	542.4		51.2
	19 Hospital stays for alcohol related harm ‡	3739	2834	1895	3276		910
	20 Drug misuse	818	9.8	8.6	26.3		0.8
	21 People diagnosed with diabetes	7108	7.0	5.8	8.4		3.4
	22 New cases of tuberculosis	1	1.1	15.4	137.0		0.0
	23 Acute sexually transmitted infections	988	786	804	3210		162
	24 Hip fracture in 65s and over	141	600	457	621		327
Life expectancy and causes of death	**25** Excess winter deaths ‡	31	8.7	19.1	35.3		-0.4
	26 Life expectancy – male	n/a	76.5	78.9	73.8		83.0
	27 Life expectancy – female	n/a	80.7	82.9	79.3		86.4
	28 Infant deaths	7	4.6	4.3	8.0		1.1
	29 Smoking related deaths	232	277	201	356		122
	30 Early deaths: heart disease and stroke	114	82.4	60.9	113.3		29.2
	31 Early deaths: cancer	197	142.7	108.1	153.2		77.7
	32 Road injuries and deaths	41	32.6	41.9	125.1		13.1

Health Profile summary for Halton 2013

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- No significance can be calculated

Domain	Indicator	Halton compared to England: 2013 profile	Halton improved or worsened since 2012 profile.	Comments on data
Our communities	**1** Deprivation			Across England this figure has become worse.
	2 Children in poverty			Across England this figure has become worse.
	3 Statutory homelessness			2012/13 published data shows number and rate have gone up to 86 people (1.7 per 1,000), from 64 and 1.3 per 1,000 in 2011/12.
	4 GCSE achieved (5A*-C Inc. Eng & Maths)			No updated data available.
	5 Violent crime			No updated data available.
	6 Long term unemployment			England average also worsened.
Children & young people's health	**7** Smoking in pregnancy			-2012/13 published data shows this has reduced from 21.2% in 2011/12 to 18.9%.now at North West average.
	8 Starting breast feeding			-2012/13 published data shows this has increased from 51.3% in 2011/12 to 52.3%.
	9 Obese children (Year 6)			Significant reduction in excess weight.
	10 Alcohol-specific hospital			*Provisional* local data for 2010/11-2012/13 shows rate has

	stays (under 18)			decreased to 72.3 (compared to 153.9 for 2007/08-2009/10 quoted on 2013 profile).
	11 Teenage pregnancy (under 18)	🔴	↓	Significant reduction to North West average of 24 per annum, a local value of 1.5
Adults' health & lifestyle	**12** Adults smoking	🔴	↓	Reduction but this is limited due to the uptake of E cigarettes.
	13 Increasing & higher risk drinking	🟡	↓	Reduction in health profile but actual increase in A&E emergency admissions.
	14 Healthy eating adults	🔴	/	Based on modelled estimates (no update in 2013 profile).
	15 Physically active adults	🔴	/	Indicator criteria changed so cannot compare. No updated data available since 2013 profile.
	16 Obese adults	🟡	/	Based on modelled estimates (no update in 2013 profile).
Disease and poor health	**17** Incidence of malignant melanoma (skin cancer)	🟡	/	No updated data available. Increasing incidence of malignant melanoma means that more people are being identified with melanoma which if it is recognized and treated early, it is almost always curable, but if it is not, the cancer can advance and spread to other parts of the body, where it becomes hard to treat and can be fatal.
	18 Hospital stays for self-harm	🔴	↓	- England average worsened. - 2012/13 *provisional* local data shows rate has decreased to 359 (from 416 in 2011/12).
	19 Hospital stays for alcohol related harm	🔴	↑	-England average also worsened. -2011/12 published data & provisional 2012/13 data shows no change from 2010/11 for Halton.
	20 Drug misuse	🔴	↓	Based on modelled estimates 2010/11. No updated data available.
	21 People diagnosed with diabetes	🔴	↑	-England average also worsened.
	22 New cases of tuberculosis	🟢	↓	Only 1-2 cases per year. No updated data available.
	23 Acute sexually transmitted	🟡	/	Indicator not included on previous profiles. No updated data

	infections			available.
	24 Hip fracture in over-65s			2012/13 p*rovisional* local data shows rate has decreased to 501 (from 600 in 2011/12).
Life expectancy and causes of death	**25** Excess winter deaths			No updated data available.
	26 Life expectancy – male			2010-12 *provisional* local data shows male life expectancy has increased to 77.3 from 76.5 in 2009-11.
	27 Life expectancy – female			2010-12 *provisional* local data shows female life expectancy was 80.6; this is no change from 2009-11.
	28 Infant deaths			2010-12 *provisional* local data shows rate has decrease to 4.1 from 4.6 in 2009-11.
	29 Smoking related deaths			No updated data available
	30 Early deaths: heart disease & stroke			2010-12 *provisional* local data shows the <75 circulatory mortality rate was 82.9; this is no change from 82.4 in 2009-11.
	31 Early deaths: cancer			-Average number of deaths remained same since 2011 profile data; rate decreased (due to population increase). -2010-12 *provisional* local data shows rate has decreased to 137.3; this is slight reduction from 142.7 in 2009-11.
	32 Road injuries and deaths			2010-12 published shows average number of road deaths was 40 per year; this has not changed since 2009-11.

B2.4 Halton Health & Wellbeing Strategy 2012-15

Informed by the Joint Strategic Needs Assessment (JSNA) and in consultation with local residents, strategic partners and other stakeholders, the strategy identified five key priorities to help us to achieve our vision. The five priorities for action are as follows:

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

The Joint Health and Wellbeing Strategy sets the framework for the commissioning of health and wellbeing services in Halton with a particular emphasis on prevention and early intervention. This has been identified as an area of strategic focus for NHS Halton CCG.

B2.5 Halton Borough Council, Communities Directorate, Directorate Plan 2014-17

The Halton Borough Council Communities Directorate Plan identifies its strategic priorities and challenges to 2017. There are several areas where NHS Halton CCG and the communities directorate will be working together to improve the health and wellbeing of the population.
These include;
Health & wellbeing – Loneliness, Falls, Urgent care
Integration – ITF, Care Homes Project, Therapy Services
Dementia
Acute & Related services
Joint Health & social care Learning Disability Self Assessment Framework.
Safeguarding, Dignity & Domestic abuse

B2.6 Better Care Fund – 2014/16

NHS Halton CCG and Halton Borough Council are already working together and moving toward full integration of health and social care for the benefit of the people of Halton to improve outcomes for both patients and people receiving health and social care services.

The Better Care Fund (BCF) plan sets out the shared vision between Halton Borough Council and NHS Halton CCG for health and social care services over the next two years.

The BCF is described as a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and Local Authorities.

In addition to the endorsement of Halton Borough Council's Executive Board and NHS Halton CCG's Governing Body, our approach to integration has the full endorsement of the Health and Wellbeing board.

The Vision identified in the BCF plan and an integral part of NHS Halton CCG's 5 year strategic plan is: To improve the health and wellbeing of Halton people so they live longer, healthier and happier lives.

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

The key components of the plan are:

1) Integrated commissioning

NHS Halton CCG is co-located alongside Halton Borough Council Social Care and Public Health and we have already seen the positive impact this has had on breaking down organisational, professional and cultural barriers. Halton's approach to urgent care, via the establishment of the urgent care partnership board, demonstrates the shared commitment to improving outcomes for service users/patients and their carers whilst making the most efficient use of public resources.

2) Working to reduce health inequalities (taking a life course approach)

Health inequalities in Halton are reducing and there have been significant improvements in rate of CVD, Smoking prevalence, Child obesity and COPD. However, challenges remain if we are to close the gap between Halton and the national average. Integrated senior management teams, commissioning meetings and planning meetings with staff from a range of backgrounds ensures a joined up approach to improving health inequalities.
Halton's Health and wellbeing service brings together the Health Improvement Team, the wellbeing GP Practices Team and the Adult Social care early intervention and Prevention team. This is a new approach that combines and aligns expertise from Public Health, Primary Care and Adult Social Care.

3) Supporting Independence

There are a range of integrated services which focus on promoting recovery from illness, preventing unnecessary hospital admissions or premature admissions to residential care, supporting timely discharge from hospital and maximising opportunities for independent living.

4) Care closer to home

There are a number of services which have been redesigned to support care closer to home, including; The reconfiguration of Both Adult Social care and Community nursing teams to align the teams around the local GP communities; The Community Multi-disciplinary Teams project; Integrated care home support teams and the Integrated Safeguarding unit.

B2.7 Public Consultation

NHS Halton CCG has already established a strong reputation as an organisation that engages with and listens to local people. In a series of public events we developed our draft commissioning intentions with patients, the public, providers, voluntary groups and employees in order to shape our plans

NHS Halton CCG takes very seriously its duty to involve patients and the public in its decision making and will continue to engage people going forward. We also recognise that there is considerable scope to increase our collaboration with patients, the public and the voluntary sector, and will continue to expand engagement activities.

B2.8 Provider and Clinical Consultation

Following production of draft list of commissioning intentions a series of events took place with participation from providers, clinicians and the Health & Wellbeing board to develop the vision, priorities for the health economy over the next five years and what services need to be commissioned over the next five years to achieve the desired outcomes.

B2.9 Halton Borough Council Public Health Commissioning Intentions 2014/15[40]

NHS Halton CCG has effective working relationships with Public Health. NHS Halton CCG plans have been developed alongside public Health commissioning intentions, the links between the plans is evident in the commissioning intentions in the NHS Halton CCG plan where public health have been identified as a partner, and likewise in the Public Health commissioning intentions where the CCG has been identified as a partner around areas of school age health, health checks, health improvement service and healthy eating services. CBT, Smoking cessation, alcohol and drug strategy.

[40] Halton Borough Council Public Health Commissioning Operational Work Plan 2014-15 Version 2 22nd January 2014

B3 Principles of effective commissioning

In addition the national and local drivers referenced above, this 5 year strategy is guided and shaped by the following principles of effective commissioning.

Right patient	In order for patients to receive optimum care, they need to be assessed and referred appropriately.
Right provider	Ensuring patients are referred to the most appropriate provider will support achievement of 18 weeks as well as the most effective use of resources.
Right treatment	The national service specification compliance process, together with the implementation of national clinical policies, will ensure that only the most effective treatments are commissioned from compliant providers, supported by outcome based evidence.
Right place	Patients should receive their treatment in the optimum care setting. This means that patients should receive care within designated centres that meet clinical standards, and that delayed admission and discharge into and out of specialised care should be considered a priority for action.
Right time	This recognises the importance of early referral and prompt treatment, with a particular emphasis on compliance with national waiting times and delayed discharges.
Right price	The development of local and national tariffs that represent best value for money whilst ensuring appropriate levels of reimbursement is fundamentally important.

Appendix C – High Impact Interventions

Using the 'Anytown Health System' NHS Tool NHS Halton CCG identified where schemes developed as commissioning intentions for the next two years were also identified as schemes with a high impact. This provided assurance that the schemes developed were foccussed in the correct areas and also provided a prioritisation tool should this be needed.

The high impact interventions (HIIs)

1 Early diagnosis
Early detection and diagnosis to improve survival rates and lower overall treatment costs
PC141505 – Review pathway around cancer presentations. This will look at the evidence across all pathways, and will include examining the evidence to introduce a targeted screening programme to increase early detection rates of lung cancer.
PC141508 – Review access to lifestyles services for patients with cancer, for example breast cancer weight loss and exercise programme
PC141512 – Review the cardiology direct access service

2 Reducing variability within primary care by optimising medicines use and referring
Reducing unwanted variation in primary care referring and prescribing
ADD141511 – Reduce variation in prescribing between practices
PCI141506 – A strategy for sustainable general practice services in Halton.

3 Self-management: Patient-carer communities
Self-management programme for those suffering with a long-term condition
PC141501 – Develop a respiratory strategy for Halton to include the possibility of using technology to manage sleep apnoea in the community, and considering whether weight management is part of the pathway.
PC141514 – Review the scope of the community diabetes provision
PCI141501 – Strengthen the GP's role at the heart of out of hospital care and supporting people to stay healthy
PCI141505 – To support GP practices and other providers where appropriate to deliver services over and above their core contractual responsibilities.

4 Telehealth/Telecare
Health apps, Telehealth and Telecare equipment which help people to manage their own long term conditions in conjunction with their clinicians, introduced to empower people whilst at the same time ensure that their own actions remain embedded in the care they receive from the NHS
PC141501 - Develop a respiratory strategy for Halton to include the possibility of using technology to manage sleep apnoea in the community,
PCI141510 – Develop an integrated Health and Social Care IM&T strategy to include the use of Telehealth and telemedicine to improve patient care.

5 Case management and coordinated care
Multi-disciplinary case management for the frail elderly and those suffering with a long-term condition
PCI141501 - Strengthen the GP's role at the heart of out of hospital care and supporting people to stay healthy by identifying people at risk of hospital admission including the introduction of a named accountable clinician
PCI141503 – Review the design of community services to focus on outcome based services
PCI141505 - To support GP practices and other providers where appropriate to deliver services over and above their core contractual responsibilities.

6 Mental Health – Rapid Assessment Interface and Discharge (RAID)
Psychiatric liaison services that provide mental health care to people being treated for physical health conditions
MHUC141502 – Review the AED liaison psychiatry model across Mid Mersey CCG's

7 Dementia pathway
Fully integrated network model to improve health outcomes and achieve efficiencies in dementia care
MHUC141515 – Care Home Liaison Service – To establish a single supplementary specialist service for dementia patients.

8 Palliative care
Community based, consultant-led palliative care service
WCF141510 – Evaluate the Mersey QIPP pilot for children's community nursing service. Including evaluation and on-going funding for end of life care for children.

Appendix D –Statistical Terminology

Quintile – The performance of a group of CCGs can be grouped together into 'qunitiles' these are 1/5ths, where the best 1/5th of performers are grouped together, followed by the next best 1/5th and so on. Performance is often judged on where a CCG sits within these quintiles.

Quartile – As per quintile but CCG's are grouped into 1/4 qtrs. This may be done where there are not enough CCG's to put into quintiles.

Confidence Interval – This is used where a performance indicator is based on a sample of population. This is most commonly found in surveys. The Confidence Interval is the range of values (often referred to as the upper and lower confidence interval) where the 'true' value is most likely to be if the whole population were surveyed.

Median – The 'average' value can be calculated in one of three ways, the 'Mean', 'Median' or 'Mode'. The most commonly used average is the 'Mean' and where a graph or table refers to the average it is usually the 'mean'

Mean – all values added together and divided by the number of values, for example, 5+10+25 = 40 the mean is 40/3 = 13.33

Median – this is the middle value of a set of data if the data were arranged in order, this is often used where one or two outling data values could potentially skew the data, for example

5+10+11+12+13+14+500 The median value would be 12

Mode – This is the most common number that appears in a data set, for example,

5+6+6+6+8+9+9+50 The Mode would be 6

GLOSSARY

A&E – Accident & Emergency

ADHD – Attention Deficit Hyperactivity Disorder

AED – Accident & Emergency Department

APMS – Alternative Provider Medical Services

BCF – Better Care Fund

CAMHS – Child and Adolescent Mental Health Services

CCG – Clinical Commissioning Group

CHC – Continuing Health Care

COPD – Chronic Obstructive Pulmonary Disease

CPN – Commniity Psychiatric Nurse

CQUINS – Commissioning for Quality and Innovation

CVD – Cardiovascular Disease

EDS – Equality Delivery System

EPACC – Electronic Palliative Care Co-ordination System

EQ5D – EuroQol 5 Dimension

FCE – Finished Consultant Episode

G&A – General & Acute

GP – General Practice

HBC – Halton Borough Council

HCAI – Health Care Associated Infection

HSCIC – Health & Social Care Informaiton Centre

HSMR – Hospital Standardised Mortality Ratio

IAPT – Improving Access to Psychological Therapies

JSNA – Joint Strategic Needs Assessment

LES –Local Enhanced Services

MDT – Multi-Disciplinary Team

MRSA - Methicillin-resistant Staphylococcus aureus

NHS – National Health Service

NWAS – North West Ambulance Service

NWCAHSN – North West Coast Academic Health Science Network

ONS – Office for National Statistics

PbR – Payment by Results

PES – Paramedic Emergency Service

PMS – Personal Medical Service

PTS – Patient Transport Service

PYLL – Potential Years Life Lost

QIPP - Quality, Innovation, Productivity and Prevention

RCA – Running Cost Allowance

RTT – Referral To Treatment

SHMI - Summary Hospital-level Mortality Indicator

SUI – Serious Untoward Incident

TIA - Transient Ischaemic Attack

VfM – Value for Money

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REPORT TO:	Health and Wellbeing Board
DATE:	17th September 2014
REPORTING OFFICER:	Director of Public Health
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Addressing Premature Mortality in Halton - Presentation
WARDS:	Borough wide

1.0 PURPOSE OF THE REPORT

1.1 A presentation will be given to the Board from Professor Chris Bentley from HINST associates. The presentation will look at how the Health and Wellbeing Board can implement practical interventions in order to reduce health inequalities locally, with a view to improving health and wellbeing and reducing premature mortality.

1.2 Chris is a public health specialist, who has also held the position of Director of Public Health. In 2006, following success in reducing health inequalities in his area, Chris was asked to head up the Health Inequalities National Support Team which supported Local Strategic Partnerships in the 80 most deprived Local Authorities in England with the poorest health. Halton was one of the areas that received this support.

2.0 RECOMMENDATION: That the Board note the contents of the report and presentation

REPORT TO:	Health & Wellbeing Board
DATE:	17th September 2014
REPORTING OFFICER:	Chief Officer, NHS Halton Clinical Commissioning Group
PORTFOLIO:	Health & Wellbeing
SUBJECT:	Developing a strategy for General Practice services in Halton
WARDS:	Borough Wide

1.0 PURPOSE OF THE REPORT

To inform the Health & Wellbeing Board of the programme to develop a strategy for general practice services in Halton.

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

3.0 SUPPORTING INFORMATION

General practice is often described as the cornerstone of the NHS, with roughly one million people visiting their general practice every day. NHS England is responsible for commissioning the core primary medical services that general practice provides. Clinical Commissioning Groups (CCGs) have a duty to support NHS England in promoting quality in general practice services.

The basic delivery model of general practice has evolved over time but not radically changed. There have been seismic shifts and environmental pressures in health and social care in recent years that have challenged the sustainability of general practice. General practice faces challenges from:

- An ageing population, growing co-morbidities and increasing patient expectations.
- Increasing pressure on NHS financial resources and increased regulation.
- Persistent inequalities in access and quality of general practice.
- Growing reports of workforce pressures, including recruitment and retention problems.
- Political pressure to change.

NHS Halton CCG and NHS England are discussing the development of formalised co-commissioning arrangements for general practice services in the borough, following an expression of interest process. This means

that NHS England may, over the next few months, be delegating more responsibility for the commissioning of general practice services in the borough to NHS Halton CCG. NHS Halton CCG and NHS England agree that strong sustainable general practice is needed in Halton to support commissioning *and* service provision. This needs a co-ordinated and engaged approach to deliver this, which is why NHS Halton CCG is supporting the development of a co-commissioning strategy for general practice services in Halton.

4.0 POLICY IMPLICATIONS

NHS England has stated their ambition for general practice services to operate at greater scale and be at the heart of a wider system of integrated out-of-hospital care. This will require a shift of resources from acute to out-of-hospital care. These ambitions are congruent with NHS Halton CCG's 2 Year Operational Plan and 5 Year Strategy and also with the Better Care Fund delivery plan developed with Halton Borough Council. NHS Halton CCG, engaging with NHS England, local practices and other partners is developing a co-commissioning strategy to meet these ambitions by focusing transformational activity in six areas:

- Improved access and resilience.
- Integrated care.
- New services in the community.
- Community development.
- Quality improvement.
- Enabling work streams (i.e. governance, finance, estate, contracting, information technology and workforce).

The presentation that accompanies this paper provides more information on the approach and rationale behind the programme to develop this strategy.

5.0 OTHER IMPLICATIONS

The strategy will impact on how general practice services in the borough are commissioned and delivered.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children and Young People in Halton

Children and young people will benefit from transformed general practice services.

6.2 Employment, Learning and Skills in Halton

None as a result of this report.

6.3 A Healthy Halton

A coherent strategy for general practice services in Halton, with an associated implementation and evaluation plan, will contribute to improving the health of the borough and reducing inequalities.

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 programme is collating a risk register as it progresses. A lack of engagement in the programme by practices and other partners is a potential risk, which is being mitigated by dedicated management resource.

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

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REPORT TO: Health and Wellbeing Board

DATE: 17 September 2014

REPORTING OFFICER: Director of Public Health.

PORTFOLIO: Health and Wellbeing

SUBJECT: Pharmaceutical Needs Assessment

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To provide members of the Board with a draft Pharmaceutical Needs Assessment (PNA) and briefing on the statutory 60-day consultation process.

2.0 RECOMMENDATION: That

1. **the Board approve the draft PNA, including the findings detailed in it; and**
2. **the Board approve the commencement of the 60-day statutory consultation in line with the process detailed in this report.**

3.0 SUPPORTING INFORMATION

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

3.2 Background to the PNA

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

At the 17 July 2013 HWB meeting, the Board authorised the

establishment of a local steering group to oversee the development of its first PNA.

In agreement with NHS England, a common framework had been developed (led by Public Health, Halton Borough Council) for PNAs across Merseyside. This is in line with Regulation 4 and Schedule 1 of the 2013 Regulations outlining the minimum requirements for PNAs. Work has been underway since the steering group was established to populate this template.

The PNA is split into sections which outline:

- The scope and methodology of the PNA including consultations
- The national Pharmaceutical Services Contract
- an overview of current providers of pharmaceutical services
- Pharmacy Premises, their locations and opening hours, access and prescribing, including cross-border provision
- Population and Health Profile
- Pharmacy activity against a range of local priorities

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

3.3 **Developing the draft PNA**

The steering group was established following the HWB authorisation in July 2013. It has met at regular intervals since then, taking into account the need to progress certain elements of the PNA as well as keep members informed of progress. The steering group is chaired by a Consultant in Public Health and consists of representatives from:

- Local Authority Public Health team,
- NHS England area team,
- Clinical Commissioning Group,
- Local pharmaceutical committee (LPC),
- Healthwatch,
- Halton & St Helens Council for Voluntary Services
- an elected representative from the HWB.

This group has overseen and supported the development of the

PNA. A Task & Finish group has also met in between steering group meetings to ensure tasks identified by the steering group are being progressed and to troubleshoot any difficulties in a timely fashion.

3.4 **Pharmacy and Public Surveys**

In addition to the statutory 60-day consultation (detiled below item 3.5), the steering group carried out a questionnaire to all pharmacies to gather up-to-date information on the services they provide. It also conducted a public survey to gain local people's views on their local pharmacy. Nearly 100 local people responded to this survey during a 4 week period. The information obtained from both the pharmacy and public surveys have been used to populate and inform the PNA.

3.5 **Findings of the PNA**

The PNA includes a series of statements outlining adequacy of provision. These are shown as key findings in the executive summary. They are duplicated at the beginning of the main document and at the end of each relevant section (as boxed conclusions). Summarised below, overall there is adequate provision to pharmacies and the majority of services they provide:

- Access to pharmacies is considered to be adequate across the borough, in both Widnes and Runcorn.
- There is variation in population-to-pharmacy ratios and this needs to be carefully monitored to determine the impact any closures may have
- There is a great deal of public satisfaction with pharmacy services, although the main comments received relted to opening hours, especially lunch-time closures and evening ie post-6pm access.
- There is adequate provision of smoking cessation services
- There are currently no services in pharmacies to reduce alcohol consumption and limited evidence of effectiveness. This will be kept under review.
- There is adequate access to Medicines Use Reviews
- There are opportunities to use signposting and the 6 health promotion campaigns (part of the essential services national contract) to increase public awareness of the early signs of depression, cancer prevention and screening and the management of long-term conditions.
- Acces to Care at the Chemist is partially adequate the CCG is already reviewing this service.
- There is adequate provision of Emergency Hormonal Contraction
- There is adequate provision of substance missue services, both Needle & Syringe Exchange and supervised

consumption

- There is adequate provisoon of palliative care services. However this service is being reviewed and this assessment may change as a result of this.

3.6 **Statutory 60-day consultation**

The Regulations set out that:

• HWBs must consult the bodies set out in Regulation 8 at least once during the process of developing the PNA. Any neighbouring HWBs who are consulted should ensure any LRC in the area which is different from the LRC for the original HWB's area is consulted;
• there is a minimum period of 60 days for consultation responses; and
• those being consulted can be directed to a website address containing the draft PNA but can, if they request, be sent an electronic or hard copy version.

Regulation 8(1) states that the HWB must consult the following list as a minimum during the development of the PNA
(a) Local Pharmaceutical Committee(s) for its area;
(b) Local Medical Committee(s) for its area;
(c) all pharmacy contractors and any dispensing doctors for its area;
(d) any LPS chemist in its area with whom the NHS England has made arrangements for the provision of any local pharmaceutical services;
(e) Local Healthwatch organisation for its area, and any other patient, consumer or community group in its area which in the opinion of HWB has an interest in the provision of pharmaceutical services in its area;
(f) NHS trusts or NHS foundation trusts in its area;
(g) NHS England
(h) neighbouring HWB.

3.7 **Proposed arrangements for the 60-day consultation**

A standard letter has been developed to invite all consultees to consider the draft PNA and inform them of the opening of the 60-day consultation period. A set of questions has also been developed to assist those wishing to respond. It also gives each individual pharmacy contractor the opportunity to check the opening times and services the PNA lists for them and make any amends.

It is proposed that the letter will be sent out electronically following the HWB decision that the draft can be issued for consultation. The PNA together with the survey will be available on Halton Borough Council's website with the weblink included in the letter. The survey will also be sent out with the letter for those who wish to work off a

separate document or send a paper response in. The letter includes the closing date for the consultation and all responses must be with Halton Borough Council by the end of this date.

3.8 **Resources**

The Halton Borough Council Customer Intelligence team ran the public survey on behalf of the steering group. It has been agreed that they will also set up the 60-day consultation survey and supply the steering group with all results following the closing date. The consultation will therefore be conducted electronically to minimise costs and the impact on the environment. The letter includes details of how people can obtain a paper copy of the PNA and the timeframe within which this will be provided to them (within 14 days maximum).

The steering group will meet shortly after the closure of the 60-day consultation period to consider the responses and any amends to the PNA as a result of them. It will analyse the results and develop a set of responses to each 'free-text' comment made. These will be included in the final PNA.

3.9 **Proposed next steps**

- Board note the findings of the PNA
- Board approve the draft PNA for consultation
- PNA and survey is made available on Halton Borough Council website
- 60-day consultation letter is sent to all consultees electronically
- Queries and requests for paper copies of the PNA are managed by the Public health team
- Customer Intelligence Unit sends all responses to the PNA steering group once the consultation period closes
- The steering group prepares a set of responses and makes the necessary amends to the draft PNA (liaising with relevant commissioners/organisations are necessary)
- The steering group submits the final PNA to the January 2015 HWB meeting.

4.0 **POLICY IMPLICATIONS**

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

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

PNA into account when making decisions around the need for pharmaceutical services.

5.0 OTHER/FINANCIAL IMPLICATIONS

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

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

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

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

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

A Safer Halton
Not applicable

6.4

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

7.0 RISK ANALYSIS

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

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

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

8.0 EQUALITY AND DIVERSITY ISSUES

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

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

None within the meaning of the Act.

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Halton Health and Well Being Board

Pharmaceutical Needs Assessment

2015- 2018

Draft for consultation

Foreword

Halton Local Authority's Health and Well Being Board has responsibility for the on-going review, development and publication of the Pharmaceutical Needs Assessment (a responsibility transferred to it from the now abolished Halton & St Helens Primary Care Trust).

This is a statutory document, by virtue of the National Health Services (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. Its content has to be taken into account by those responsible for the approval of pharmacy contract applications (at NHS England) as well as those commissioning all other health services for our local population. From a Primary Care perspective this includes Clinical Commissioning Groups and Local Authorities looking to commission and develop local services from Pharmacy Contractors, General Practice, Dental and Optometry.

As such we are very happy to present our first formal Pharmaceutical Needs Assessment 2015 –2018 which outlines the Pharmaceutical Services available to our population. This document provides information around current enhanced services being commissioned and proposals for future changes and developments.

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

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

Signed

Chief Executive

Halton Borough Council

Chair

Halton Health and Well Being Board

Version Control

Editor: Sharon McAteer along with members of the PNA Working Group

Issue Date: April 2015

Review Date: Annual review with Supplementary Statements as necessary with a formal review by April 2018

Version	Summary of Changes	Date of Issue
2011 PNA	First formally approved PNA for Halton & St Helens PCT	1st February 2011
	Supplementary Statement	November 2012
2015 PNA	Paper to Halton Health and Wellbeing Board on PNA and to seek approval to set up PNA steering group	July 2013
	Framework developed across Merseyside	September 2013
	Draft 2 presented to the PNA working group	June 2014
	Draft 3 presented to the PNA steering group	July 2014
	Halton Health and Well Being Board's draft PNA for consultation	September 2014
	Final draft presented to the PNA steering group	January 2015
	Completed version to Halton Health and Well Being Board	February 2015
	Published PNA	1 April 2015

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Bertha Brown	**Chief Officer, Local Pharmaceutical Committee (Knowsley, Halton and St Helens)**
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Cllr Marie Wright	**Elected member, Portfolio Holder Health & Wellbeing**
James Watson	**Public Health Intelligence Officer**
Diane Lloyd	**Public Health Programme Support Officer**

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Executive Summary

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

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

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

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

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

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

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

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

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

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

Process undertaken to develop the PNA

Key principles of the PNA are:

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

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

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

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

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

[i]. NHS Employers (2009) *Developing Pharmaceutical Needs Assessments: A practical guide*

[ii]. NHS Employers (2009) *Pharmaceutical Needs Assessments (PNAs) as part of world class commissioning Guidance for primary care trusts*

[iii] NICE stands for National Institute for Health & Clinical Evidence. They produce best practice guidance based on evidence of effectiveness and cost effectiveness.

Patient and Public Involvement

During May 2014 we asked the people of Halton for their experiences of using pharmacy services and their views on how services might be improved. We wanted to know this because:

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

Nearly 100 people filled in the questionnaire. Feedback from this has been incorporated in to the report.

60-day consultation

The consultation of the PNA is part of the involvement strategy. A formal 60-day consultation is required for the development of the PNA. This began on Monday 22 September 2014 and closed at the end of business Monday 24 November 2014. It was distributed widely to local authorities, neighbouring HWBs, acute trusts, local strategic partnerships, Local Pharmaceutical Committee (LPC), Local Medical Committee (LMC) and to Equity Target Groups and community & voluntary sector groups throughout the borough. Comments have been collated and a separate consultation response paper written, published alongside the PNA. Each comment was assessed by the steering group and amendments required as a result of them made to the final PNA.

Developments which may precipitate the need for changes to pharmacy services

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

Workload and demand in pharmacy is driven by two factors:

- Population growth and changing structure, which in Halton is predicted to be around 3% by 2021 (2012 Office of National Statistics mid-year population estimates). This is lower than the North West region which is projected to grow by 4% and nationally, which is projected to grow by 9%
- The change in population is not evenly distributed between the age groups; the 65+ population is estimated to see an increase of 33% over the 10 year period (6,100 more persons in age band). The 0-15 population is also estimated to increase by 10% over the same period. The 15-65 population will decrease by 5%. As a heavy user of health and social care, this 'aging' of the population is especially important
- Nationally for 2013[1], 1,030.1 million prescription items were dispensed overall, a 3.0% increase (29.6 million items) on the previous year and a 58.5% increase (380.4 million

items) on 2003. The average number of prescription items per head of the population in 2013 is 19.1, compared to 18.7 items in the previous year and 13.0 in 2003

- The total net ingredient cost of prescriptions dispensed rose for the first time in three years (1.2% rise (£102 million)) to £8.6 billion. In 2003 the total cost was £7.5 billion. The average cost per head of the population has fallen to £160.18, from a peak of £169.13 in 2010. In 2003 the average cost per head was £150.61. The average net ingredient cost per prescription item has fallen from £8.52 in 2012 to £8.37 in 2013. In 2003 this figure was £11.56

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

Key Findings

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

Focus on **advanced services** specifically:

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

Develop **local services** commissioning:

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

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

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

Topic Specific Conclusions

Access to pharmacies

- Overall access is considered to be adequate
- Compared to the national average, Halton has a higher pharmacy: population ratio than the national average
- However, there is wide variation in the pharmacy–to-population ratio across wards, even taking town centre locations in to account. Any decisions regarding new pharmacies need to take the population-to-pharmacy ratio in to account. Conversely, any closures need to be carefully monitored to determine the impact this will have on access, especially, in those wards where the level of pharmacy provision is already low
- There is a great deal of satisfaction with pharmacy services. Overall, members of the public find them accessible, friendly and helpful
- Members of the public commented that it is not always easy to access pharmacy services in the evening, i.e. after 6pm, and weekends
- The patient survey revealed that patients would like the option of getting hospital discharge and outpatient prescriptions filled at their local pharmacy

Tobacco Control

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

Alcohol

- Pharmacies do not currently provide services to reduce alcohol consumption. Evidence of effectiveness for pharmacies role in conducting screening for unsafe levels of alcohol consumption and offering brief interventions is limited. Any exploration of this role as part of the alcohol strategy needs to keep abreast of new research
- Under the essential services contract pharmacies should support six health education campaigns per year. Community pharmacies are well placed to take part on local and national campaigns around alcohol misuse. As a local JHWBS priority this should be considered

Planned care

- There is generally good access to both NMS and MURs across the borough
- Monitoring the targeting of MURs in line with nationally defined target groups is important as well as consideration of which other patients would most benefit

from them. Intelligence from patient groups, pharmacy contractors and GPs should be used to help identifying and address barriers to uptake of MURs

Unplanned/urgent care

- There is currently partially adequate access to Care at the Chemist (CATC), including 100-hour evening and weekend provision. Increasing provision across the borough is already being investigated for 2014/15. The formulary and protocols in use are also being reviewed in full
- Cross-border collaboration between boroughs (Liverpool, St Helens and Knowsley) has increased both access and choice
- Ways of improving awareness of CATC amongst key target groups should be investigated and once the full review is complete a re-launch of the service will be undertaken
- Influenza vaccination uptake needs to improve, especially for at risk groups under age 65, and Public Health England (PHE) are putting plans into place to do this. This will include commissioning pharmacies to provide NHS free vaccinations. This will be done on a restricted trial basis of one year during the 2014/15 'flu season' with the potential to extend, depending on trial outcomes

Managing and identifying long term conditions, including NHS Health Checks

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

Cancers

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

Sexual Health: Emergency Hormonal Contraception (EHC)

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

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Older people

- As part of the borough plans for influenza vaccinations, community pharmacies could have a role to play. Training where necessary and systems for data collection and reporting would need to be implemented

Palliative Care

- This service provides convenient access and can only be provided by community pharmacy
- This service is primarily designed to provide access to infrequent and unpredictably required specialist drugs
- There is currently no evidence to suggest that more provision is required. There is evidence to suggest that the geographical spread and formulary needs to be reviewed – this is already underway 2014-15. Hence provision is adequate as it stands at the moment but following a review this may change

MAIN DOCUMENT

Key Findings

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

The PNA addresses the following broad questions:

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

The provision of pharmacy services within Halton is considered adequate, to meet the needs of the population. This assessment is based on the following observations:

- Halton has an average of 26 pharmacies per 100,000 population. This compares to 21 per 100,000 for England as a whole and 24 per 100,000 across the North West
- It is possible to compare prescribing volume by converting total items prescribed in to a monthly prescribing rate per 1,000 population. In 2013/14 Halton CCG had a higher prescribing rate than England and Cheshire & Merseyside but was lower than the North West average
- The wide spread availability of premises with consultation facilities in Halton means that our population has adequate access to such facilities. However, there are some areas where access is poor
- There is fair access to pharmacy services throughout the week, into the evening and at weekends across Halton. This takes into account needs in both Widnes and Runcorn. Where any specific service level gaps exist these will be addressed initially through dialogue with existing, specific contractors. Our existing network provides a comprehensive essential pharmaceutical service to our population
- There is adequate provision of locally commissioned services across our population. We will continue to work with our existing contractors to ensure that this provision continues to match the needs of our population and that any inequalities in activity are minimised
- Feedback and information provided by patients, the public and other stakeholders consulted during the development of the needs assessment

Developments which may precipitate the need for changes to pharmacy services

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

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

- Population growth and changing structure, which in Halton is predicted to be around 3% by 2021 (2012 ONS mid-year population estimates). This is lower than the North West region which is projected to grow by 4% and nationally, which is projected to grow by 9%
- The change in population is not evenly distributed between the age groups; the 65+ population is estimated to see an increase of 33% over the 10 year period (6,100 more persons in age band). The 0-15 population is also estimated to increase by 10% over the same period. The 15-65 population will decrease by 5%. As a heavy user of health and social care, this 'aging' of the population is especially important.
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The combined effects of population change and prescribing growth have a compounding effect on the workload of pharmacy. Halton pharmacies currently dispense more prescription items than the average for England. It is expected that growth in the future will continue as at a similar rate. Prescription volumes and service provision needs to be monitored to identify where demand is likely to exceed supply. Planned developments with our partners must also be monitored to ensure we continue to be able to respond to the needs of our population for pharmacy services.

Optimising pharmacy services

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

Table 1: Summary assessment of services including gaps in provision

Service	Community Pharmacy only?	Current provision adequate	Other providers	Comments
Minor Ailments -Care at the Chemist	Yes	Partially adequate	GP, walk in centre, A&E	Review of formulary and protocols already underway. Increase in provision also already in progress
Stop smoking	No	Yes	GP and specialist service	
Supervised admin	Yes	Yes	CRI	
Needle and syringe provision	No	Yes	CRI	
Medicines Use review	Yes	Yes		
Emergency Hormonal Contraceptives	No	Yes	GP, walk-in centres, community sexual health	Gaps in pharmacy provision in areas with high teenage pregnancy but community healthcare provision
On Demand Availability of Palliative Care Medicines	Yes	Yes	GP out of hours service	Review of sites and formulary already underway
Pharmacy essential service including dispensing	Yes	Yes		

Table 2: Summary gaps in pharmacy service provision against JSNA& JHWBS priorities

JHWBS* and JSNA priority	Potential pharmaceutical service	Community Pharmacy only?
Alcohol*	Advice, campaigns and signposting	No
Cancers*	Advice, campaigns and signposting	No
Mental Health*	Advice, campaigns and signposting	No
Unplanned care	Influenza vaccination for at risk groups	No
Older people	Influenza vaccination; advice and campaigns e.g. falls prevention*	No
Health checks	Referrals and campaigns to increase uptake of Health checks	No

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1. Introduction and Purpose

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

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

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

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

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

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

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

See appendix 1 for policy context

2. Scope and Methodology

2.1. Scope of the PNA

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

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

2.2. Methodology and Data Analysis

Key principles of the PNA are:

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

Figure 1: PNA development process

Development of the Halton Local Authority Health and Well Being Boards PNA has been initiated and overseen by the Director of Public Health and a multi-professional steering group. The steering group consists of representatives from the following:

- Public Health (chair and officers)
- Community Pharmacy Professional Lead from NHS England Merseyside area team
- Clinical Commissioning Group (CCG)
- Local Pharmaceutical Committee
- Healthwatch
- Voluntary Sector
- Elected member

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

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

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

- Joint Strategic Needs Assessment
- Joint Health & Wellbeing Strategy
- Census data
- Data on socio-economic circumstances of the local area
- Public pharmacy services questionnaire
- Core Strategy, Strategic Housing Land Assessment 2012, Housing Strategy Evidence Paper 2013

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

2.3 Consultation

A draft Pharmaceutical Needs Assessment was published on Monday 22 September 2014 inviting comments to be made prior to the closing date of the consultation period on Monday 24 November.

The draft document was distributed as follows:-

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

- GP's and other Primary Care Staff

- Community Pharmacies
- Social Services
- Community Health Service Providers
- Mental Health Trust
- Local Hospital Trusts
- Local Pharmaceutical Committee
- Local Medical Committee
- Neighbouring Local Authorities HWBs: St Helens, Warrington, Liverpool, Knowsley, Cheshire East, Cheshire West & Chester
- Local Hospices
- Public Health Staff
- NHS England
- CCG

Patients and Public

- Healthwatch
- Voluntary Sector Groups
- Patient Participation Groups in Primary Care

Other Methods

- Press release to local Newspapers

Website and Use of Survey Monkey

Full documentation was published on Halton Borough Council's website on Monday 22 September 2014 with a Survey Monkey facility to help readers make comments on the PNA. Respondents were offered paper copies of the PNA if required and they could also complete the survey using a copy of the questions supplied with the invitation letter. Written comments could therefore be made via Survey Monkey, completion of the questionnaire electronically or print version sent back to the Public Health team.

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

2.4. PNA Review Process

The PNA will be refreshed as an integrated part of the annual commissioning cycle as well as when any changes to the pharmacy contractor list occurs. This action will be overseen by Halton Health and Well Being Board with input from the NHS England Pharmacy Contracts Group (PCG). As a minimum the document will be checked and updated with significant changes in the following areas, once every year:

- New pharmacy contracts
- Pharmacy closures
- Changes to pharmacy locations
- Pharmacy opening hours
- Local intelligence and significant issues relating to pharmacy enhanced service provision

- Appliance provision changes
- Significant changes in Public Health intelligence or primary care service developments that may impact either complimentary or adversely on pharmacy based services

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

2.5 How to use the PNA

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

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

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

3. National Pharmaceutical Services Contract

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

The pharmaceutical services contract consists of three different levels;

- Essential services
- Advanced services
- Enhanced services

3.1. Essential Services and Prescription Volume

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

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

3.1.2. Prescriptions - During 2013/14 the 17 GP practices in Halton issued a total of 2,603,330 individual prescription items with a further 34,516 items prescribed by other healthcare providers (total 2,637,846 individual prescription items).74.4% of total prescription items*(1,963,104 items)* were dispensed by Halton pharmacies. *(636,403, 24.1%)* were dispensed by pharmacies in bordering areas (boroughs in Cheshire & Merseyside). A further *(38,339, 1.5%)* were dispensed nationwide.

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

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

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

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

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

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

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

3.2. Advanced Services

There are four advanced services[iv] within the NHS Community Pharmacy contract, two of which were introduced in April 2010, and the fourth in October 2011. Community pharmacies can opt to provide any of these services as long as they meet the requirements set out in the Secretary of State Directions. They require accreditation of the pharmacist and/or pharmacy.

3.2.1. Medicines Use Review (MUR) & Prescription Intervention Service - The pharmacist conducts a concordance medication review with the patient. The review assesses any problems with understanding current medication, its administration / patient compliance. The patient's knowledge of their medication regime is assessed and a report is provided to the patients GP. The patient's knowledge of their medication and why they are taking it is increased; problems with their medication are identified and addressed. The MUR is conducted on a regular basis, e.g. every 12 months, or when pharmacist decides an intervention MUR is required. . MURs have to be conducted in a consultation area which ensures patient confidentiality and privacy. Pharmacists must successfully pass a competency assessment before they can provide MUR services.

3.2.2. Appliance Use Review (AUR) –An Appliance Use Review was the second advanced service, introduced in April 2010.This service is similar to that above where it relates to patients prescribed appliances such as leg bags, catheters, stoma products.

3.2.3. Stoma appliance customisation (SAC) service

Stoma appliance customisation was the third advanced service introduced in April 2010. This service involves the customisation of stoma appliances, based on the patient's

[iv] Pharmaceutical Service Negotiating Committee (PSNC) accessed from www.psnc.org.uk/pages/advanced_services.html (June 2010)

measurements or a template. The aim of the service is to ensure proper use and comfortable fitting of the stoma appliance and to improve how long they are used for, thereby reducing waste and unnecessary patient discomfort.

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

3.3. Locally commissioned services

3.3.1 Enhanced Services

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

3.3.2 Locally Commissioned Services

These services can be commissioned from the pharmacy / individual pharmacist by organisations such the HWB, Local Authority Public Health Team (LAPHT), CCG, and NHS trusts. Both community NHS trusts and secondary care NHS trusts (hospital trusts) may commission services from community pharmacists.

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

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

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

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

3.4. Funding the Pharmacy Contract

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

4. Overview of current providers of Pharmaceutical Services

4.1.Community Pharmacy Contractors

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

Halton has 34 "Pharmacy Contractors" who between them operate out of a total of 31community pharmacy premises, plus 3 distance selling 'internet' pharmacies. The population of the area is 125,700 (ONS population estimate 2012) total resident population which equates to approximately one pharmacy for every 3,809 residents or 26 pharmacies per 100,000 population. This is the same as the North West rate and better than the England rate of 22 pharmacies per 100,000 population. Consequently the population of Halton is well served.

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

In terms of the type of Community Pharmacies in our area there are:

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

Further details of community pharmacies operating in Halton can be found in Chapter 5 of this PNA.

4.2 Dispensing Doctors

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

4.3 Appliance Contractors

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

4.4. Local Pharmaceutical Services (LPS)

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

4.5. Acute Hospital Pharmacy Services

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

4.6. Mental Health Pharmacy Services

The population of Halton is served by the 5 Boroughs Partnership NHS Foundation Trust. They employ pharmacists to provide clinical advice within their specialist areas and they also commission a "dispensing service" from a Community Pharmacy in order to dispense the necessary medications for their patients at the various clinics across the patch.

4.7. GP Out of Hours Services

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

There is one walk in centre in Widnes that can also provide medication out of hours directly to patients but this is done via a Patient Group Direction and would only apply to a limited number of medications and for limited patient groups. Patients may also be seen by a nurse clinician who has a non-medical prescribing qualification. In this instance a prescription can be provided to the patient if there is likely to be access to a pharmacy.

4.8. Bordering Services / Neighbouring Providers

The population of Halton can access services from pharmaceutical providers not located within the Local Authority's own boundary. When hearing pharmacy contract applications or making local service commissioning decisions, the accessibility of services close to the

borders will need to be taken into account. For further information on such services please refer to the relevant neighbouring Health and Well Being Boards own PNA.

4.9. Quality Standards for Pharmaceutical Service Providers: Community Pharmacy Contract Monitoring

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

As stated within the NHS review 2008[3], high quality care should be as safe and effective as possible, with patients treated with compassion, dignity and respect. As well as clinical quality and safety, quality means care that is personal to each individual.

This statement is as meaningful to pharmacies as to other NHS service providers and is the principle that the NHSE adopts when carrying out the Community Pharmacy Contract Monitoring visits for essential, advanced services and locally commissioned enhanced services.

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

- Submission of the Community Pharmacy Assurance Framework (CPAF) by all pharmacies
- Structured, pre-arranged visits where deemed necessary according to the CPAF results
- Scrutiny of payment submission processes
- Scrutiny of internal processes for confidential data management
- Structured action plan with set timescales for completion

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

4.10. Locally Commissioned Public Health Services

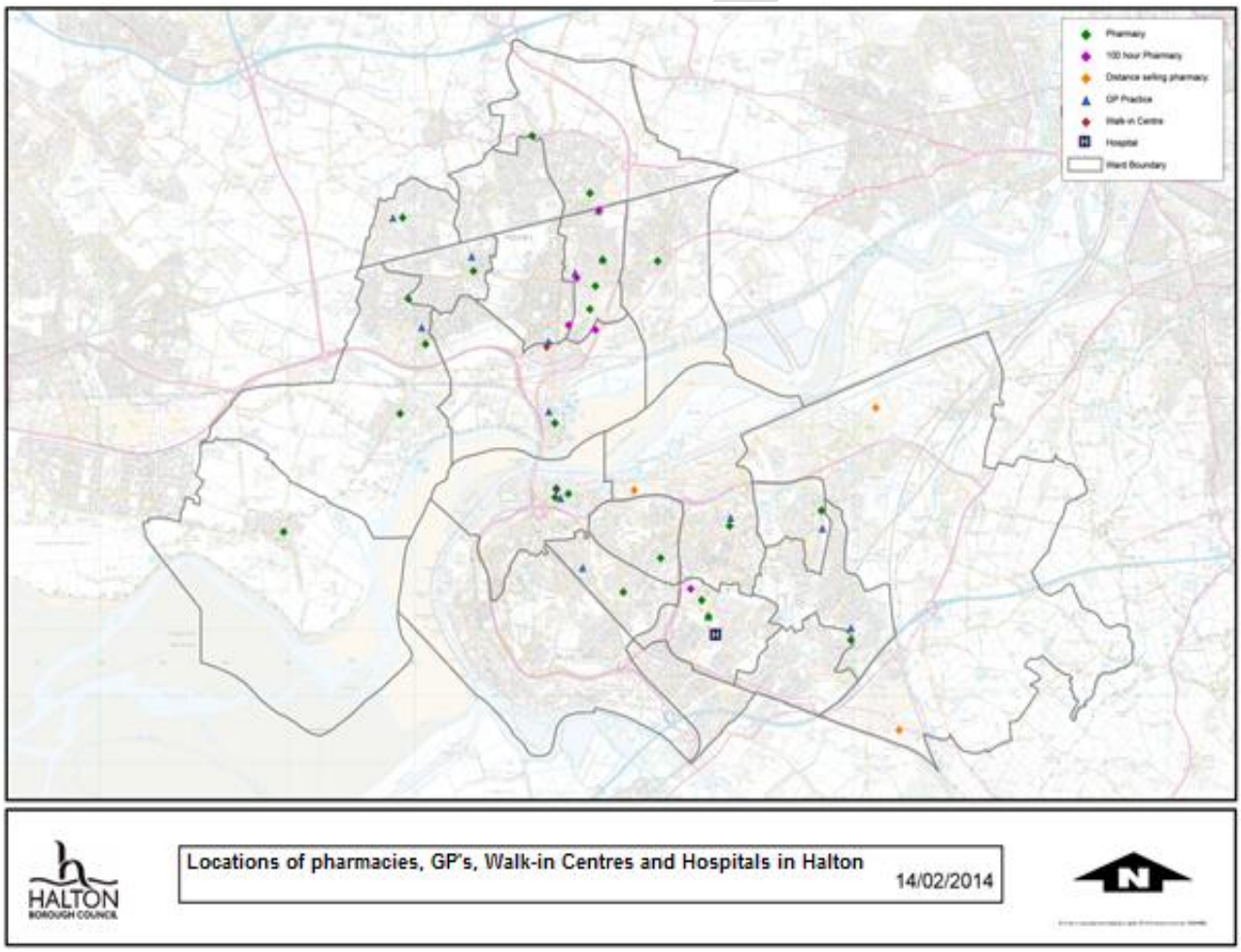
Halton Borough Council is in the process of developing a Provider Assessment Process for future commissioning purposes. Pharmacies who wish to apply to provide Public Health commissioned services will need to register on the Chest electronic procurement system and complete a mandatory service questionnaire and quality questions to ensure that they meet the required minimum standards. All pharmacies will be informed of this process in due course and a training session on how to apply will be provided. Participating pharmacies will be subject to random quality checks on the services provided.

5. Pharmacy Premises

5.1. Pharmacy locations and level of provision

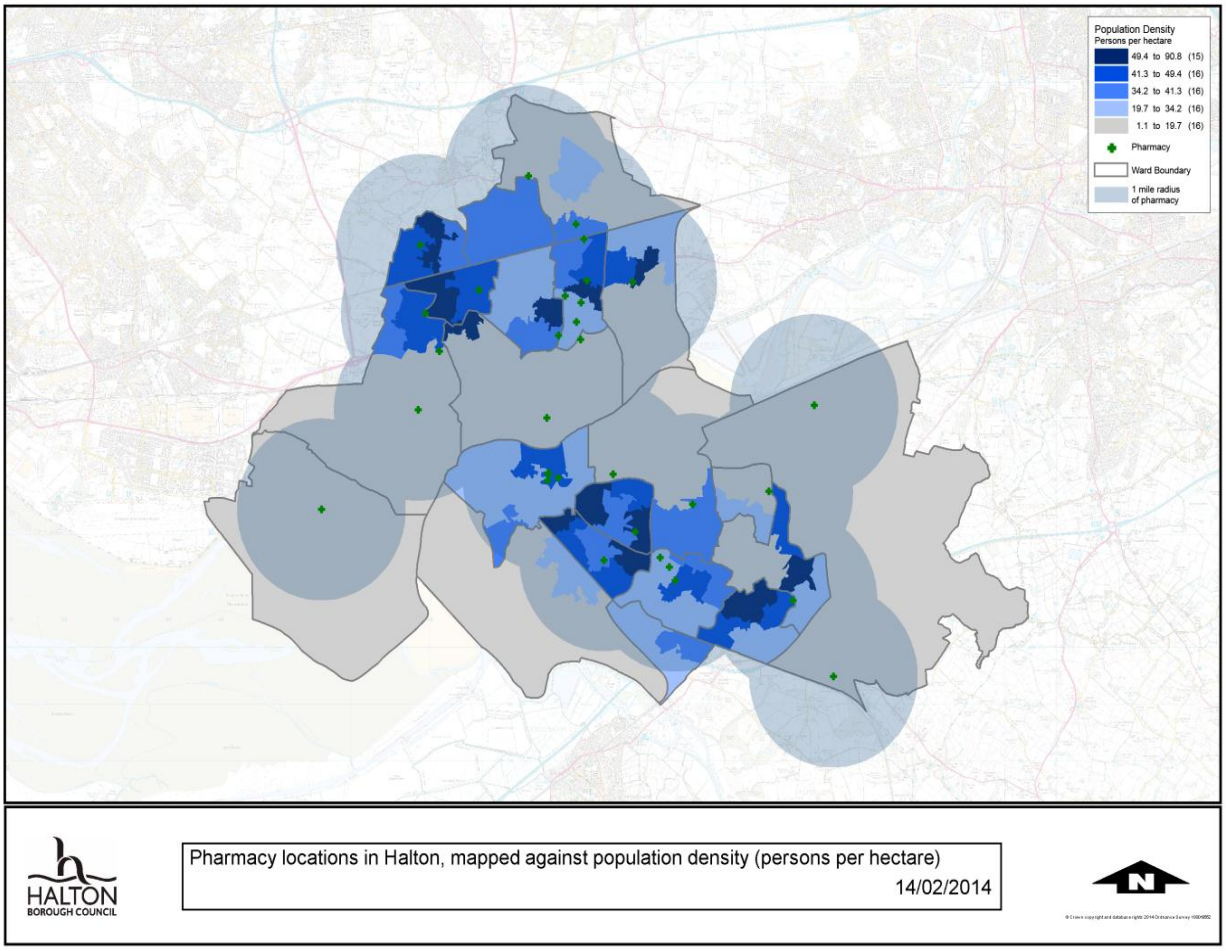
As of August 2014 there are 31 pharmacies across Halton with a further 3 distance-selling 'internet only' pharmacies making a total of 34 pharmacies in Halton (see Map 1 and Appendix 3 for full list of community pharmacies). Nationally there are a total of 11,495 community pharmacies for a population of 53,107,000, giving an average of approximately one pharmacy for every 4,620 members of the population. Halton has one pharmacy for every 3,809 (based on estimated resident population).

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



There are 13 community pharmacies in Runcorn and 18 in Widnes. All three distance selling pharmacies have their office base in Runcorn, on its industrial estates. Map 2 shows that in all areas of high population density there is pharmacy provision within an 'as the crow flies' one mile distance. Only areas with the lowest population density have to travel more than one mile.

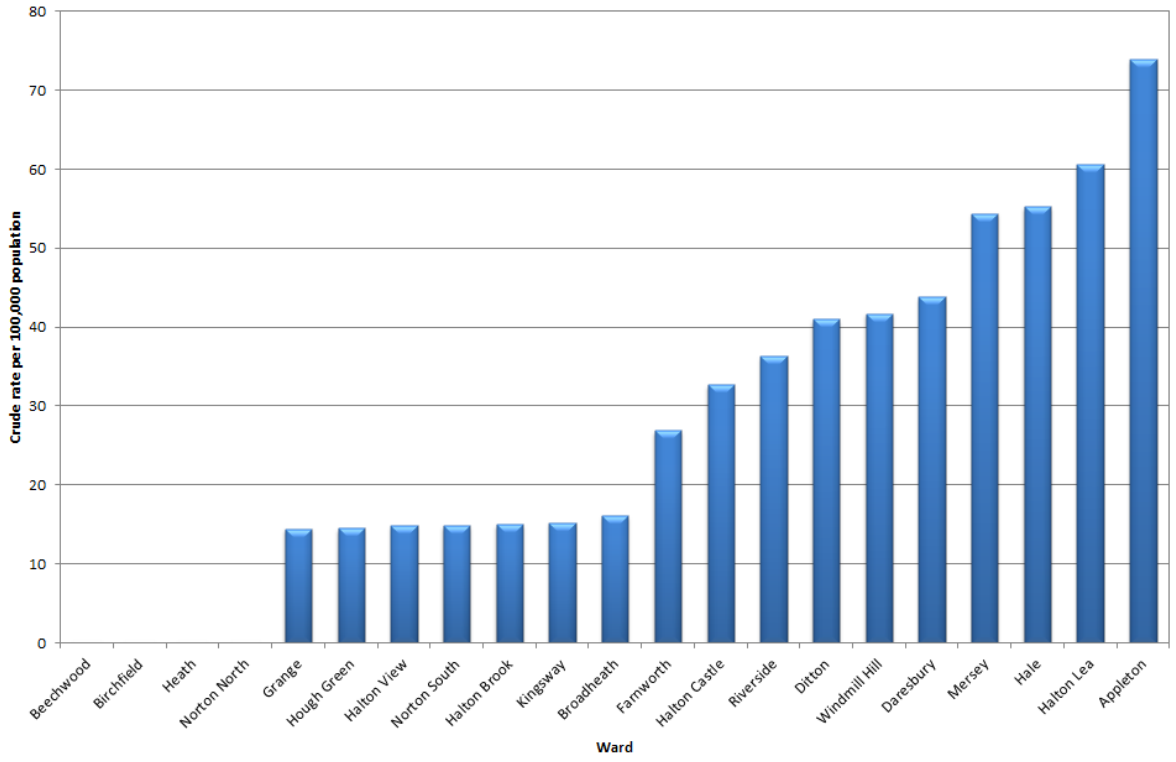
Map 2: Pharmacy location mapped against population density



Halton has a larger number of pharmacies in relation to the size of its population (25.5 per 100,000) when compared to the England (21.5 per 100,000) and a similar level to the North West average (25.6 per 100,000 population).

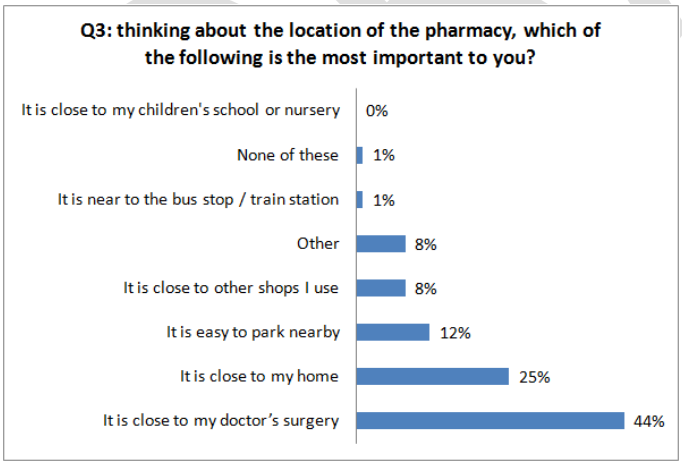
However, as Figure 2 shows this value ranges widely across the borough when analysed in terms of pharmacies per 100,000 population at electoral ward level. In several wards there are no pharmacies, while in others there are several (see Map 1). The four electoral wards containing the highest concentration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

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



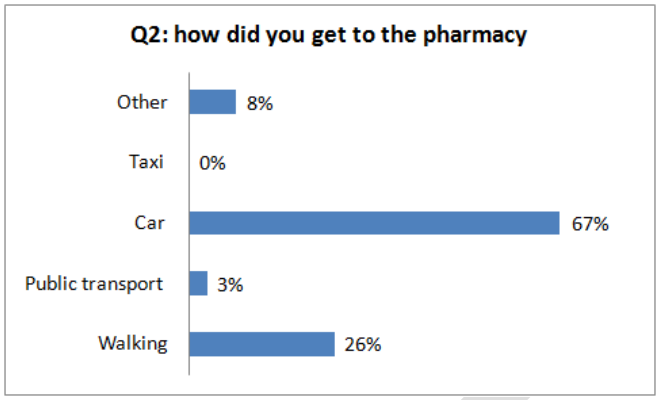
In the public survey of community pharmacy services 44% stated the most important reason for choosing the pharmacy they regularly use was that it was close to their doctor's survey and 25% that it was close to home.

Figure 3: importance of location, question three of public survey of community pharmacy services, 2014



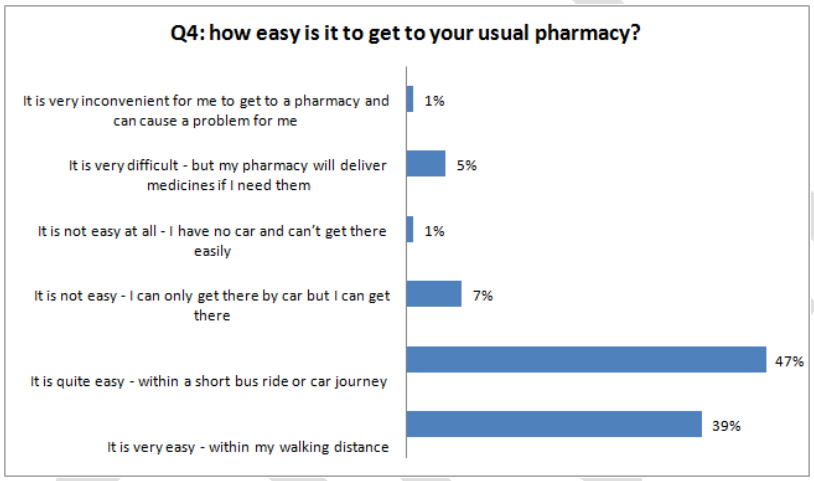
Respondents to the community pharmacy services survey were also asked how they got to the pharmacy. For the 2011 PNA 40% of people responded that walked to the pharmacy and 43% used the car, suggesting that local pharmacy services within residential communities are well used. That survey was across Halton and St Helens with a larger number of respondents. In the latest survey covering Halton alone the percentage responding that they walked had fallen and the percentage using the car had increased.

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



The majority stated that it was very easy (39%)– within walking distance - or quite easy (47%) – within a short bus ride or car journey – to get to the pharmacy.

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



Conclusion
• All of this information, used together, means that access is adequate.

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

Under the new contract community pharmacies must be open for a minimum of 40 hours each week but they are free to set their own hours of opening as long as this minimum is provided. Just under two thirds of the pharmacies are open for less than 50 hours per week. Three pharmacies are open for over 60 hours per week but less than 100 hours(two in Runcorn and one in Widnes). The pharmacies that have extended opening hours are located in areas with good transport links. There are six 100-hour pharmacies, and increase of three since the 2011 PNA. Full details of each pharmacy opening can be found in Appendix 3. There are 3 distance selling, 'internet, mail order' pharmacies. These are not open to the public for essential services. The location of 100-hour and internet only pharmacies is shown in Map 1.

91% of respondents to the public survey of community pharmacy services said they were satisfied with the opening hours of their pharmacy. However, of those who included comments the most common related to availability of late night and weekend opening and pharmacies closing over the lunchtime period.

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

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

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

The majority of pharmacies with consultation areas have wheelchair access or are able to make provision for consultations and MURs for anyone confined to a wheelchair. In respect of people with mobility problems, for 24 out of 34 pharmacies, or70%,there is parking provision (including roadside parking) within 10m of the pharmacy.

A question on access for disabled persons was included in the public survey. 39% stated that it was possible to park within 10m (30 feet) of the pharmacy, 36% stated it was not possible and 25% responded that they did not know.

5.5. Access for clients whose first language is not English

7 pharmacies responding advised that they had a pharmacist or other member of staff who could speak at least one language in addition to English – mostly commonly, Spanish, French, Arabic, Gujarati, Hindi and Urdu – with a further 1 pharmacy stating they could do this through an NHS interpretation service.

5.6. Pharmacy consulting rooms

In a questionnaire to all pharmacies they were asked:

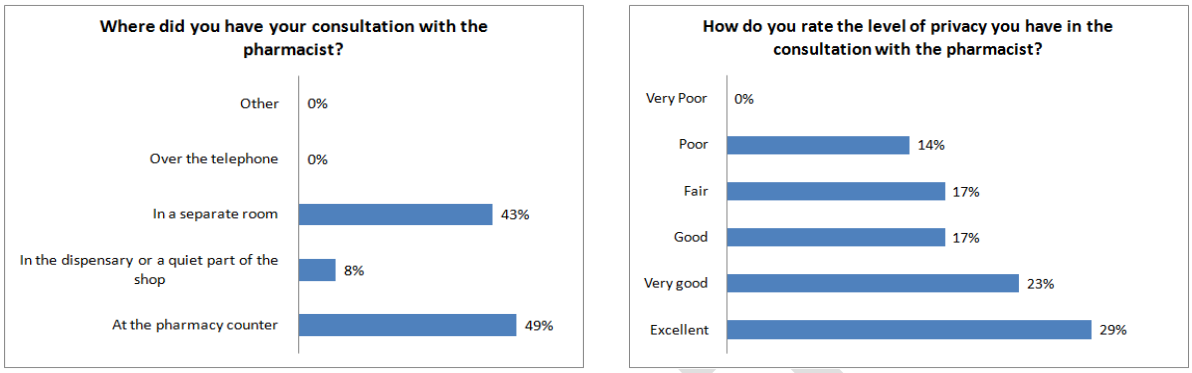
> *Is there a consultation area available that meets the criteria for Medicine Use Reviews where a patient and pharmacist can sit down together, talk at a normal speaking volume without being over heard by customers or staff and is clearly signed as private consultation?*

This question was asked irrespective of their answer to the question about whether they were commissioned to provide MURs as patients may wish to discuss other matters in a private, quite space. All 13 pharmacies in Runcorn and 13 out of 18 pharmacies in Runcorn stated that they have this facility.

38% of respondents to the public survey had had a consultation with their pharmacist within the last 12 months, with 49% of consultations being undertaken taken at the pharmacy counter. 8% were conducted in the dispensary, or a quiet part of the shop and 43% of consultations where undertaken in a consultation room.

69% of people found privacy levels excellent, very good or good, whilst 31% of people rated privacy levels between fair or poor. No respondents rated privacy as very poor.

Figure 6: consultations and satisfaction with privacy during them

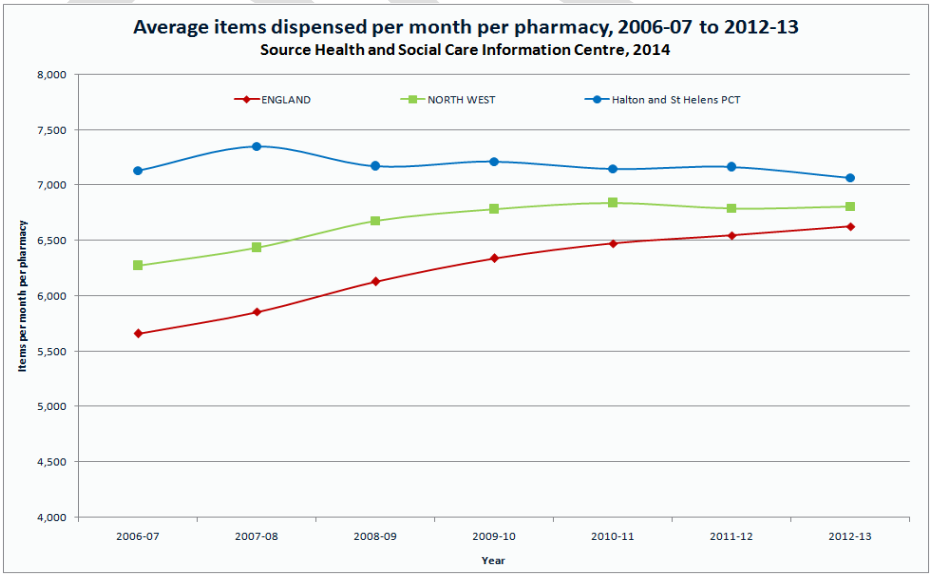


5.7. Prescribing

Benchmarking data is available from the Health & Social Care Information Centre (HSCIC) for 2012/13. However, some analysis is only available at Halton & St Helens PCT level data. It is nevertheless useful to be able to analyse Halton prescribing against England and the North West.

Figure 7 shows that Halton & St Helens PCT community pharmacy dispensing volume pattern was consistently above the North West and England levels when looking at average items dispensed per month, per pharmacy for the time period 2006/07 to 2012/13.

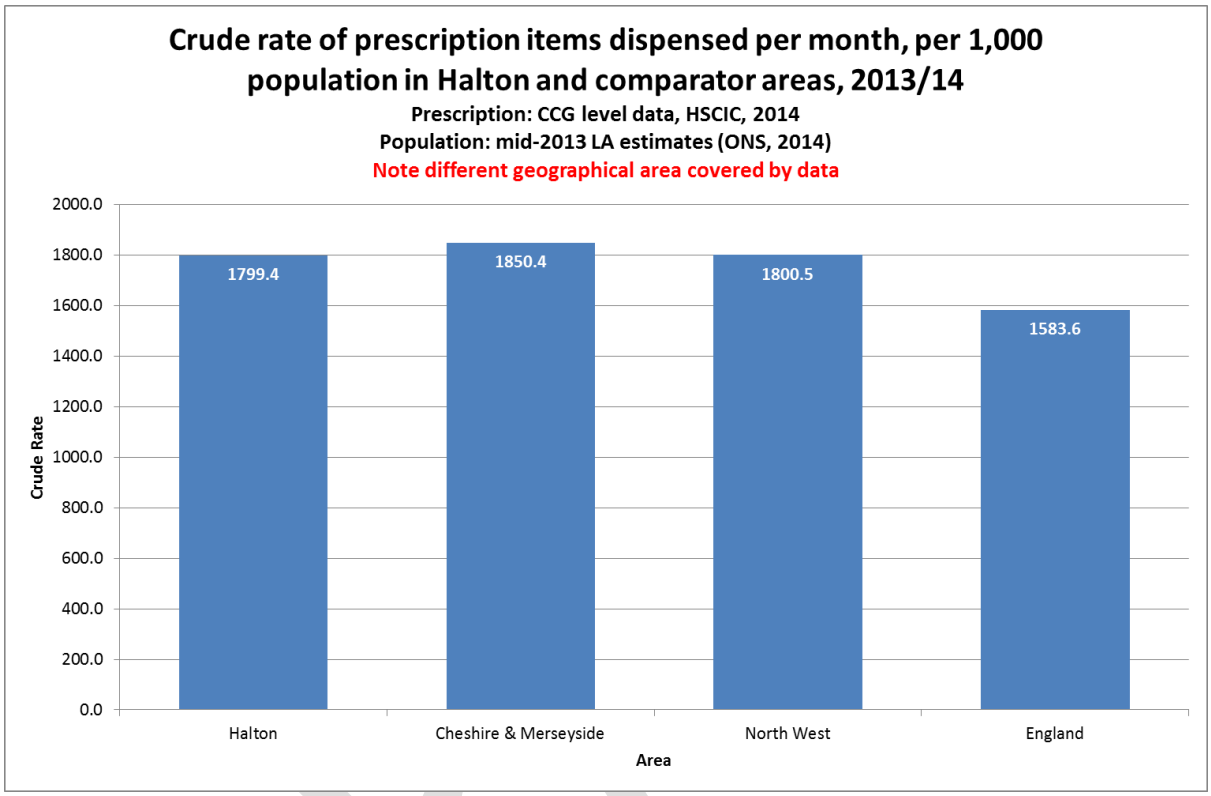
Figure 7: Mean number of prescription items dispensed per month per community pharmacy 2006/07 to 2012/13



To judge the prescribing behaviour at a Halton CCG only level a different type of analysis is possible. The crude rate, per 1,000 population, per month of prescriptions dispensed

between 1 April 2013 and 31 March 2014 shows that the Halton prescribing rate is above the England average but slightly below the North West and similar to Cheshire & Merseyside rates.

Figure 8: Prescribing rate per month, 2013/14



In terms of the types of diseases and conditions drugs and prescribed for cardiovascular disease accounts for the largest single cause, followed by conditions of the central nervous system and gastro-intestinal system. Together these accounted for just over half of all prescription items dispensed during 2013/14. The percentages are broadly similar to those seen across the North West and England as a whole, as Table 3 shows.

Table 3: Items dispensed by Halton CCG, NW CCG's and England during 2013/14, by Chapter (type of prescription)

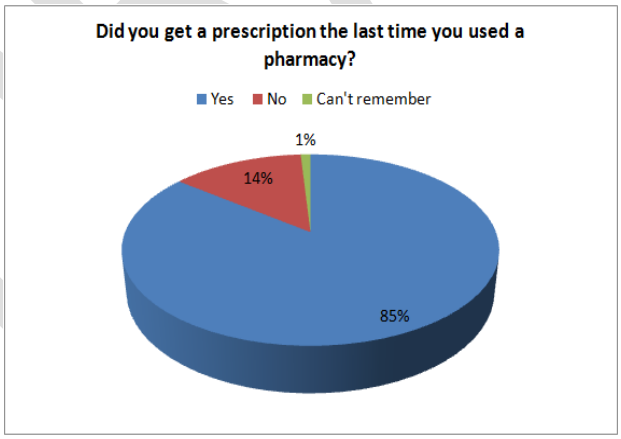
							Halton % Diff from	
Chapter*	Halton CCG	% of 2013/14	NW CCG's	% of 2013/14	England	% of 2013/14	NW CCG's	England
Cardiovascular System	785858	28.9%	45394626	29.6%	308633720	30.2%	-0.7%	-1.3%
Central Nervous System	549944	20.2%	29856833	19.5%	186528208	18.2%	0.8%	2.0%
Gastro-Intestinal System	254403	9.4%	13983813	9.1%	88324139	8.6%	0.2%	0.7%
Endocrine System	228525	8.4%	13257259	8.6%	96456857	9.4%	-0.2%	-1.0%
Respiratory System	205977	7.6%	10802130	7.0%	66314541	6.5%	0.5%	1.1%
Nutrition And Blood	143142	5.3%	8003363	5.2%	51072835	5.0%	0.0%	0.3%
Infections	120996	4.4%	6245060	4.1%	43579888	4.3%	0.4%	0.2%
Skin	102174	3.8%	5966387	3.9%	41192968	4.0%	-0.1%	-0.3%
Musculoskeletal & Joint Diseases	87161	3.2%	4802014	3.1%	32372045	3.2%	0.1%	0.0%
Obstetrics,Gynae+Urinary Tract Disorders	55583	2.0%	3453635	2.3%	25311820	2.5%	-0.2%	-0.4%
Eye	41388	1.5%	2877269	1.9%	20105323	2.0%	-0.4%	-0.4%
Appliances	38455	1.4%	2284105	1.5%	16714333	1.6%	-0.1%	-0.2%
Immunological Products & Vaccines	29778	1.1%	1913999	1.2%	14272963	1.4%	-0.2%	-0.3%
Ear, Nose And Oropharynx	26202	1.0%	1641822	1.1%	11329218	1.1%	-0.1%	-0.1%
Dressings	17599	0.6%	1109254	0.7%	8287210	0.8%	-0.1%	-0.2%
Stoma Appliances	12174	0.4%	626064	0.4%	4387502	0.4%	0.0%	0.0%
Malignant Disease & Immunosuppression	9461	0.3%	570478	0.4%	4161737	0.4%	0.0%	-0.1%
Other Drugs And Preparations	4131	0.2%	202572	0.1%	1242341	0.1%	0.0%	0.0%
Incontinence Appliances	4037	0.1%	261809	0.2%	1846644	0.2%	0.0%	0.0%
Anaesthesia	3107	0.1%	216386	0.1%	1487057	0.1%	0.0%	0.0%
Preparations used in Diagnosis	0	0.0%	1	0.0%	57	0.0%	0.0%	0.0%
Grand Total	2720095		153468879		1023621406			

Source: HSCIC, 2014

* Note: ordered by Halton CCG % of 2013/14 accounted for

The majority of people using the pharmacy get a prescription as the 2014 public survey shows.

Figure 9: Reasons for visiting the pharmacy



Source: Patient survey 2014

65% of people were informed of how long it would take to have their prescription filled. 10% were not told and would have liked to have been with 23% not told but stated that they did not mind this.89% of people said that they thought they waited for a reasonable period of time for their medicines.

85% percent of people surveyed, stated that they got all the medicines they needed, however, 14% stating that they did not.

91% of people stated that the reason for not receiving their entire prescription was because 'The pharmacy had run out of my medicine'. When this happened27% of people received their medicines the day after, with the majority, 64% receiving it within two or more days and 9% waiting over a week. Unfortunately, there is no way to determine the impact of these longer waiting periods on the patient, or whether this was measured at the pharmacy and alternative arrangements discussed.

89% of people stated that they would like to be able have their hospital prescription dispensed at their local chemist, while on 11% said 'No'.

5.8. Prescription Collection and Delivery Services

Although community pharmacies are not contracted to do so, all but one of them provide a Prescription Collection Service and 28 out of 34 offer a Prescription Delivery Service. 7 of these indicated that they may or do levy a charge to some patients for medicines delivery or only deliver for certain patient groups or to certain areas. This service improves access to medicines for a wide range of people. The picking up prescriptions and delivery of medication is a service valued by local residents, as determined by responses to the 2014 pharmacy services survey.

5.9. Patient & Public satisfaction with pharmacy services

As during the previous public survey, the vast majority of people were very satisfied with the services they received. Convenience, expertise and friendly, helpful staff were the most commonly cited things people valued when they visited the community pharmacy. Being able to get advice on minor ailments quickly without visiting the GP, handling of repeat prescriptions and the delivery service where also valued. Typical respondent views can be summed up by one respondent who stated the pharmacy has

'Local friendly staff who you get to know'

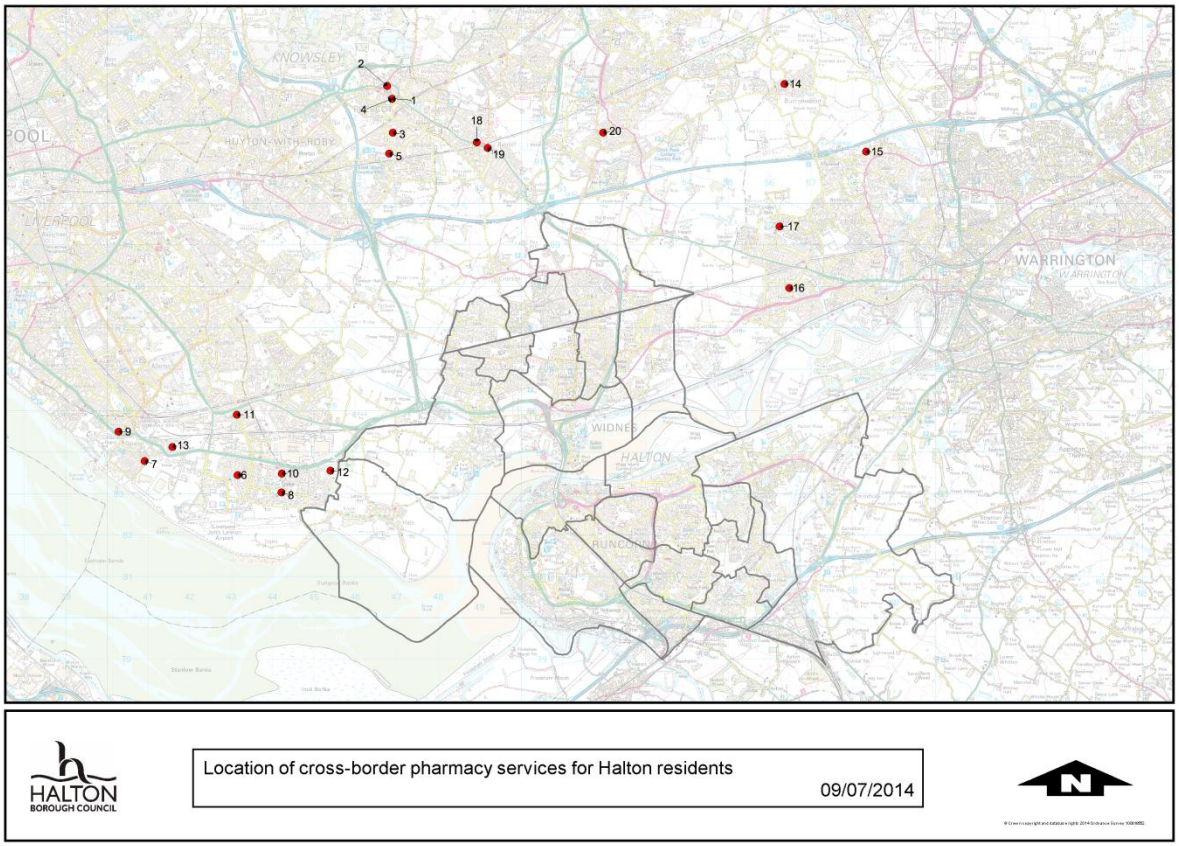
71% of respondents to the pharmacy services survey 2014 were satisfied with the range of services pharmacies provide and 19% stated that they wished pharmacies could provide more services for them.

5.10. Access to and provision of community pharmacy services in local authorities bordering Halton

The framework for Halton's PNA was developed using a template shared by Cheshire HWBs and in collaboration with Merseyside PNA leads and NHS England. Halton has geographic borders with a number of local authorities, namely Liverpool, St. Helens, Knowsley, Warrington, Cheshire East, Cheshire West & Chester. This approach facilitated the identification of pharmaceutical services along the borders of neighbouring boroughs that Halton's population may access. For example, a pharmacy in a neighbouring borough may be closer to a resident's home or place of work although they are registered for NHS Services with GP practices in Halton. Map 3 shows the locations of these cross border pharmacies. A list of the services each provides together with their opening times is

available in Appendix 5. The numbers in Map 3 below correspond to the list of pharmacies in Appendix 5.

Map 3: Pharmacies in other boroughs most likely to be used by Halton residents



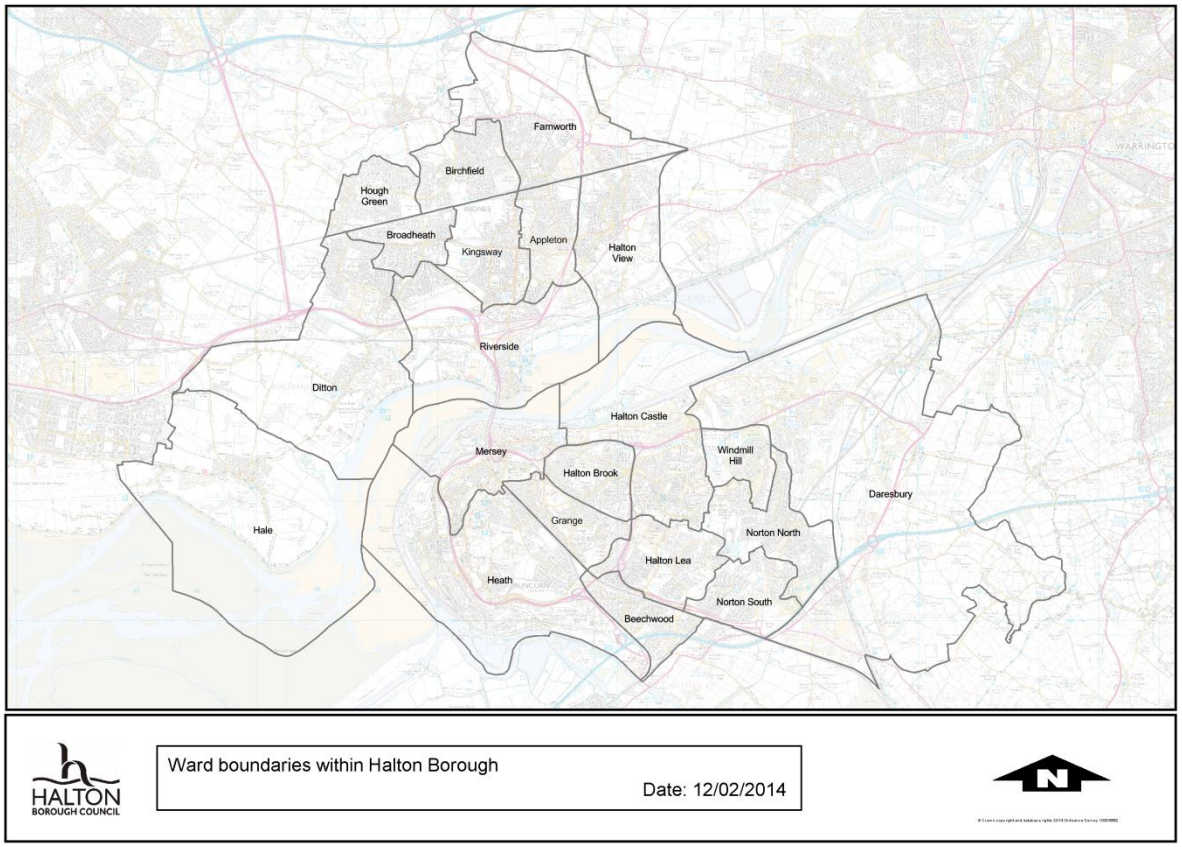
Analysis of the information supplied identified that there is adequate service provision on the borders of Liverpool, St. Helens, Knowsley and Warrington. There is also good access to pharmacies with several open at weekends and at least one on a Sunday. Most pharmacies have a consultation room and the majority provide MURs. Cross-border collaboration between Halton and the boroughs of Liverpool, St Helens and Knowsley has increased both access and choice to CATC (minor ailments) scheme. However, with the exception of emergency hormonal contraception advanced and locally commissioned services are not available to Halton residents using pharmacies in Warrington. Although Halton has geographical borders with Cheshire East and Cheshire West & Chester populations are scarce at these borders and there is no pharmacy provision near the borders.

6. Population and Health Profile of Halton

6.1. Location

Halton is made of the towns of Runcorn and Widnes, located on the Mersey estuary. It has a legacy of chemical industry and 1960s Runcorn New Town development providing an influx from the neighbouring city of Liverpool. With the reduction of the chemical industry the area struggles with high local unemployment rates. Newer service and communication industry developments have taken place in Daresbury & Manor Park and the science park has high quality laboratories.

Map 4: Location of Halton Borough



6.2. Population Structure and Projections

The estimated resident population of an area includes all people who usually live there, whatever their nationality. Members of UK and non-UK armed forces stationed in the UK are included and UK forces stationed outside the UK are excluded. Students are taken to be resident at their term time address.

6.2.1. Resident population

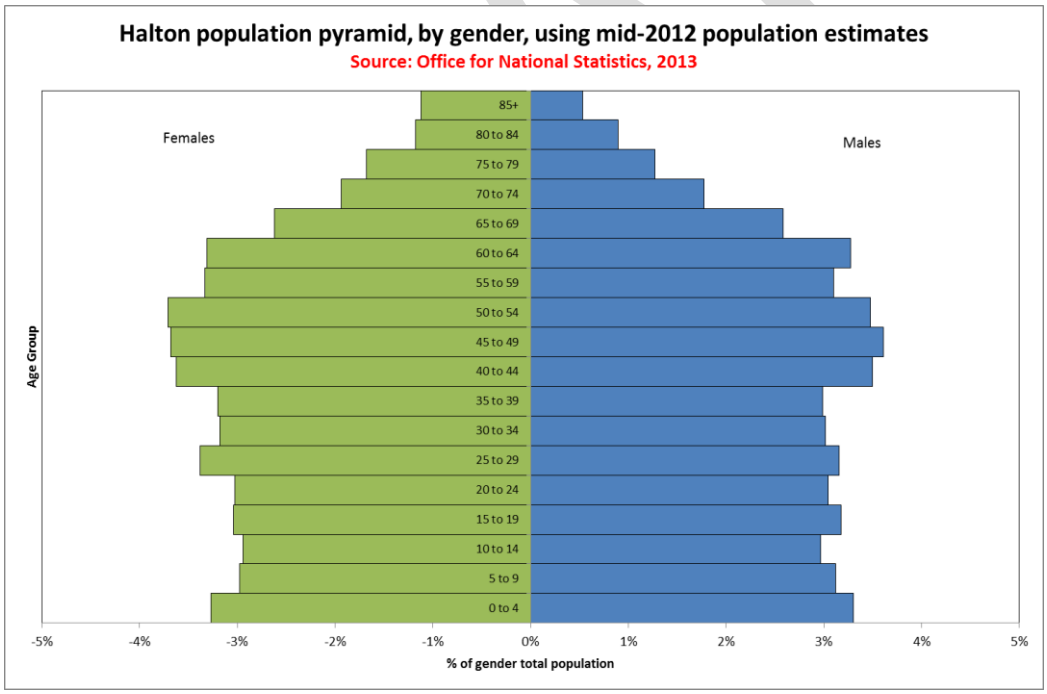
Population estimates are **estimates** of what the resident population make-up should look like at that time, based on previous years' births, deaths and net migration. Mid-2012 population estimates:

- Halton has 125,692 persons
- 49% of these are Male and 51% Female

The population age structure is detailed in Figures 9. Compared to the England average the resident population of Halton has a slightly different structure:

- Age bands covering 0-14 year olds: larger proportion than England
- Age bands covering 15-19 year olds: similar proportion than England
- Age bands covering 20-34 year olds: smaller proportion than England
- Age bands covering 35-49 year olds: similar/slightly smaller proportion than England
- Age bands covering 50-64 year olds: larger proportion than England
- Age bands covering 65+ year olds: smaller proportion than England

Figure 10: Resident Population, mid-2012 estimated age and gender structure

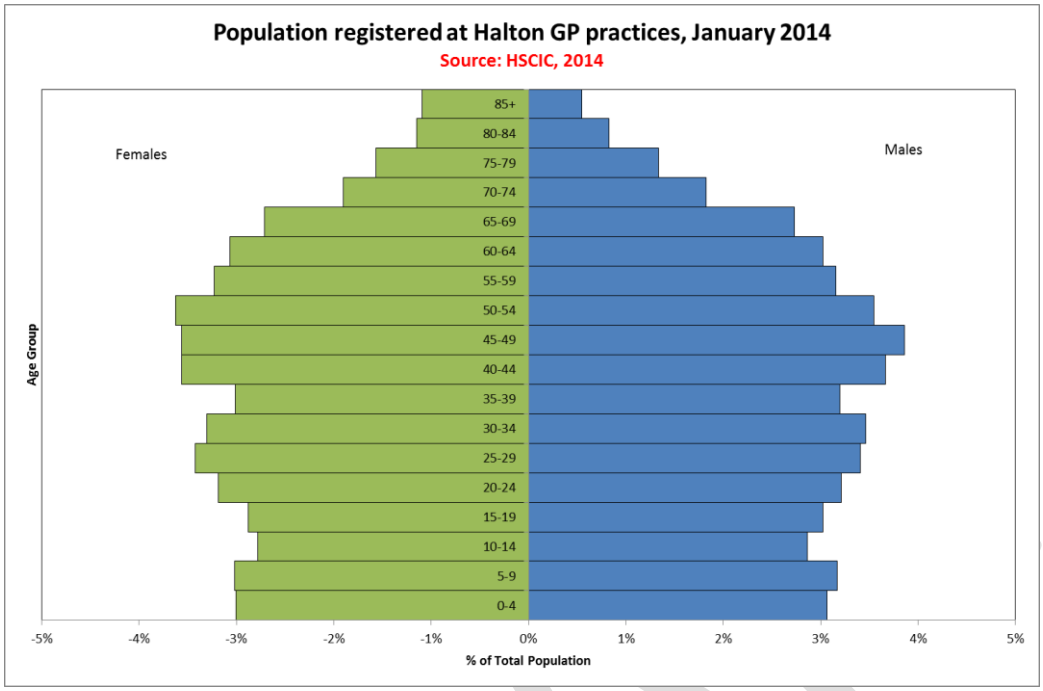


6.2.2. GP Registered Population

The majority of people who reside in Halton are registered with a Halton GP for their primary health care. However, there is not a 100%: people who move into and out of the borough may prefer to stay with their original GP. This means some people residing in neighboring boroughs are registered with Halton GPs and some Halton residents will be on a

GP register outside the borough. There are more people registered with a Halton GP than there are residents, 129,078 registered (as at April 2014) compared to 125,692 resident (2012 mid-year estimate). The age profile is very similar.

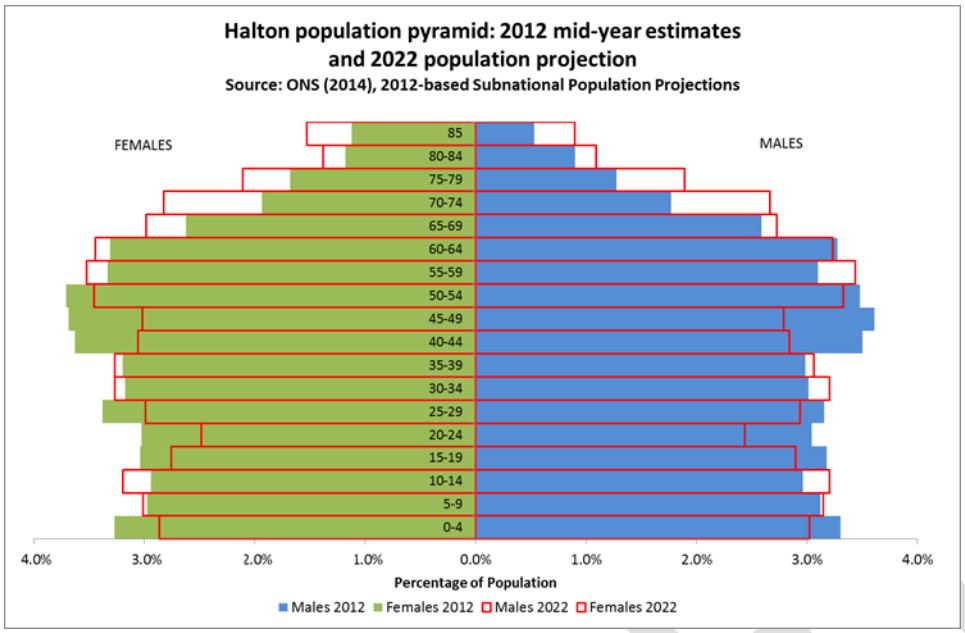
Figure 11: GP registered population age and gender structure, as at January 2014



6.2.3. Resident Population Forecasts

Although currently Halton's population structure is 'younger' than that of England i.e. it has higher proportions than England in the younger age bands and lower proportion in the 65+ age bands, the borough's population structure is predicted to shift over the next decade. Figure 101 shows that the 5-14 age bands are predicted to increase as a proportion of the overall population, the 'working age' population is predicted to shrink whilst the larger proportion increase will be in the 65+ age population. This 'aging population' is likely to increase pressures on NHS and social care as this age group makes up a disproportionately large percentage of GP consultations, hospital admissions and social services.

Figure 12: Population projections 2012 to 2021



The projections form a "baseline" view of what the population dynamics would be in the given areas if recent demographic trends were to continue into the future. It is important to note that these projections are consistent across all local authorities in England.

- In the short term (2011 - 2014) Halton's population is projected to grow by 1% from 125,700 to 126,800
- In the medium term (2011 - 2017) Halton's population is projected to grow by 2% from 125,700 to 128,000
- In the long term (2011 - 2021) Halton's population is projected to grow by 3% from 125,700 to 129,300. This is still lower than the North West region which is projected to grow by 4% and nationally, which is projected to grow by 9%
- Younger people (0 - 15 year olds) - population projected to grow by 10% (2011 - 2021)
- Working age (16 - 64 year olds) - population projected to decline by 5% (2011 - 2021)
- Older people (65+) - population projected to grow by 33% from 18,600 in 2011 to 24,700 in 2021

Following national and regional trends, Halton's population continues to age with older people making up an increasing proportion of the population. The growth in the numbers of older people will increase the demands for both formal and informal support. Small decreases in the working age population mean there are fewer people to provide and pay for this additional support.

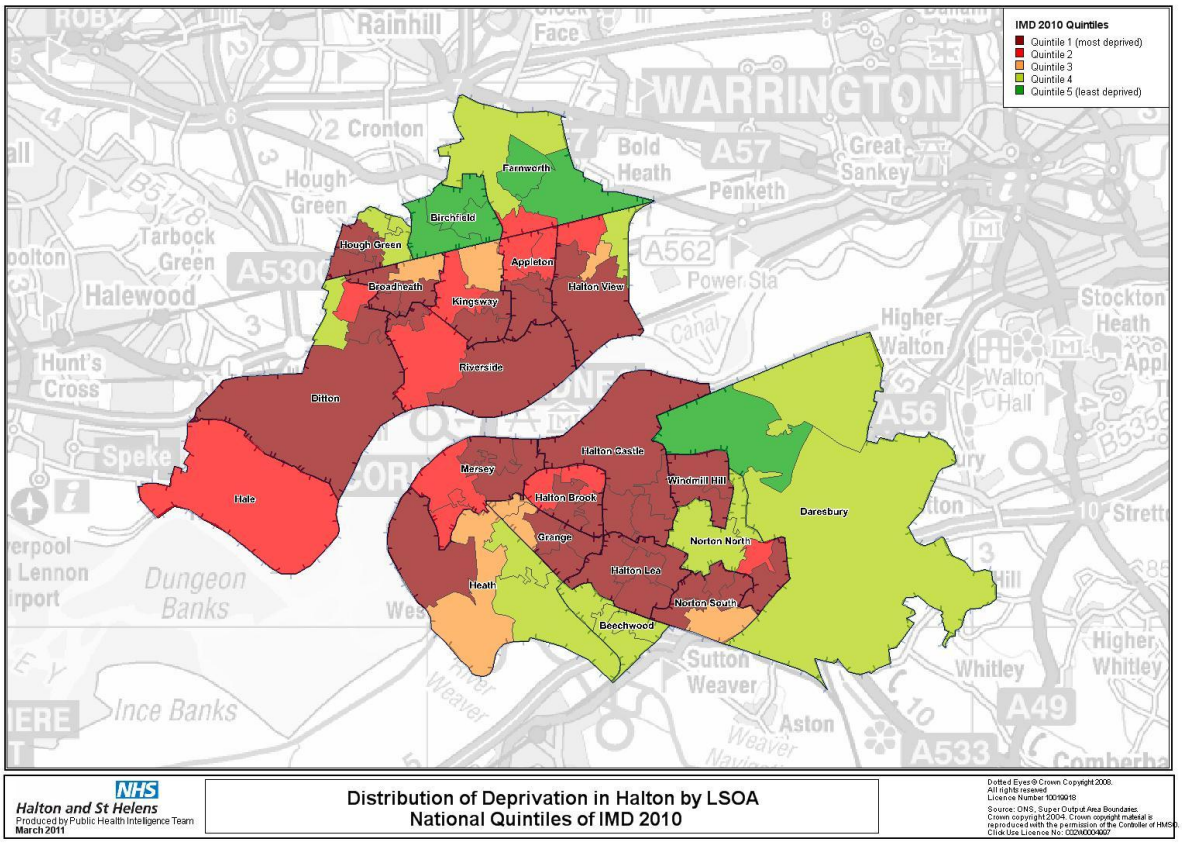
6.3. Deprivation and Socio-economic factors

The English Indices of Deprivation 2010 (ID 2010) are the government's official measure of deprivation and they update ID 2004 and ID 2007. The Index of Multiple Deprivation 2010 (IMD 2010) is constructed by combining seven domains, each of which relates to a major social or economic deprivation. The scores for each domain are combined into a single

deprivation score for each small area in England. This, therefore, allows each area to be ranked relative to one another according to their level of deprivation.

Halton is ranked as the 27th most deprived local authority in England (out of 326 local authorities) putting it in the most deprived 10% nationally. Compared to 2007 when it was the 30th most deprived, means that Halton's relative level of deprivation has increased, even though its deprivation score decreased slightly. The most deprived ward in Halton is Windmill Hill, while the least deprived ward in Halton is Birchfield. Figure 12 shows the levels of deprivation across the borough, by lower super output area or LSOA (statistical geographical areas of approximately 1,500 population).

Map 5: Levels of deprivation in Halton, IMD 2010



6.4. Future Planning

6.4.1. Housing Development

The last Strategic Housing Land Availability Assessment 2012[4] estimates the numbers of households needed to meet demand over the next 11 years and beyond. The report assesses the borough's potential level of new housing supply within three key phases:

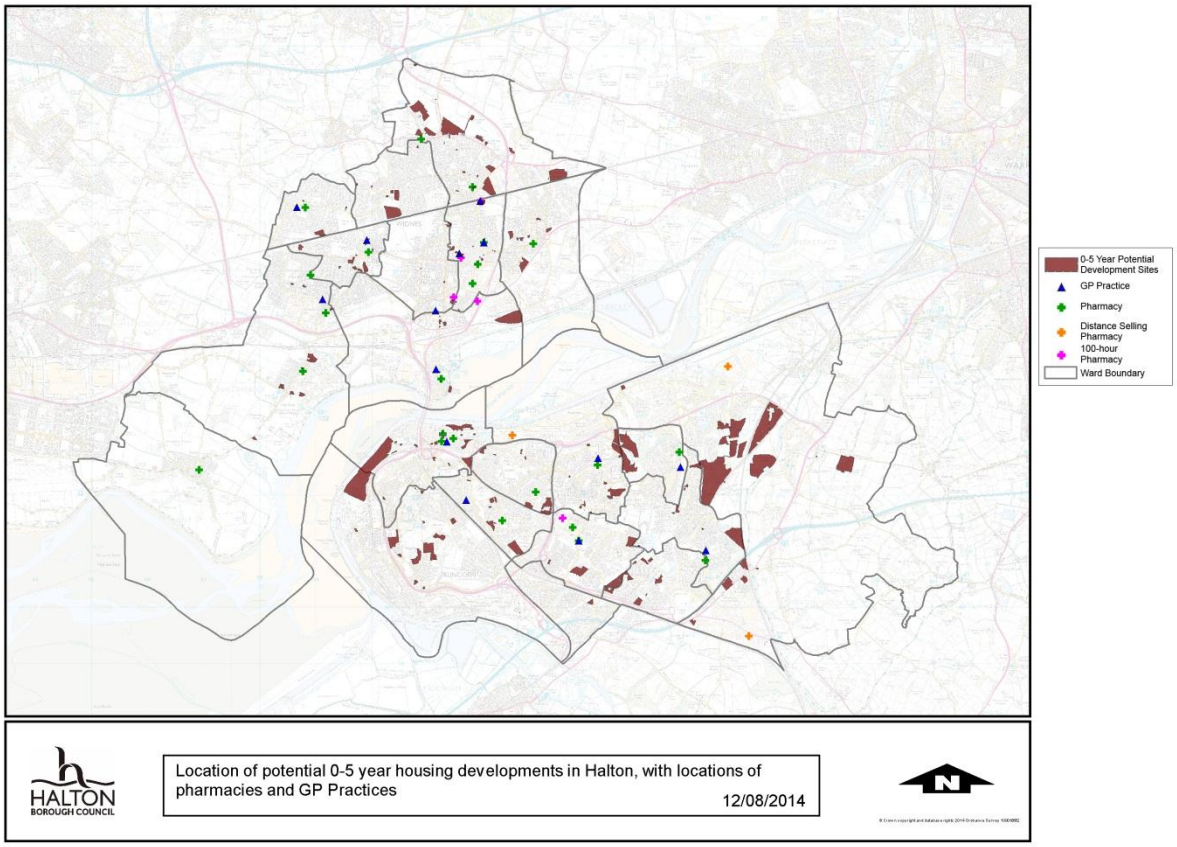
- 0-5 years: 'Deliverable' supply of residential sites
- 6-10 years: 'Developable' supply of residential sites
- 11+ years

The Halton Core Strategy[5] and Housing Strategy 2013-2018 suggest that taking account of demographic, economic and policy factors, there should be an annual household growth rate of 552 additional homes built in the borough per year. This is based upon a minimum 9,930 net additional homes being provided between 2010 and 2018, 5660 in Runcorn and 4,270 in Widnes and Hale.

The Core Strategy and the Housing Strategy include a target for 100 new affordable homes to be made available each year, meaning 25% of new developments built should be affordable housing, subject to site viability assessment. There is also an aim to reduce the number of people affected by the under occupancy penalty. Both also recognise the needs of vulnerable groups. The needs for current or future homes to have suitable aids and adaptations to meet disability needs and also the need for 100 units of additional older persons housing over the housing strategy period (2013-2018). The Castlefields estate development is nearing completion with at least 350 new (predominantly private) homes by 2023 and a further 150 new affordable homes by 2015/16.

The geographical location of the deliverable supply of housing for the next 0-5 years (within the 'life' of this PNA) is shown in Map 5, alongside pharmacy locations. The shaded areas those where developments exceed 50 homes. There are numerous smaller developments across both Widnes and Runcorn. The map indicates that additional pharmacy provision will not be required, as plans are located within areas of existing provision.

Map 6: Deliverable housing developments of 50 homes or more and pharmacy locations



6.4.2. Mersey Gateway Bridge

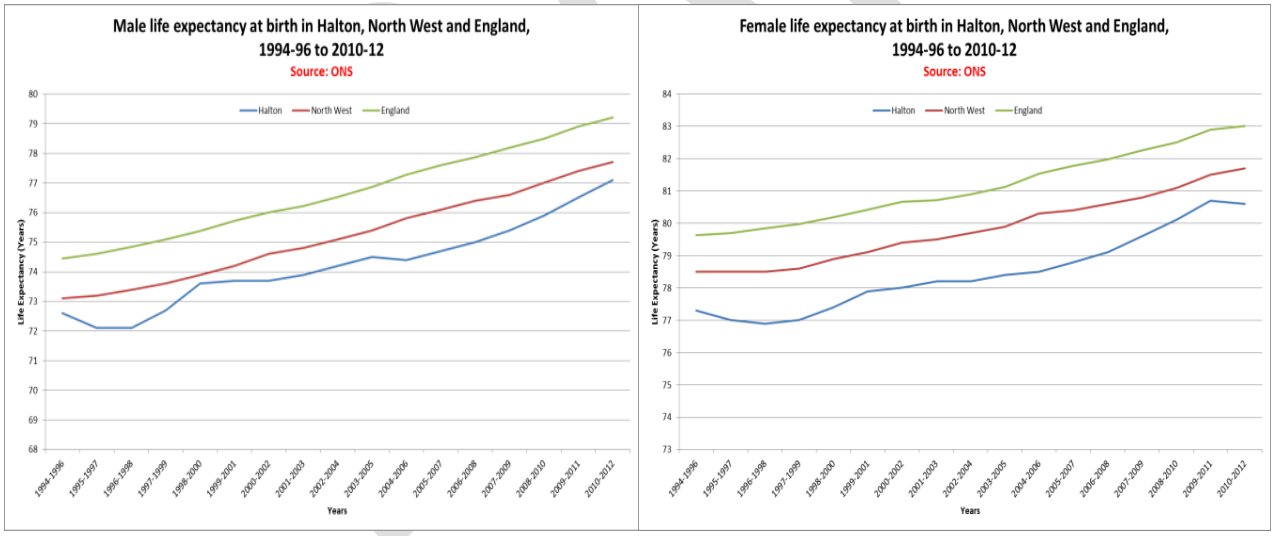
Work started on the Mersey Gateway Project on 7 May 2014. In autumn 2017 a new six lane toll bridge over the Mersey between the towns of Runcorn and Widnes will open to relieve the congested and ageing Silver Jubilee Bridge. The original plan was that both the new Mersey Gateway Bridge and the Silver Jubilee Bridge would be tolled with most local residents receiving up to 300 free one-way trips per year. However, in late July 2014 an agreement was reached with central government that Halton residents would be except from toll fees. Therefore the new bridge should have no adverse effects on access to healthcare including pharmacies.

6.5. Life Expectancy

As a result of the reduction in mortality, life expectancy has improved but remains substantially below the England rates. Life expectancy in the borough remains below both the North West and England averages. The gap between the national and local life expectancy rates has reduced over recent years. However, Halton women have some of the lowest life expectancy in England.

Reducing all age all-cause mortality inequalities between Halton and the national average will in turn reduce the life expectancy difference.

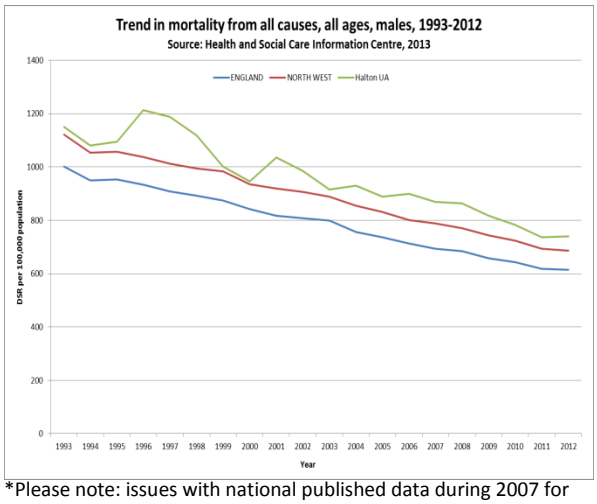
Figure 13: Trend in life expectancy at birth, males and females, 1994/6 to 2010/12

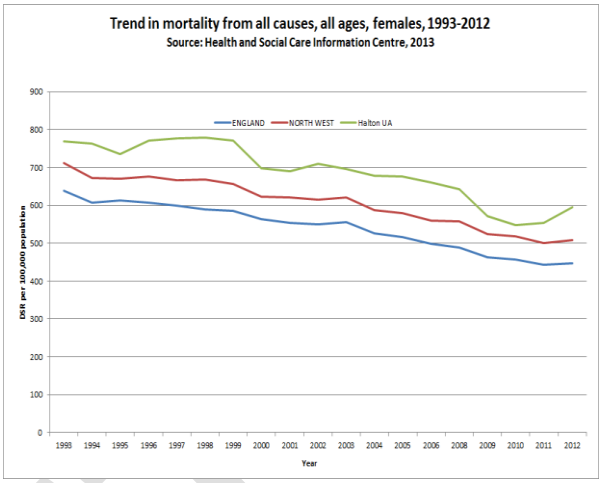


6.6. All Age All-Cause Mortality

Reducing all age all-cause mortality is one of the key priorities for the partner organisations in Halton as it is key to tackling health inequalities. Whilst mortality rates have declined, they remain above the national and regional averages.

Figure 14: Trends in all age all-cause mortality for males and females, 1993 to 2012





*Please note: issues with national published data during 2007 for females means they have not been included within this analysis.

6.7. Health & Wellbeing Priorities

The Joint Strategic Needs Assessment (JSNA) has been used to inform leaders and commissioning decisions about the health and wellbeing needs of the borough as well as the wider determinants that impact on these issues. Following an extensive engagement and prioritisation process Halton's Health and Wellbeing Board agreed a core set of priorities for its 2013-2016 Joint Health and Wellbeing Strategy. With a focus on prevention and early detection, these are:

- Cancers
- Mental Health
- Alcohol
- Child Development
- Falls amongst older people

Action plans were developed for each priority and are being overseen by multi-agency partnership groups.

7. Pharmacy Activity that supports local priorities

7.1. Tobacco Control

7.1.1. Level of Need

Smoking is the most significant modifiable risk factor for both heart disease and cancer. In men, it accounts for 59% of social class differences in death rates between 35 and 69 years.[6]

According to 2014 Health Profile[7] the adult smoking rate in Halton was 22.6%, a reduction since the 2009 Health Profile when the rate was estimated to be 30.5%. This compares to the England average of 19.5% with the worst rate in England being 30.1% and the best being 8.4%. Although there have been reductions in smoking levels locally these figures show that the borough rates remain significantly worse that the England average even though the gap has narrowed. Data from a collaborative Lifestyles survey conducted across all Merseyside boroughs showed higher rates than those seen in the Health profile. Differing methodologies make direct comparisons problematic. However, despite differing figures both demonstrate the significant burden smoking continues to exert on borough residents.

As such, tobacco control has a major role to play in reducing health and social inequalities. The borough's strategy has been to reduce exposure to second-hand smoke, prevent people from starting smoking in the first place, and help smokers to quit.

With regards to helping smokers to quit, the local authority public health team (LAPHT) commissions a range of smoking cessation services with efforts to support smokers to quit being offered as part of a comprehensive tobacco control and smoking cessation plan. All GPpractices are been actively involved in providing smoking cessation support, predominantly by practice nursing staff or by GPs providing a brief intervention and referral to the specialist smoking cessation service, depending on patient need and wishes.

7.1.2. Evidence of effective interventions in the community pharmacy setting

Evidence suggests that community pharmacies have a key role to play in providing advice, support and even brief interventions for smoking cessation.[8;9;10;11] Details of how they can provide this support can be found in guidance such as that published by Pharmacy Health Link[12]. However, this requires adequate training to enhance confidence and skills[13;14]. This is based on evidence that community pharmacist smoking cessation support can have similar success rates as that of nurses but lower than that of specialist advisors. There is also some evidence that involving community pharmacy support staff in brief interventions around smoking can increase the provision and the recording of smoking status in patient's medications records.[15] Whilst other studies show community pharmacy smoking cessation services may produce lower quit rates than group-based support these are more intensive and cost more. Both types of support are highly cost effective[16]. Quit rates will vary also depending on the number of sessions offered by the pharmacy[17]. Despite these differences the key message remains that the evidence strongly points to community pharmacies having a key role to play in local efforts to support people to stop smoking[18].

7.1.3. Local provision

Halton has 20 pharmacies providing smoking cessation services (Map 7 and Appendix 4). Under Local Commissioned Services pharmacies can offer two levels of support to those wanting to stop smoking.

Stop Smoking Voucher Dispensing Service

The stop smoking dispensing service dispenses of nicotine replacement therapy (NRT) against vouchers issued by the Specialist Smoking Cessation Service.

Stop Smoking Intermediate Service

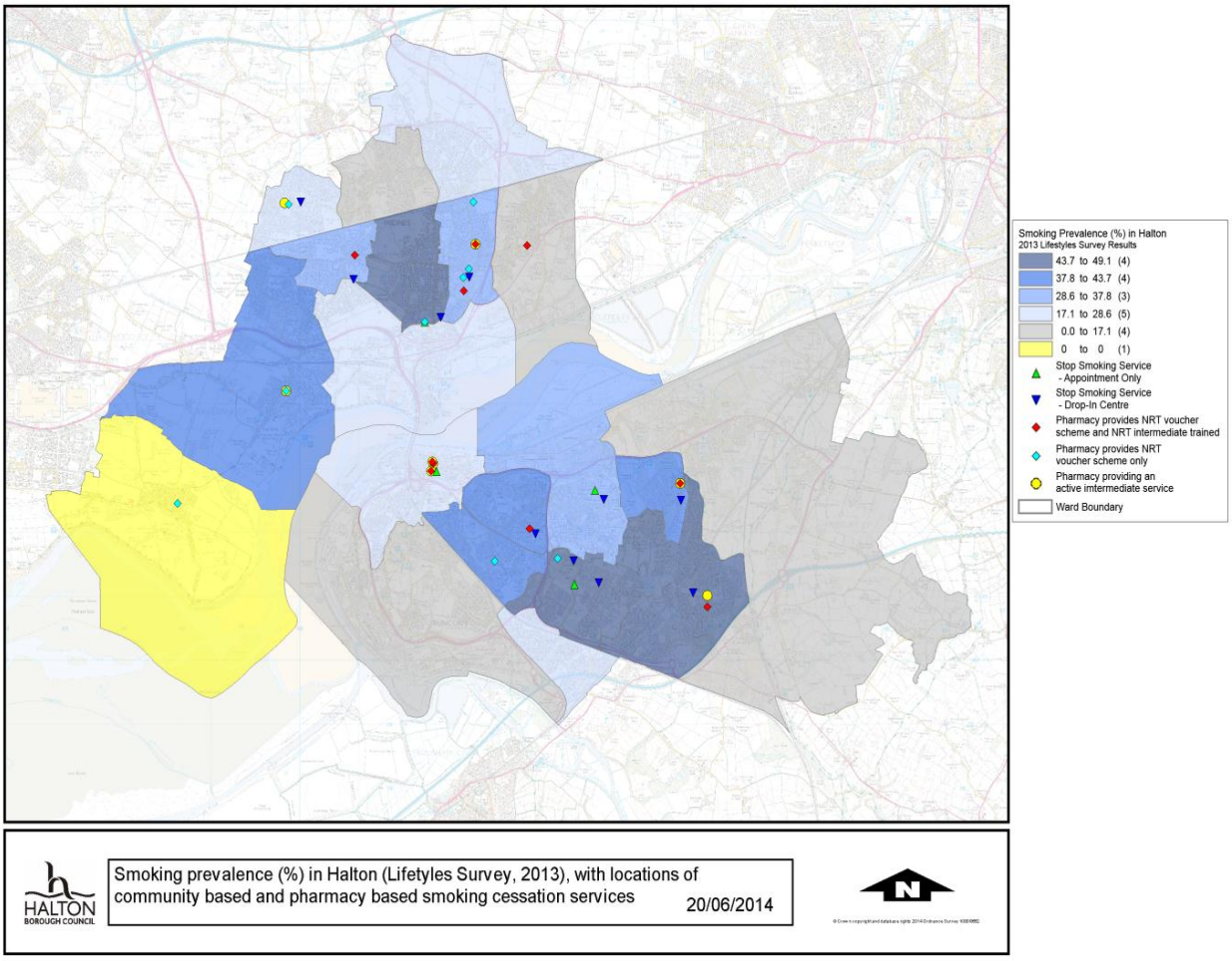
The Pharmacy Stop Smoking Intermediate Service has been established to deliver one-to-one support and advice to the user, from a trained pharmacist or a member of the Pharmacy team. Where appropriate nicotine replacement therapy is supplied or a referral is made to the person's GP for a prescription of alternative stop smoking drugs. The service is provided during normal pharmacy opening hours but may not necessarily be available on every day that the pharmacy is open.

All pharmacies that provide smoking cessation services do so via the NRT vouchers and currently a small number also provide the intermediate service.

Commissioners from Cheshire and Merseyside LAPHTs have been developing a Patient Group Direction (PGD) for the administration of Varenicline which will enable products such as *Champix* which has a higher quit rate than NRT products to be administered in community pharmacies.

80% of respondents to the local community pharmacy services survey stated that they think advice on stopping smoking and/or vouchers for nicotine patches/gum etc. should be available through community pharmacies. This suggests the public see this as a good venue for support to quit smoking.

Map 7: Provision of pharmacy and other community smoking cessation services



Map 7 shows that in all wards with high levels of smoking prevalence (dark blue colour on map) there is at least one specialist stop smoking service clinic and one pharmacy providing smoking cessation support. Therefore provision of community smoking cessation support is adequate.

Conclusions

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

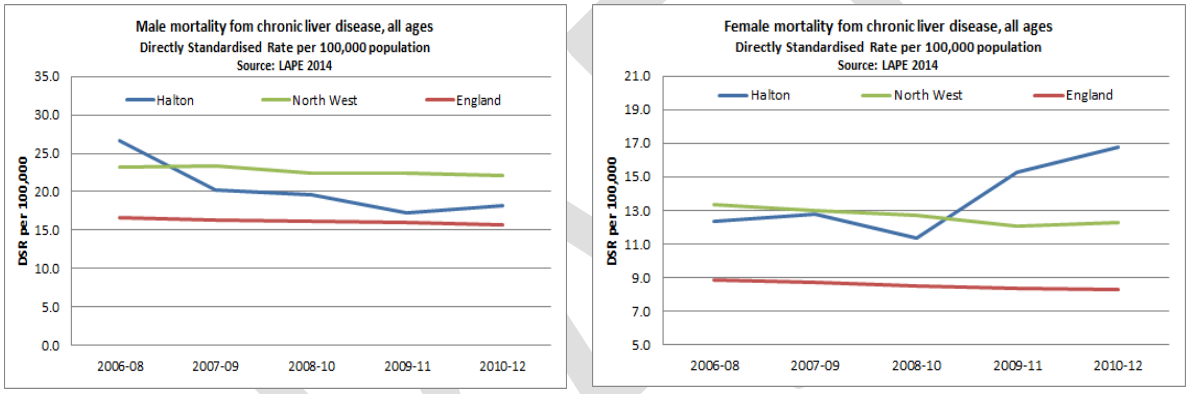
7.2. Alcohol

7.2.1. Level of Need

Levels of alcohol use have been rising over recent years. Alcohol misuse is directly linked to deaths from certain types of diseases, such as liver cirrhosis. This trend can be seen in Figure 15. For Halton it is one of the major causes of the gap in life expectancy.

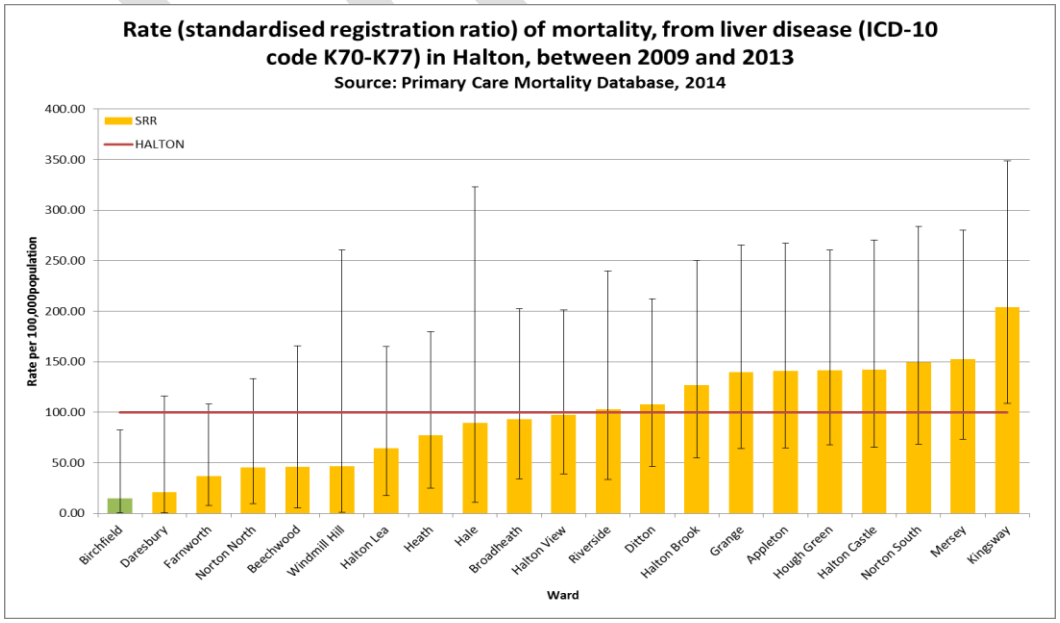
Nationally rates in mortality from chronic liver disease including cirrhosis have been rising steadily. In England between 2000/03 to 2010/12 they rose 9.7%. In the same period Halton's rate rose by 11.9%. As well as having a larger increasing rate there is a notable gap between England and the borough and this is particularly so for females. Although rates are lower for women than for men, the difference between the genders has been decreasing over recent years.

Figure 15: Death rate from chronic liver disease including cirrhosis, 2006/08 to 2010/12



The impacts alcohol has on deaths due to chronic liver disease are not experienced uniformly across the borough as Figure 16 shows.

Figure 16: Ward level death rates from chronic liver disease in Halton, 2009 to 2013



The increase in alcohol use amongst adults has seen a corresponding increase in alcohol-related admissions. However, admissions to hospital amongst those aged under 18 have seen falling rates in recent years. Again, this is a reflection of the changing pattern of alcohol use amongst young people. Further details of hospital admissions can be found in the JSNA[v] and the Local Alcohol Profiles for England (LAPE) annual profile[vi].

7.2.2. Evidence of effective interventions in the community pharmacy setting

There is little in the published research on this area. However, community pharmacies have been effective in supporting people to stop smoking using brief interventions (BI) and there is evidence in the literature that such an approach is also effective for alcohol within other primary care settings[19;20]. It is therefore not implausible to suggest that they could play a key role in local plans to address alcohol misuse, one of the boroughs top priorities. Research undertaken in the North West indicates that alcohol BI and referral to services is acceptable to both pharmacies and the public. However, this research did not consider the effectiveness of such services[21]. Given the UK Department of Health's stated aim to include community pharmacies in BI to reduce alcohol harms, an important Randomised Control Trial (RCT) study is underway in all community pharmacists in the London borough of Hammersmith and Fulham.[22]This will be the first RCT study to assess the effectiveness of BI delivered by community pharmacists.

7.2.3. Local provision

Alcohol is a local Joint Health & Wellbeing Strategy (JHWBS) priority. The focus of the JHWBS is one of wellbeing, prevention and early detection across the life course. This is in line with the national alcohol strategy.

Pharmacy-based alcohol services have been established or commissioned in other areas of the UK, but these vary considerably in their design and have been subject to little evaluation. Locally community pharmacies support national and local alcohol harm awareness campaigns as part of the national pharmacy contract. There are no pharmacy enhanced or locally commissioned alcohol services in the borough.

As noted above a large RCT investigating the effectiveness of delivering BI by community pharmacists is currently ongoing. As such, the role of community pharmacists related to this agenda will be kept under review as part of the local alcohol harm reduction strategy. The training of community pharmacists in providing brief interventions around alcohol would be needed.

It will be essential to involve relevant stakeholders in service development, to ensure that services are desirable, feasible and acceptable. Of note 48% of respondents to the local community pharmacy services survey stated that they think advice and treatment for drug and alcohol problems should be available through community pharmacies. 33% stated they did not think these services should be available through the community pharmacy and 19% were unsure. This is a substantially lower 'Yes' response than for other services.

v http://www4.halton.gov.uk/Pages/health/JSNA.aspx
vi http://www.lape.org.uk/

Conclusions

- Pharmacies do not currently provide services to reduce alcohol consumption. Evidence of effectiveness for pharmacies role in conducting screening for unsafe levels of alcohol consumption and offering brief interventions is limited. Any exploration of this role as part of the alcohol strategy needs to keep abreast of new research
- Under the essential services contract pharmacies should support six health education campaigns per year. Community pharmacies are well placed to take part on local and national campaigns around alcohol misuse. As a local JHWBS priority this should be considered

7.3. Planned care

7.3.1. Level of Need

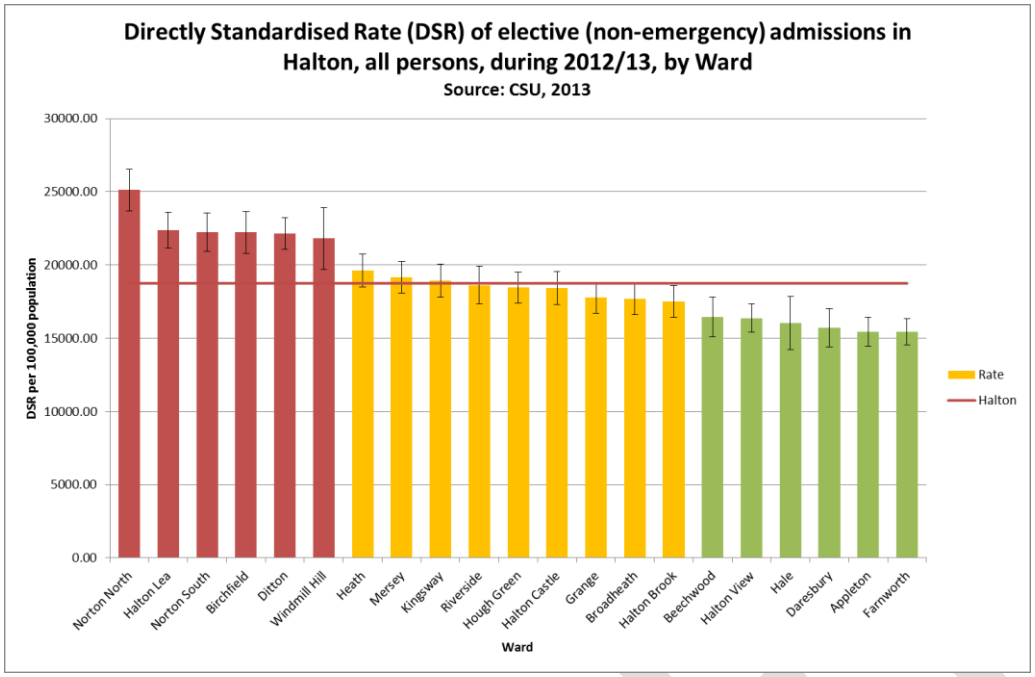
Based on changing population numbers and age structures it is estimated that the number of people being admitted to hospital for a planned procedure will increase. The current reasons for planned (elective) admissions are broadly similar in both boroughs with diseases of the digestive system, of the genitourinary system, cancers (neoplasms), and of the musculoskeletal and accounting for nearly 57% of planned admissions.

Table 4: 2012/13 Elective hospital admissions, top 10 causes

ICD-10 Chapter	Elective Admissions	Percentage
Diseases of the digestive system	4439	20.09%
Diseases of the genitourinary system	2921	13.22%
Neoplasms	2737	12.39%
Diseases of the musculoskeletal system and connective tissue	2489	11.26%
Diseases of the circulatory system	2064	9.34%
Diseases of the eye and adnexa	1516	6.86%
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	1342	6.07%
Factors influencing health status and contact with health services	1204	5.45%
Diseases of the respiratory system	493	2.23%
Diseases of the nervous system	488	2.21%

Figure 17 shows that the rates of admissions are not uniform across the borough. Rates are statistically significantly higher than the borough average in Norton North, Windmill Hill, Norton South, Ditton, Halton Lea, Mersey and Birchfield. They are statistically significantly lower than the borough average in Halton Brook, Halton View, Farnworth, Hale, Beechwood, Daresbury, and Appleton.

Figure 17:Rate of elective admissions by ward, Halton 2012/13



7.3.2. Evidence of effective interventions in the community pharmacy setting

Medicines adherence support services are an important part of the community pharmacist's role[23]. A study of 10,000 adults aged 35+ found that 76% of women but only 63% of men had obtained medicines or asked for advice with only 12% asking for advice but not obtaining medicines[24]. The difference in gender is not surprising and offers some particular challenges to targeting men for advice especially around lifestyle issues. As a Men's Health project in Knowsley found, most men being targeted for a health check (in the pilot year 400 men aged 50-65 were given a health check) had never had such lifestyle advice from a pharmacist. However, once on-board the majority made a positive lifestyle change[25]. Despite these differences this and other studies demonstrate that pharmacies are an important first port of call for advice on minor ailments[26].

Many people do not use their medicines correctly[27] with limited health literacy[vii] impeding patients understanding of medicines instructions[28;29]. This could lead to medicines wastage, with cost implications for the healthcare system[30]as well as long-term conditions not being optimally managed.

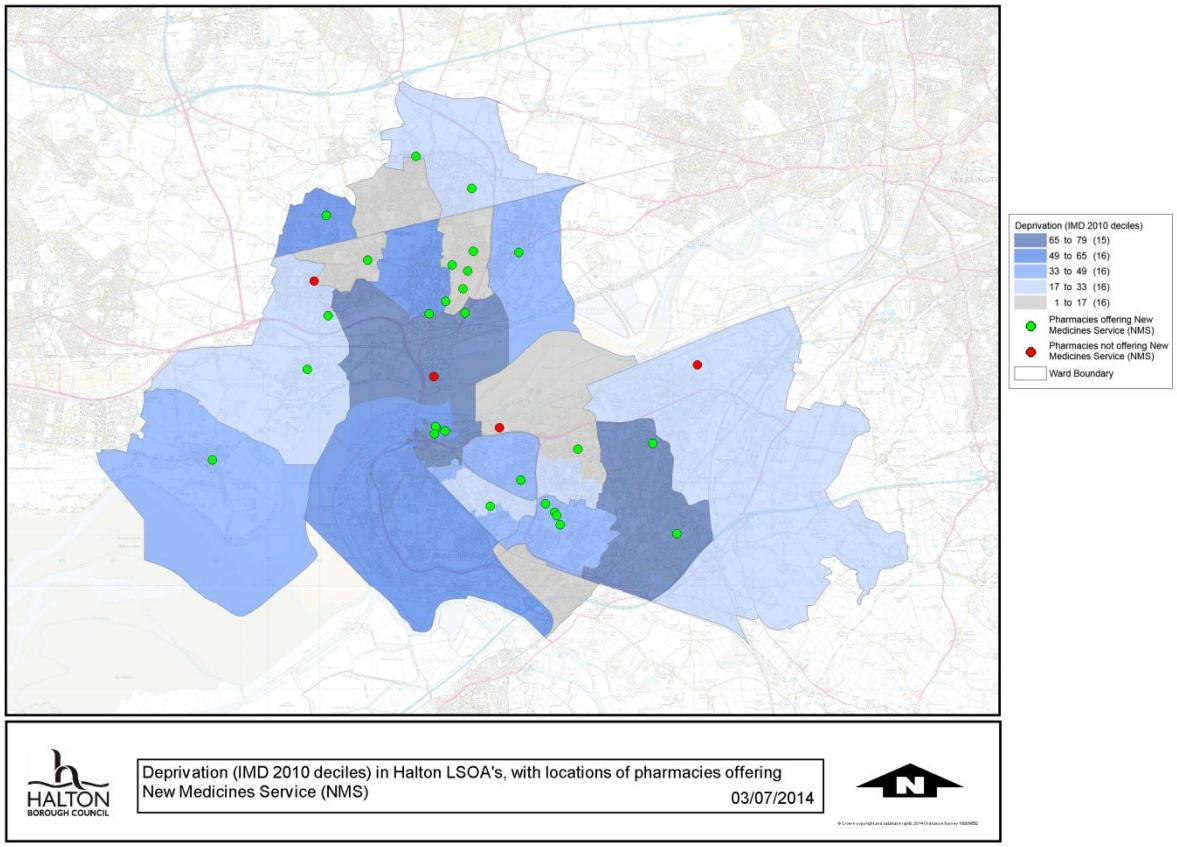
7.3.3. Local provision

New Medicines Service (NMS) was introduced in October 2011, as an advanced service, and provides support with medicines adherence for patients being treated with new medicines in four conditions/therapy areas. These are Asthma / COPD, Type 2 Diabetes, Hypertension and Antiplatelet / Anticoagulation therapy. The pharmacist provides face to face counselling

[vii] Evidence shows that health literacy - "the capacity to obtain, interpret and understand basic health information and services and the competence to use such information and services to enhance health" - is a more useful predictor of the use of preventative services than level of education.

about the medicine at the point when the patient first presents with their prescription at the pharmacy. Arrangements are then made for the patient to be seen 10-14 days later to assess adherence and discuss any problems with the new medicine. The patient is followed up 14 days later to check all is well at which point they exit this service. All but four Halton pharmacies provide NMS as Map 6 shows, giving a good geographical spread in both Widnes and Runcorn.

Map 8: Pharmacies providing new medicines service (NMS)



Medicines use reviews (MURs) form part of the pharmacy contract, the advanced service. Medicines reviews are structured reviews undertaken by an accredited pharmacist to help patients manage their medicines – to improve their understanding, knowledge and use of medicines they have been prescribed.

The introduction, in October 2011, of three national target groups for MURs was designed to help community pharmacy demonstrate to commissioners the benefits of the MUR service and provide assurance that it is a high quality, value for money service that can yield positive health outcomes for patients who will benefit most. The national target groups are:

- Patients taking high risk medicines
- Patients recently discharged from hospital who had changes made to their medicines while they were in hospital. Ideally patients discharged from hospital with receive an MUR within four weeks of discharge but in certain circumstances the MUR can take place within eight weeks of discharge

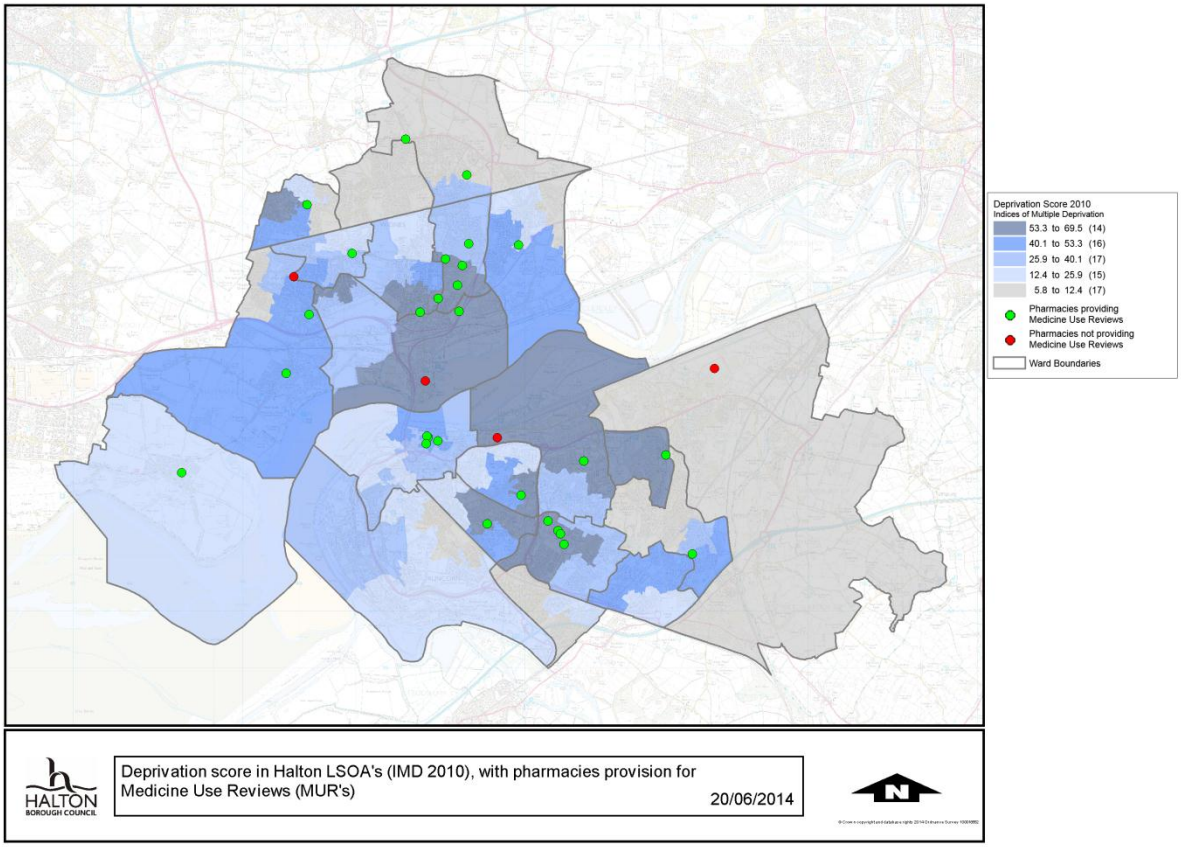
- Patients with respiratory disease

At least 50% of all MURs undertaken by each pharmacy in each year should be on patients within the national target groups. MURs can also be carried out on patients who are not within the target groups. Pharmacists will select patients who will benefit from the MUR service.

MURs are conducted either on a regular basis, e.g. every 12 months, or when the pharmacist feels it is a necessary intervention. They must be conducted in a consultation area to ensure patient confidentiality and privacy. Pharmacists must successfully pass a competency assessment before they can provide MUR services.

86% of respondents to the local community pharmacy services survey stated that they think review or medicines on repeat prescription e.g. when to take them, what they are for and side-effects, should be available through community pharmacies.

Map 9: Pharmacies providing medicines use reviews (MURs)



All areas with high levels of deprivation have at least one pharmacy conducting MURs. Only four Halton pharmacies do not provide MURs, giving good geographical spread in both Widnes and Runcorn.

Conclusions

- There is generally good access to both NMS and MURs across the borough
- Monitoring the targeting of MURs in line with nationally defined target groups is important as well as consideration of which other patients would most benefit from them. Intelligence from patient groups, pharmacy contractors and GPs should be used to help identifying and address barriers to uptake of MURs

7.4. Unplanned/Urgent Care

7.4.1. Level of Need

As with planned admissions, unless current trends can be stemmed, the number of unplanned (non-elective) admission is set to rise across the borough, particularly those that should not usually require hospital care. Using historic data and assuming a linear trend, these numbers are projected to increase by a possible 20% by 2018/19. This includes admissions for acute conditions such as ear/nose/throat infections, kidney/urinary tract infections, certain forms of influenza and pneumonia, some infectious diseases[viii].

Figure 18: Rising numbers of unplanned admissions for acute conditions that should not usually require hospital admission

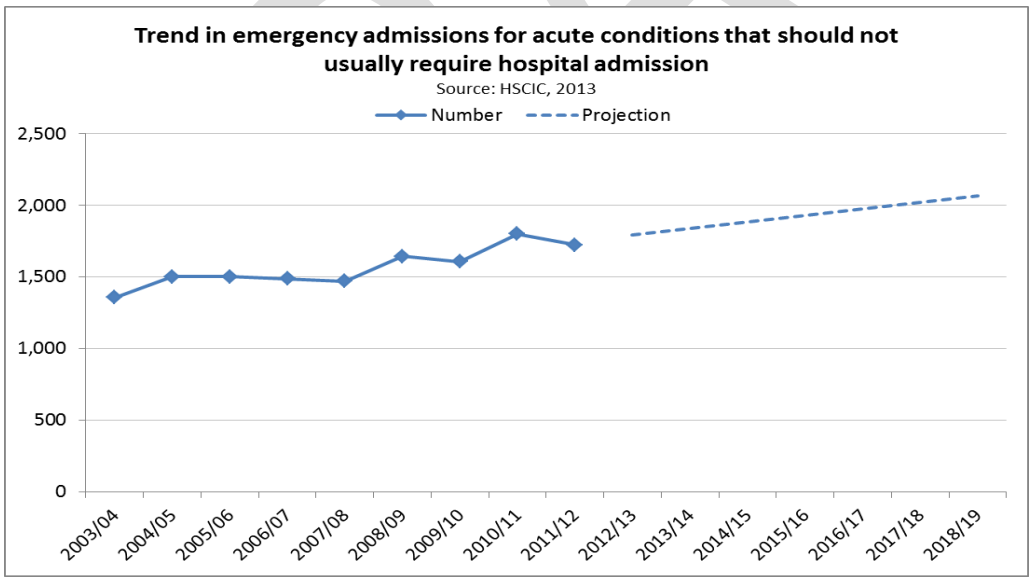


Table 5 illustrates that, as with elective admissions, the top four reasons for people being admitted to hospital as an emergency case make up nearly 60% of all such admissions.

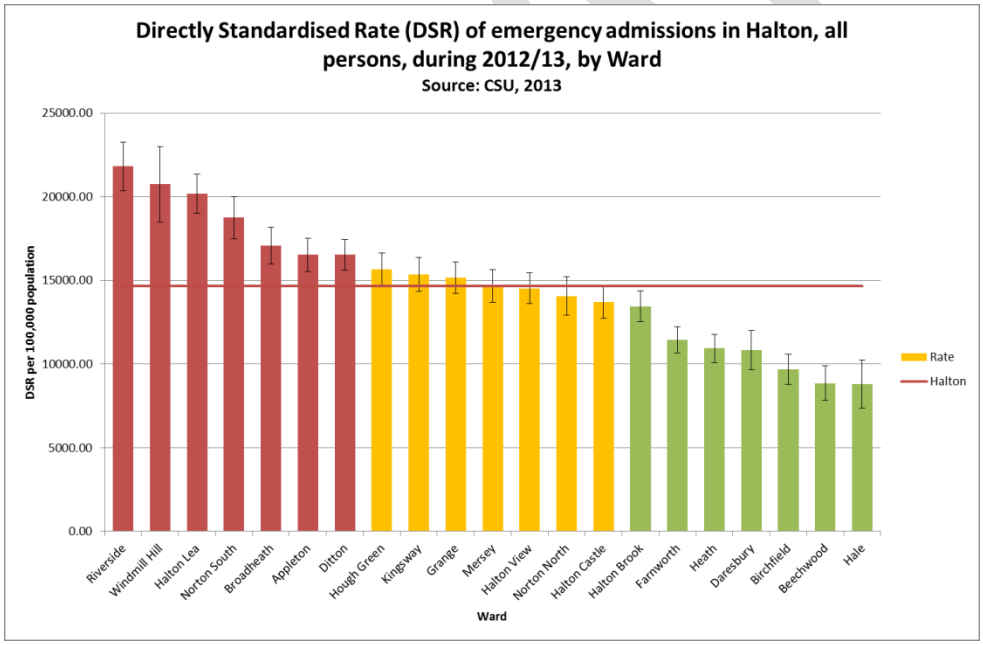
[viii] Emergency admissions for acute conditions that should not usually require hospital admission – indicator specification https://indicators.ic.nhs.uk/download/Outcomes%20Framework/Specification/NHSOF_3a_I00711_S_V5.pdf

Table 5: 2012/13 Emergency hospital admissions, top 10 causes

ICD-10 Chapter	Emergency Admissions	Percentage
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	4365	25.31%
Injury, poisoning and certain other consequences of external causes	2475	14.35%
Diseases of the respiratory system	2034	11.80%
Diseases of the circulatory system	1309	7.59%
Diseases of the digestive system	1259	7.30%
Diseases of the genitourinary system	986	5.72%
Certain infectious and parasitic diseases	967	5.61%
Diseases of the musculoskeletal system and connective tissue	887	5.14%
Mental and behavioural disorders	584	3.39%
Diseases of the skin and subcutaneous tissue	474	2.75%

As with planned admissions, rates for non-elective admissions vary widely across the borough as Figure 19 shows. For 2012/13 there were 8 wards with rates statistically significantly higher than the borough average, 5 with rates not statistically significantly different and 8 wards with statistically significantly lower rates.

Figure 19: Rate of non-elective (emergency) admissions by ward, Halton 2012/13



7.4.2. Evidence of effective interventions in the community pharmacy setting

Several of the research papers identified by the literature search including in their health outcomes reduction in unplanned/emergency admissions. An enhanced medicines management scheme of patients with heart failure post discharge from hospital included community pharmacists as part of multi-disciplinary teams. This improved patient outcomes and decreased unplanned readmissions[31]. Unfortunately, a scheme focused on medicine

reviews of high risk elderly found no difference in hospital admissions but did result in modest prescribing savings. However, it was not possible to determine the cost-effectiveness of this intervention[32]. Similarly a study by Walker et al also failed to reduce hospital readmissions. Using a quasi-experimental study evaluating post discharge health care resource use of patients discharged from hospital, the study intervention added a pharmacist to the discharge team to identify and reconcile medication discrepancies at discharge[33].

Results revealed that whilst the pharmacist identified medication discrepancies at discharge and reconciled all of them, no significant differences in hospital readmission rates and emergency department visits were found. However, the authors note that the strength of the intervention might have been compromised by (1) broad inclusion criteria that might not have identified patients at high risk for hospital readmission and (2) the pharmacist not completing follow-up calls for all intervention patients However, studies in Trafford PCT and Darlington Memorial Hospital both helped to identify and reconcile medications changes. The Darlington study included an analysis of the impact the intervention had on hospital readmissions and found they had reduced amongst those who had taken part in the study[34]. Similarly a scheme in Bournemouth and Poole PCT has also seen positive impacts on admissions, with savings being far greater than the cost per patient of the scheme[35] .

The community pharmacist is an important first port of call for advice on minor ailments[36]. A survey conducted in support of the development of the White Paper of pharmacies found that 14% of people had used pharmacies to treat one-off common conditions, such as colds, coughs, aches and pains, and stomach problems[37] . Thus, increasing the use of minor ailments schemes would be beneficial for both GP workload and A&E attendance. Other studies have shown that helping patients to take medications correctly, such as for asthma and COPD can reduce emergency hospital admissions associated with these conditions[38].

For most people, influenza (flu) is an unpleasant illness making people feel unwell for several weeks, but it's not serious in healthy people. However, certain people are more likely to develop potentially serious complications of flu, such as bronchitis and pneumonia. This can result in emergency hospital admissions or even death. The following groups of people are now offered free NHS influenza vaccination each year:

- Those aged 65 years and over (see also section on older people)
- Pregnant women
- Those who have certain medical conditions[ix] –
    - chronic (long-term) respiratory disease, such as asthma, chronic obstructive pulmonary disease (COPD) or bronchitis
    - chronic heart disease, such as heart failure
    - chronic kidney disease
    - chronic liver disease, such as hepatitis

ix Note this list is not definitive and GPs clinical judgement will be used to assess if a person has an underlying illness that may be exacerbated if they catch the flu

  - chronic neurological conditions, such as Parkinson's disease or motor neurone disease
  - diabetes
  - problems with your spleen – for example, sickle cell disease, or if you have had your spleen removed
  - a weakened immune system due to conditions such as HIV and AIDS, or as a result of medication such as steroid tablets or chemotherapy
- Those living in a long-stay residential care home or other long-stay care facility
- People receiving carer's allowance, or who are the main carer for an elderly or disabled person whose welfare may be at risk if they fall ill
- Healthcare workers with direct patient contact or social care workers

Research has shown that immunisation services can be safely provided in community pharmacy settings[39], that the review of medication records is a useful tool in flagging up those 'at risk' and inviting them to take part in the programme[40]. Such programmes are also well received by both patients and doctors[41] .

7.4.3. Local provision

The Urgent Care Working Group is responsible for overseeing all significant service changes required to deliver Urgent Care across the Halton Health Economy by ensuring that patients can access high quality emergency and follow up care, together with preventing patients from reaching crisis point so that they need to access emergency care.

Halton CCG is developing two Urgent Care Centres which are due to open at the end of 2014/15. The Widnes Centre will be on the existing walk-in-centre site in Widnes town centre. The Runcorn centre will replace the existing minor injuries unit on the Halton hospital site. Opening from early morning until late evening, the centres will have extended access to x-ray, ultra-sound scanning and a range of bio-chemical and haematology diagnostic services. The centre's will have medical as well as nursing staff on site and will be able to receive patients via paramedic staff. The centre in Runcorn has a limited medication stock provided through to Patient Group Directives (PGDs). This is maintained by Warrington and Halton Hospitals NHS Foundation Trust. The Widnes site uses a combination of PGDs and FP10 prescriptions[x], with a commercial pharmacist on site open until early evening Monday to Saturday.

The development group are working on understanding the potential medicine needs of the patient population and looking to ensure appropriate access to medication via the use of agreed on site stocks and FP10 prescription pads. Later opening of on-site pharmacies will be explored as part of this development.

All pharmacies offer an over the counter service which provides medication for a range of minor ailments and injuries. Additionally there is commissioned provision of Care at the Chemist, NMS and MURs (see planned care section for NMS and MURs).

x Prescribing for patients in community settings will often occur on FP10 prescription forms which can be taken by the patient to a community pharmacist of their choice for dispensing.

Minor ailments scheme: Care at the Chemist (CATC)

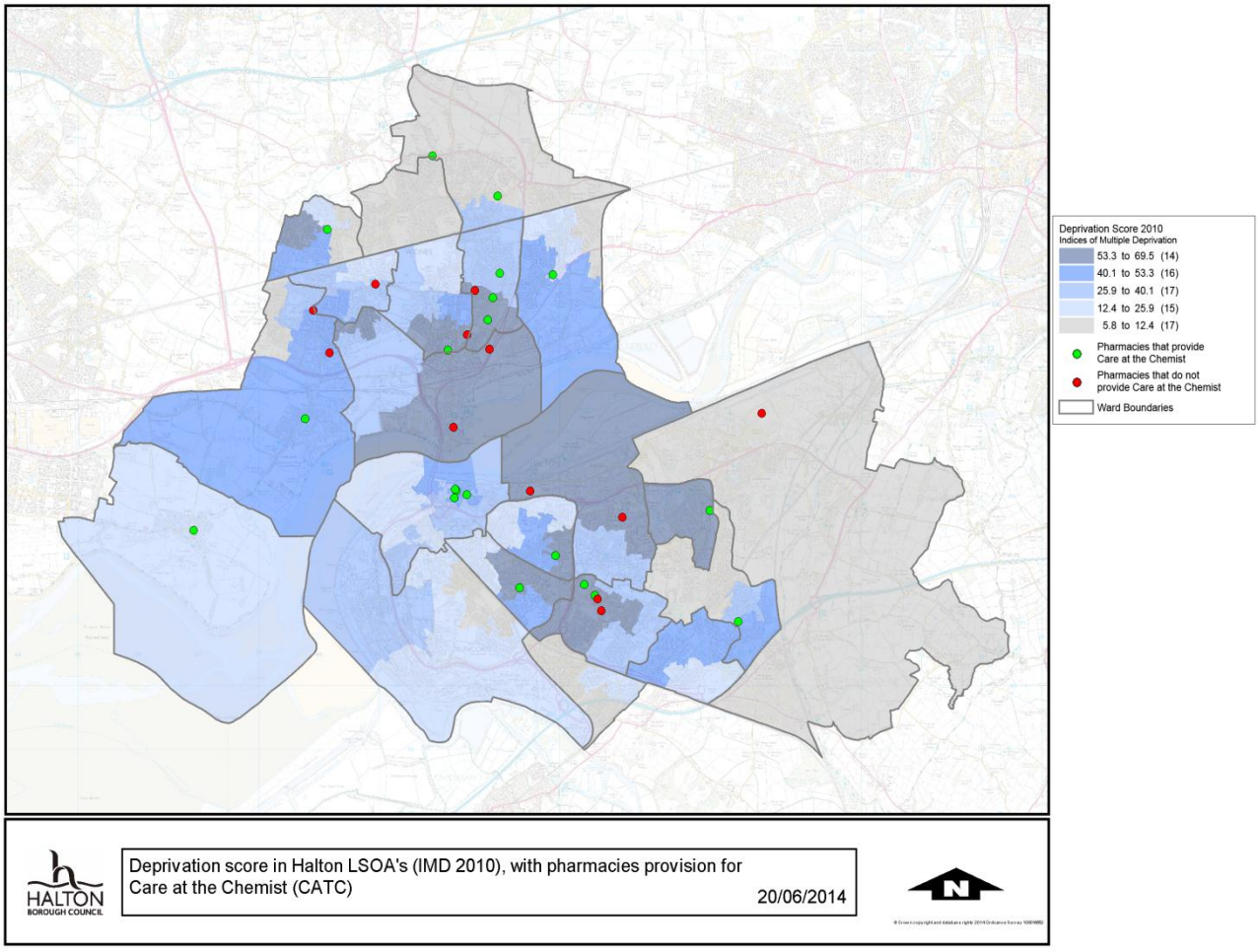
Unlike GPs, community pharmacies are a 'walk up and get seen' service. As such they are a key resource for advice on treating minor, self-limiting, ailments and the purchase of appropriate over-the-counter medicines. The minor ailments service takes this concept a stage further. Patients can attend a participating community pharmacy and ask to be seen under the scheme, if the condition is covered by the scheme the patient will receive a consultation and are provided with advice or medication as appropriate from a dedicated formulary. This service is open to patients resident within Halton CCG and is delivered by accredited Halton pharmacies who have signed up to participate in scheme.. The service cannot be commissioned from Internet only pharmacies. The aim of the service is to improve access and choice for people with minor ailments by promoting self-care through the pharmacy, including provision of advice and where appropriate, medicines without the need to visit their GP practice. There is a defined list of conditions that can be treated under the scheme and an extensive formulary that is currently being reviewed. The service provides additional benefit by creating capacity within general practice to provide services to patients requiring more complex management such as the management of long term conditions.

NHS Halton CCG currently has 22 of its 30 community pharmacies providing Care at the Chemist (CATC) across the borough (see Map 10). The service is well used, with data showing higher uptake in pharmacies in the more deprived wards of Halton. Available data illustrates a large variation in client uptake between pharmacies. The most common ailments patients access the service for minor pain, coughs and colds, stomach upset and head lice.

Historically there were difficulties in provision of CATC at border locations around the CCG. However there is now a mutual agreement for pharmacies from neighbouring CCGs of Liverpool, St. Helens and Knowsley to provide Minor Ailment Services to residents of Halton so this is no longer the case.

87% of respondents to the local community pharmacy services survey stated that they think treatment of minor services should be available through community pharmacies.

Map 10: Pharmacies providing Care at the Chemist service



Halton Castle is the only ward with high levels of deprivation that has no CATC service.

Influenza vaccination amongst at risk people aged under 65

Influenza vaccination is offered to a range of 'at risk' patients under the age of 65 as well as to all those aged 65 and over (see older people's section for more details in vaccination uptake amongst those aged 65+). Some of these annual invites have been established for many years, whilst others are more recent. Public Health England (PHE) is now responsible for commissioning all NHS vaccination and immunisation programmes. These are run predominantly through GP practices, with invitations generated through practice lists and disease registers plus any other patients GPs feel would benefit. Data for the 2013/14 vaccination season is shown in Table 6. All elements of the influenza vaccination have a 75% uptake target in line with WHO recommendations.

Table 6: Influenza vaccination uptake rates for those at risk under age 65 years, 2013/14

	Halton CCG	Merseyside Area Team	England*
All those at risk aged under 65 years	51.9%	55.3%	52.3%
Chronic heart disease	52.8%	55.1%	
Chronic respiratory disease	51.5%	55.3%	
Chronic kidney disease	59.7%	60.7%	
Chronic liver disease	46.0%	49.3%	
Chronic neurological disease (including stroke/TIA, cerebral palsy and MS)	51.1%	52.1%	
Those with immunosuppression	55.2%	59.1%	
Pregnant women	38.3%	42.9%	39.8%
All 2 year olds	47.3%	38.2%	42.6%
All 3 Year Olds	43.4%	35.9%	39.6%
Healthcare workers	56.0%	72.8%	

Source: ImmForm, Department of Health, via NHSE public health team

*Note: only limited data at an England level is available until late autumn 2014. This table will be updated once data is released.

As can be seen no element of the programme is achieving the 75% target. Some GP practices did achieve it for certain patient groups during 2013/14 but the majority did not. PHE, working with the CCG and LAPHT, are looking at ways to increase uptake. This includes the role of community pharmacies in awareness raising, signposting and on a one-year trial basis 2014/15 the commissioning them to provide NHS free flu vaccinations to at risk groups. Practice level reports are provided.

Conclusions

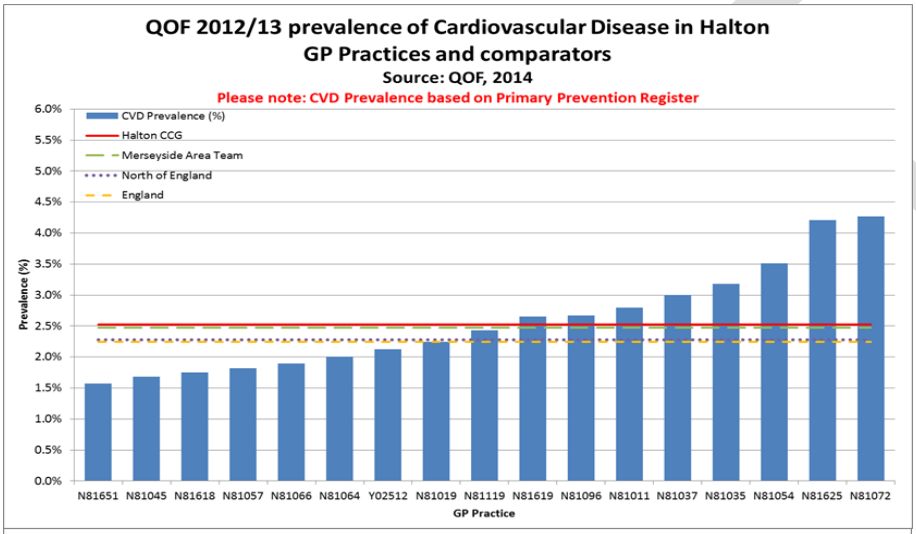
- There is currently partially adequate access to Care at the Chemist (CATC), including 100-hour evening and weekend provision. Increasing provision across the borough is already being investigated for 2014/15. The formulary and protocols in use are also being reviewed in full
- Cross-border collaboration between boroughs (Liverpool, St Helens and Knowsley) has increased both access and choice
- Ways of improving awareness of CATC amongst key target groups should be investigated and once the full review is complete a re-launch of the service will be undertaken
- Influenza vaccination uptake needs to improve, especially for at risk groups under age 65, and Public Health England (PHE) are putting plans into place to do this. This will include commissioning pharmacies to provide NHS free vaccinations. This will be done on a restricted trial basis of one year during the 2014/15 'flu season' with the potential to extend, depending on trial outcomes

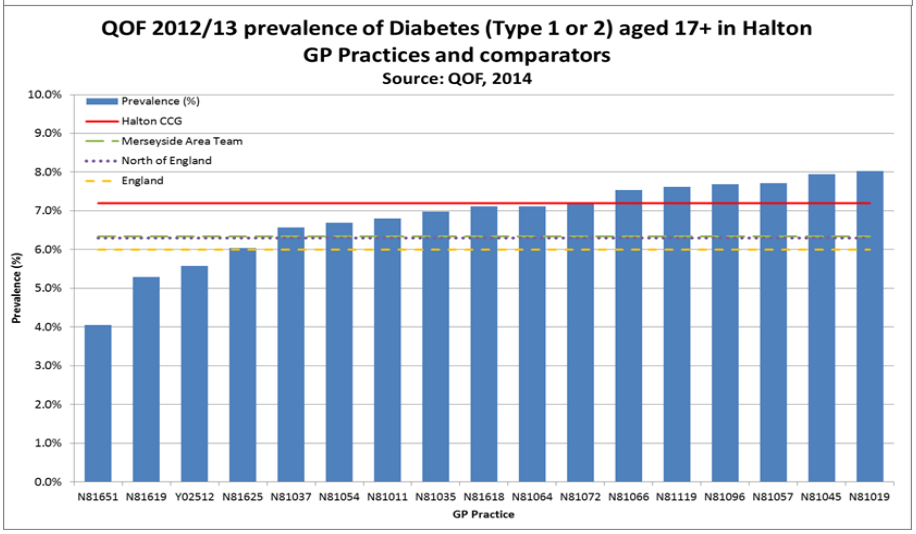
7.5. Supporting and identifying people with Long Terms Conditions

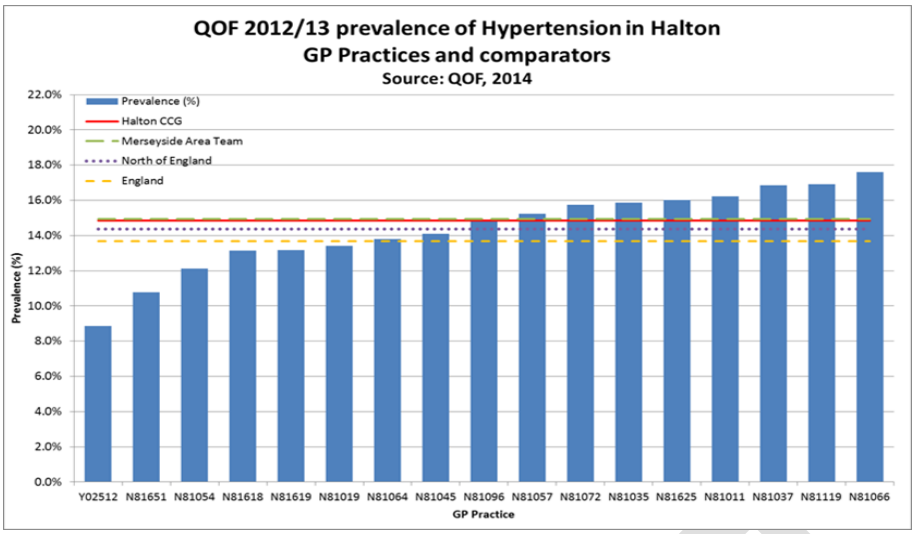
7.5.1. Level of Need

The known prevalence of cardiovascular disease, diabetes and hypertension is higher in Halton than for its comparators. Whilst this may in part be due to proactive case finding estimated prevalence rates are also higher than the England averages suggesting these long-term conditions place a higher burden on the local population and healthcare provision.

Figure 20: Diagnosed prevalence of cardiovascular disease, diabetes and hypertension, 2012/13

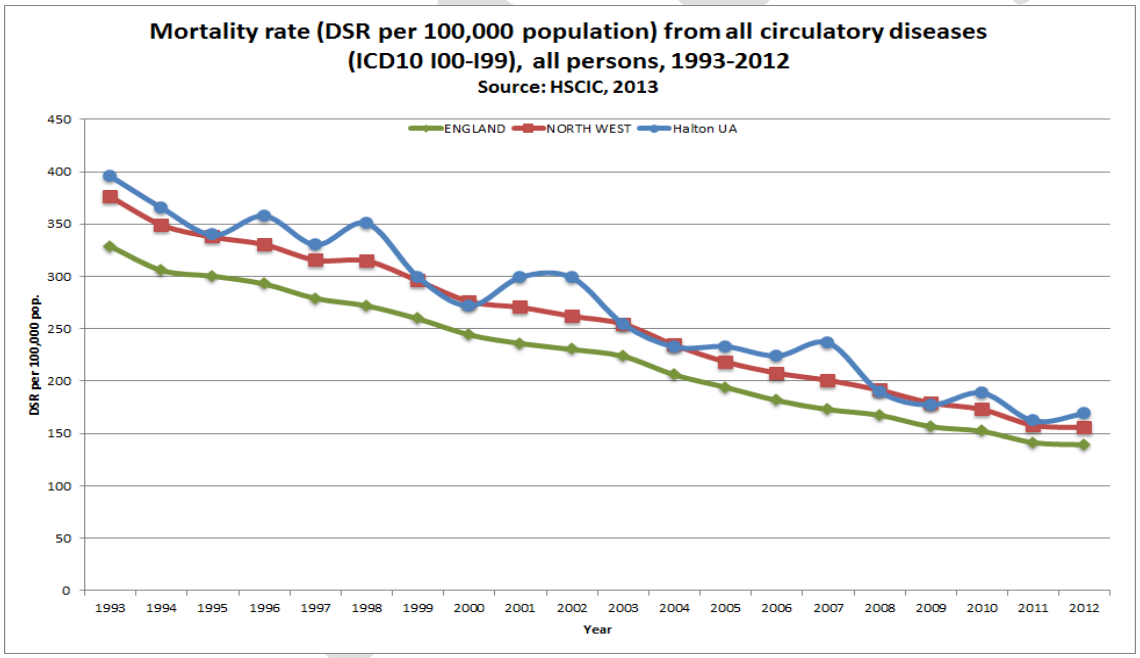






The impact of this level of need can be seen ultimately in death rates. Rates have fallen substantially over the last two decades. However, the gap between Halton and England remains, albeit having narrowed the gap slightly.

Figure 21: Trend in death rates from circulatory disease, 1993 to 2012



7.5.2. Evidence of effective interventions in the community pharmacy setting

Research studies on the community pharmacy role in reducing the risk and improving outcomes for patients with cardiovascular disease (CVD) are one of the areas where evidence of effectiveness is strongest. Community pharmacy-based initiatives are particularly effective in reducing lipid levels, in reducing systolic blood pressure[42;43;44]and risk assessment.[45]They are less effective for more complex, multi-component interventions aimed at addressing medicines management and lifestyles as part of one programme.[46;47]Even when successful such complex interventions may not be cost-effective.[48]NICE produced public health guidance on proactive case finding to reduce health

inequalities in deaths from cardio-vascular disease and smoking-related deaths[49]. It included a recommendation to provide services in places that are easily accessible to people who are disadvantaged (such as community pharmacies and shopping centres) and at times to suit them. However, an evaluation of the North Tees Health Checks programme, pharmacy element, was carried out in 2010/11[50]. Conducted by interviewing staff from community pharmacy, staff members from the commissioning Primary Care Trusts and with Local Pharmaceutical Committee members it found a number of challenges presented covering 4 categories:

(1) establishing and maintaining pharmacy Healthy Heart Checks, (2) overcoming IT barriers, (3) developing confident, competent staff and (4) ensuring volume and through flow in pharmacy.

It thus concluded that delivering NHS Health Checks through community pharmacies can be a complex process, requiring meticulous planning, and may incur higher than expected costs. Given these barriers, the local implementation of the NHS Health Checks programme should continue to be run through GP practices until such barriers can be overcome and evidence suggests pharmacies-run programmes do not incur higher costs. However, it is clear from the evidence that community pharmacies can play a role in supporting people with long-term conditions.

Long-term condition management initiatives run in the community pharmacy setting do not have to be pharmacist-led to be effective. A peer health educator programme in which GPs referred older patients with hypertension to a community-pharmacy based volunteer health programme was well received by patients and GPs[51].

Community pharmacy-based interventions can be effective in the management of those with Type 2 diabetes and the pharmacist can be an important member of the multidisciplinary team managing patients with diabetes.[52;53] Research has shown interventions can reduce HbA1c levels[54;55;56;57;58,] improve glycaemic control,[59;60;61]bring about improvements in CVD risk in patients with diabetes[62]and general adherence to clinical guidelines through patient education and medicines assessments.[63] They can be effective in targeting those at high risk providing them with point-of-care blood glucose testing and referral being more effective and cost effective than targeting and referral alone. This can reduce emergency hospital admissions. Type 2 diabetes and other CVD screening is effective in diagnosing new cases and bringing about positive therapy changes[64;65] and simple tools can be developed to do this.[66].

7.5.3. Local provision

Many of the commissioned services already described will support people in the borough who have an identified long term condition such as MURs and CATC. For those who have a newly diagnosed condition for which medication is prescribed the NMS can be offered.

Health checks are no longer commissioned through pharmacies. However, several pharmacies who responded to the pharmacy premises and services questionnaire indicated that they currently provide non-commissioned blood pressure monitoring, cholesterols tests, diabetes tests and asthma management support. This means patients pay the

pharmacy directly for this service. This may identify patients who have a LTC and are unaware they have it.

The Department of Health introduced a vascular health checks[67] initiative aimed at reducing the burden of cardiovascular disease and mortality, including inequalities in this burden.

The initiative, known as the NHS Health Check programme, is a public health programme for people aged 40-74 which aims to keep people well for longer. The programme aims to prevent heart disease, stroke, diabetes and kidney disease. Together these conditions account for a third of the difference in life expectancy between the most deprived areas and the rest of the country.

Although not a statutory requirement, the risk management element of the programme, provided through lifestyle interventions, is important to ensure that the programme has long term benefits for public health. The guidance recommends that everyone receiving a health check is given individually tailored advice to help motivate them to make appropriate lifestyle changes to manage their risk (unless clinically unsafe to do so). Such advice may include referrals to:

- Local stop smoking services
- Physical activity interventions
- Weight management programmes
- Alcohol use interventions
- Signposting to dementia services

The recently revised Health Checks programme is delivered through all GP practices. In 2012/13 5,217 eligible patients (between the ages of 40 to 74 and not currently on a GP disease register) were invited for a Health Check ands of these 2,179 had a Health Check. This equates to 6.2% of the overall eligible population. In an attempt to boost the number of patients receiving Health Checks, health trainers from the Health & Wellbeing Service have been located in some practices. This offer has the advantage of being able to sign patients up for appropriate lifestyle services there and then rather than making a referral. A community based approach is in the process of being developed but it is unlikely to involve pharmacist in delivering the programme directly. The role of the community pharmacies will be required to focus on the management of any medication needs that may result from the health check. It is expected that for an annual population of people invited for a Health Check to primary care 1264 will be smokers and 1214 obese or overweight, 515 will require statins and 138 will require medication for high blood pressure. The pharmacy has a very clear role in provision of this medications and support to enable compliance.

In addition to Health Checks there are well established disease registers within GP practices to ensure the proactive management of patients with established long-term conditions such as cardiovascular disease, diabetes, respiratory disease, asthma and others.

85% of respondents to the local community pharmacy services survey stated that they think tests to check blood pressure, cholesterol and whether they might get diabetes or other conditions should be available through community pharmacies. 80% stated that smoking

cessation and/or nicotine replacement therapy should be available and 74% thought weight management should be available.

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

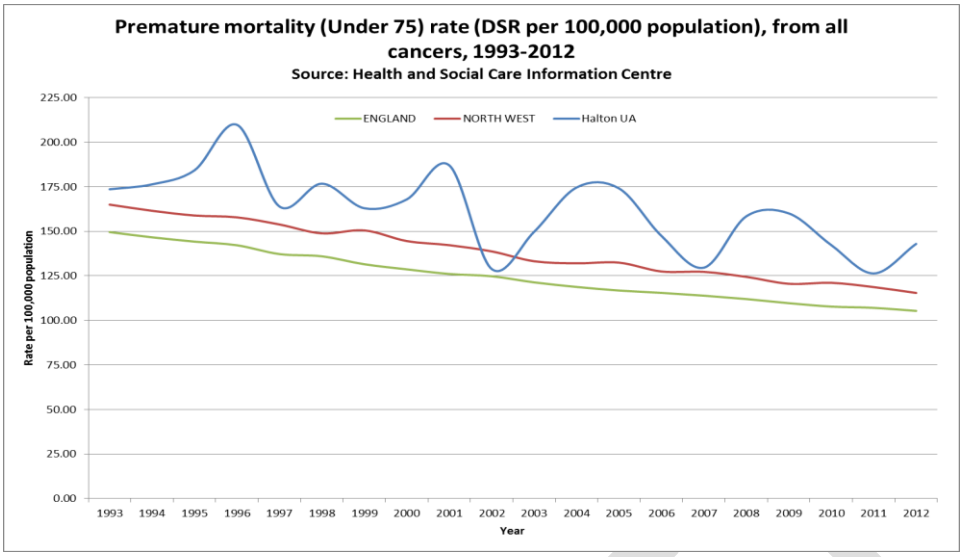
7.6. Cancers

7.6.1. Level of Need

Whilst the evidence indicates that substantial reduction in deaths from cancers can be achieved by healthy lifestyles, interventions to bring about this change are long-term. Local assessment suggests capacity in secondary care is not a significant issue. In the short term the most likely way to improve survival times and reduce deaths from cancer is to get people who have symptoms to come forward for treatment faster.

Figure 22shows that Halton has significantly higher mortality rates than England and also the North West (except for 2002 and 2007) since 1993. Despite this the overall trend is downwards. Cancer remains one of the top priorities for the borough, as laid out in the 2013-16 Joint Health & Wellbeing Strategy.

Figure 22: Cancer mortality trends amongst those aged under-75, 1993 to 2012



7.6.2. Evidence of effective interventions in the community pharmacy setting

See also tobacco control

The community pharmacy is an ideal place for the public to obtain information on cancer. Pharmacy-based information, such as touch screen technology, appears to be effective in raising awareness of sun risks, and trained pharmacists are more likely to be proactive in counselling clients. However, the effect of this advice on the behaviour of clients is currently unknown[68]. This could be rolled out to include awareness campaigns about skin and bowel cancer and screening. Feedback from a scheme in Essex showed that over 92% of the public consulted reported that they are comfortable discussing issues such as cancer in a pharmacy setting with the pharmacy team.[69]For those with established cancers pharmacies can play an important role in identifying common drug-related problems (DRP) via medication therapy management (MTM) services[70].

7.6.3. Local provision

The local Cancer Strategy emphasises prevention and early detection. The *Get Checked* programme has been running since 2008, and has subsequently adopted the national campaign messages of *Be Clear on Cancer*. This early detection of cancer initiative combines social marketing with clinical staff training. Social marketing is used to encourage people with symptoms to seek medical advice. Their campaigns use a wide range of outlets and vehicles to spread the key messages, including Pharmacies. However, it would not be appropriate for pharmacies to offer cancer screening. Both the breast and cervical screening require specialist equipment and staff. The bowel screening programme is based on home testing that is posted direct to laboratories. Cancer is a local JHWBS priority. As such, and based on the evidence, it would be appropriate to include cancer screening and sun awareness as one of the six health education campaigns pharmacies should support each year as part of their essential services, national contract.

Conclusions

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

7.7. Sexual Health

7.7.1. Level of Need

Improving the sexual health of the population is a national and local priority with the most recent national Public Health strategy[71] and sexual health framework outlining the reasons and approach.[72]

Locally our population suffers from poor sexual health. Teenage conception rates have fallen in recent years but remain above the national and regional rates (Figure 23). This is also the case for abortions amongst under-18s (Figure 24). The borough also has rising numbers of sexually transmitted infections (STIs) and HIV being diagnosed. Halton's overall rate of STIs for 2012 was slightly below the Cheshire & Merseyside average and was the fourth highest of the nine local authorities in the sub-region (Figure 25).

Figure 23: Teenage conception rates 1998 to 2012

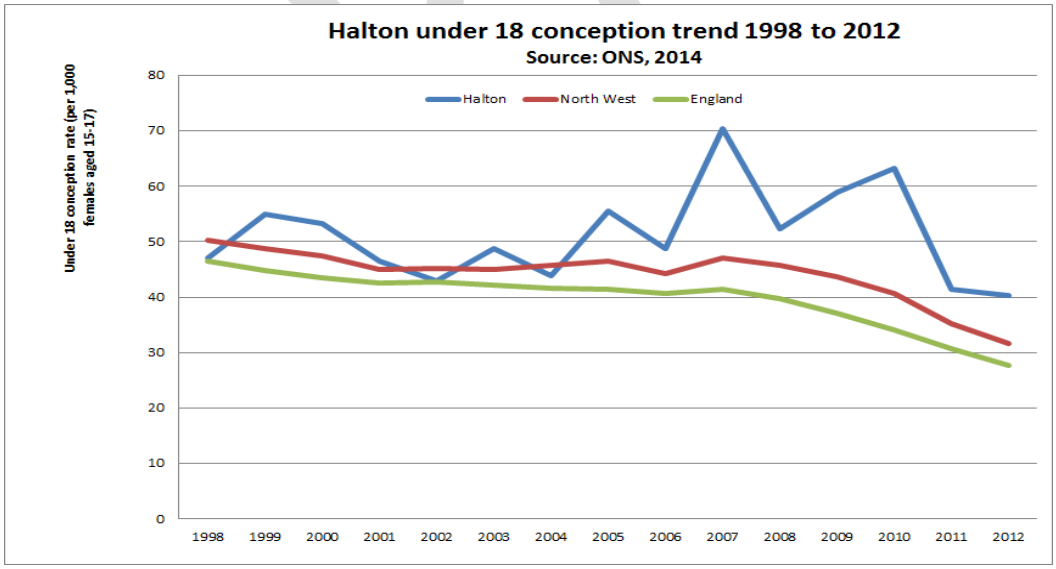


Figure 24: Abortion rates amongst women aged less than 18 years of age, 1998 to 2012

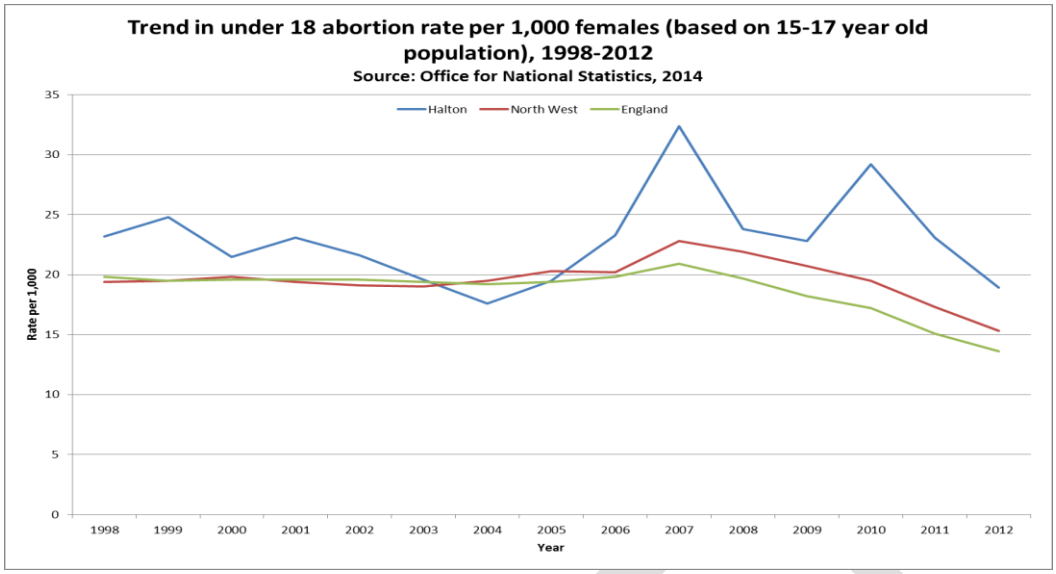


Figure 25: Sexually transmitted infection rates in Halton 2008 to 2012 and compared to other local authorities in Cheshire & Merseyside, 2012

7.7.2. Evidence of effective interventions in the community pharmacy setting

NICE guidance on contraceptive services for young people (up to the age of 25)[73], key recommendations include:

- Establish collaborative, evidence-based commissioning arrangements between different localities to ensure comprehensive, open-access services are sited in convenient locations, such as city centres, or near to colleges and schools. Ensure no young person is denied contraceptive services because of where they live
- Ensure pharmacies, walk-in centres and all organisations commissioned to provide contraceptive services (including those providing oral emergency contraception) maintain a consistent service. If this is not possible, staff should inform young people, without having to be asked, about appropriate alternative, timely and convenient services providing oral emergency contraception
- Doctors, nurses and pharmacists should where possible, provide the full range of contraceptive methods, especially long-acting reversible contraception (LARC), condoms to prevent transmission of STIs and emergency contraception (both hormonal and timely insertion of an intrauterine device). Adequate consultation time should be set aside

- Provide additional support for socially disadvantaged young people to help them gain immediate access to contraceptive services and to support them, as necessary, to use the services. This could include providing access to trained interpreters or offering one-to-one sessions. It could also include introducing special facilities for those with physical and sensory disabilities and assistance for those with learning disabilities
- Ensure all young women are able to obtain free emergency hormonal contraception, including advance provision
- Offer support and referral to specialist services (including counselling) to those who may need it. For example, young people who misuse drugs or alcohol and those who may have been (or who may be at risk of being) sexually exploited or trafficked may need such support. The same is true of those who have been the victim of sexual violence
- Ensure young men and young women know where to obtain free advance provision of emergency hormonal contraception
- In addition to providing emergency hormonal contraception, professionals should ensure that all young women who obtain emergency hormonal contraception are offered clear information about, and referral to, contraception and sexual health services
- Encourage all young people to use condoms and lubricant in every encounter, irrespective of their other contraceptive
- Ensure staff are familiar with best practice guidance on how to give young people aged under 16 years contraceptive advice and support.[xi] Ensure they are also familiar with local and national guidance on working with vulnerable young people

A review of the contribution of community pharmacists to the public health agenda[74]found:

• Emergency hormonal contraception (EHC) can be effectively and appropriately supplied by pharmacists

• Pharmacy supply of EHC enables most women to receive it within 24 hours of unprotected intercourse

• Community pharmacies are highly rated by women as a source of supply and associated advice for EHC on prescription, by Patient Group Directions (PGDs), or over-the-counter (OTC) sales

• 10% of women, choose pharmacy supply of EHC in order to maintain anonymity

• Pharmacists were positive about their experience of providing emergency hormonal contraception through PGDs and over-the-counter sales

• The role of pharmacy support staff in provision of EHC services is reported by pharmacists to be important, but there are no data available to enable assessment of their contribution

7.7.3. Local provision

Across Halton emergency hormonal contraception is provided by a host of providers at different times:

- Pharmacy under patient group direction (Local Service)
- GP's
- Walk in Centre
- A & E
- Community Sexual Health Services

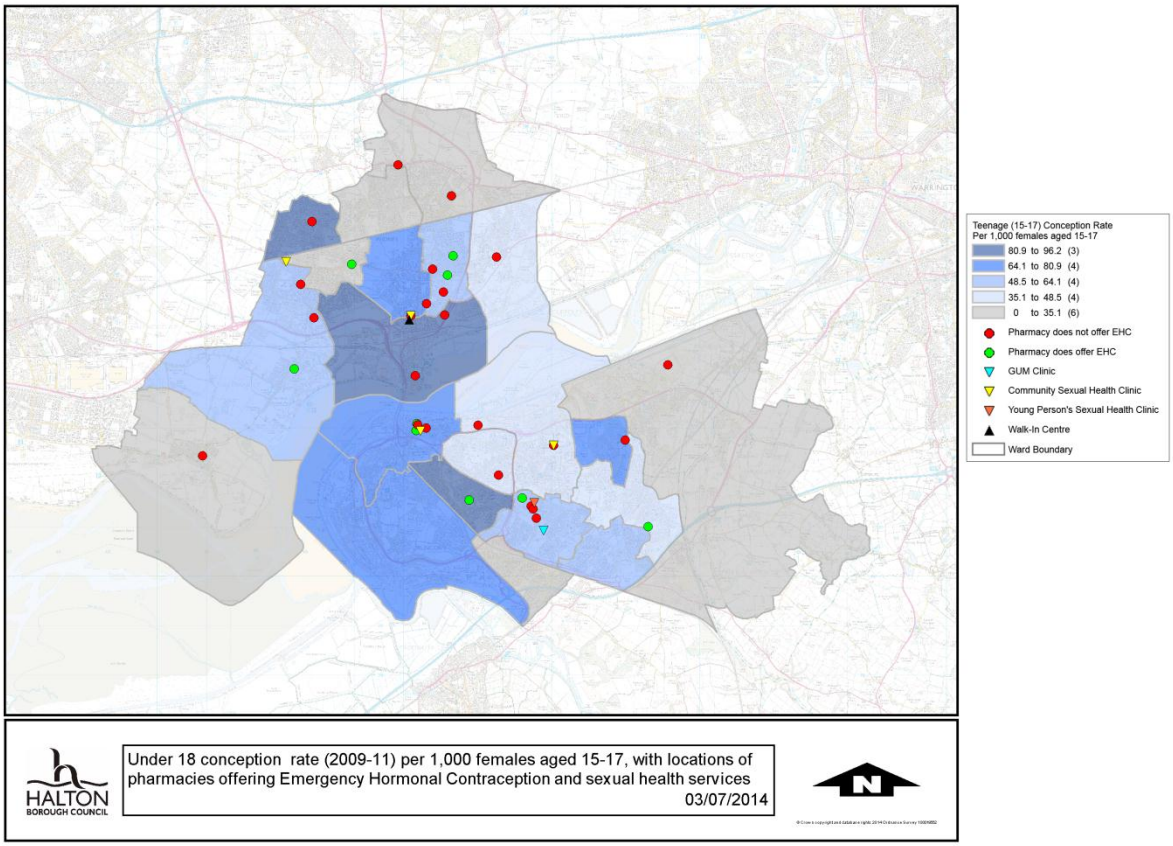
[xi]Department of Health (2004) Best practice guidance for doctors and other health professionals on the provision of advice and treatment to young people under 16 on contraception, sexual and reproductive health. London: Department of Health.

- School nursing
- Genito-urinary medicine (GUM)

9 pharmacies provide Emergency Hormonal Contraception (EHC) as a locally commissioned service during the pharmacy's normal opening times. Pharmacists must be accredited to provide the service; the pharmacist also provides advice and signposting in respect of contraception and sexual health. Whilst pharmacies providing EHC can advise and signpost people to other services, neither chlamydia screening or screening for other STIs, is commissioned. 15 pharmacies do have toilet facilities that clients could use for screening and pregnancy testing, 5 of which are commissioned and provide EHC. The c-card scheme enables people to access free condoms. These are available at community sexual health clinics and pharmacies who provide EHC.

Map 11 shows the level of teenage conceptions by ward and the distribution of pharmacy EHC services in the borough. Some pharmacies that have been commissioned to provide the service are currently not providing it. From previous experience this is generally due to accredited pharmacists moving on from that location or accreditation requirements for pharmacists not being completed.

Map 11: Emergency Hormonal Contraception provision by community pharmacies and other community healthcare providers



Whilst the map shows that whilst there are wards in the borough with higher teenage pregnancy rates and no community pharmacy EHC provision there is some community

health care EHC provision including the Widnes walk-in centre in those areas. Therefore provision is adequate.

74% of respondents to the local community pharmacy services survey stated that they think advice on contraception and supply of EHC should be available through community pharmacies. 19% thought it should not be available. The percentage stating they think it should be available is slightly lower than for some other types of advice and service but 2 out of 3 respondents still think it should be available.

Conclusions

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

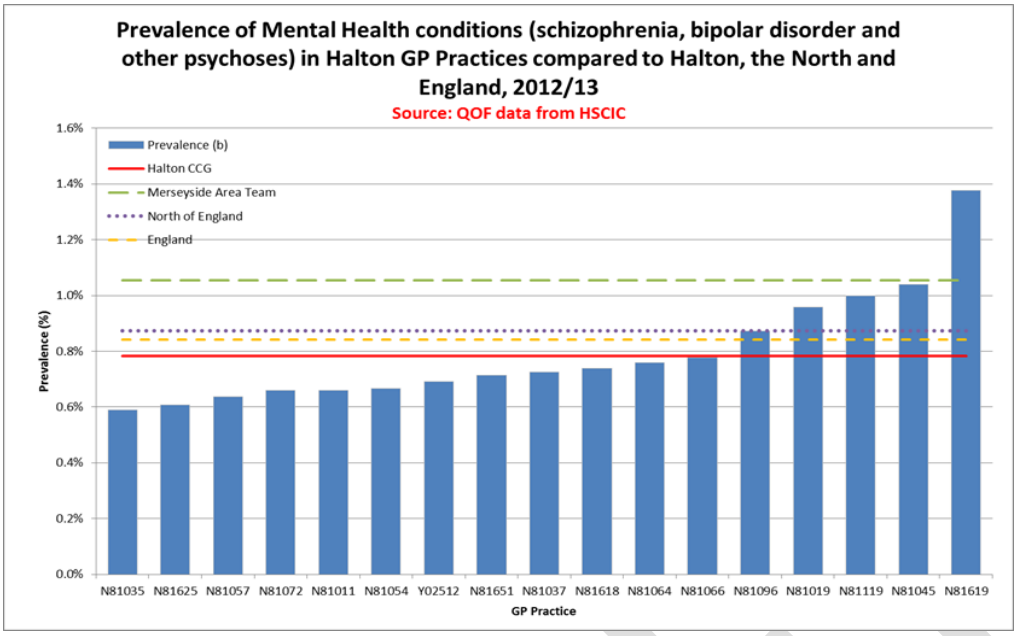
7.8. Mental Health

7.8.1. Level of Need

Mental Health is one of Halton's Health & Wellbeing Strategy priorities, with an emphasis on wellbeing as well as prevention and early detection of mental illness.

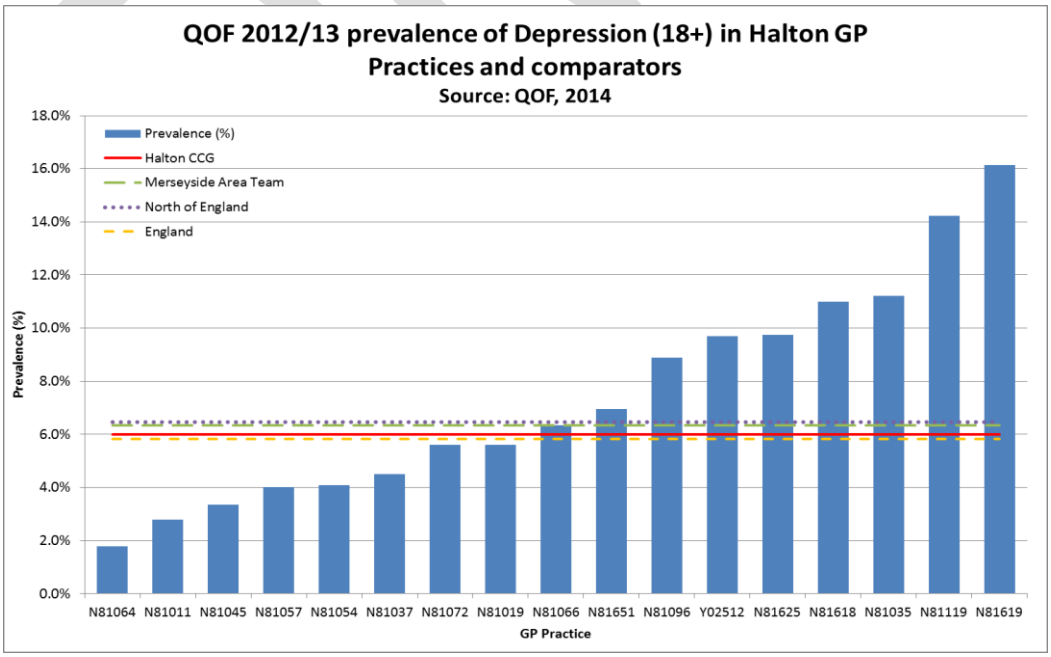
Since 2008-9 the Quality Outcomes Framework (QOF) has included that the GP register of mental health includes all people with a diagnosis of schizophrenia, bipolar affective disorder and other psychoses rather than a generic phrase that is open to variations in interpretation. This brings mental health in line with other areas of the QOF. Such patients should receive a review every 15 months which includes health promotion and prevention advice, have a care plan, the follow-up of those who do not attend for their annual review and monitoring of the use of lithium therapy.

Figure 26: Prevalence of mental illness identified on GP registers in Halton, compared to Merseyside and England, 2012/13



Further changes to QOF for 2009-10 included the introduction of a register for those aged 18 and over who have been diagnosed with depression. Clinical management indicators include the percentage of patients on the diabetes and/or CHD register who have been assessed for depression, for those newly diagnosed with depression, the percentage of whom have had an assessment of the severity of newly diagnosed their depression at the onset of treatment and the percentage of those who receive an assessment who then receive a follow-up assessment 5-12 weeks after this.

Figure 27:Prevalence of depression identified on GP registers in Halton, compared to Merseyside and England, 2012/13



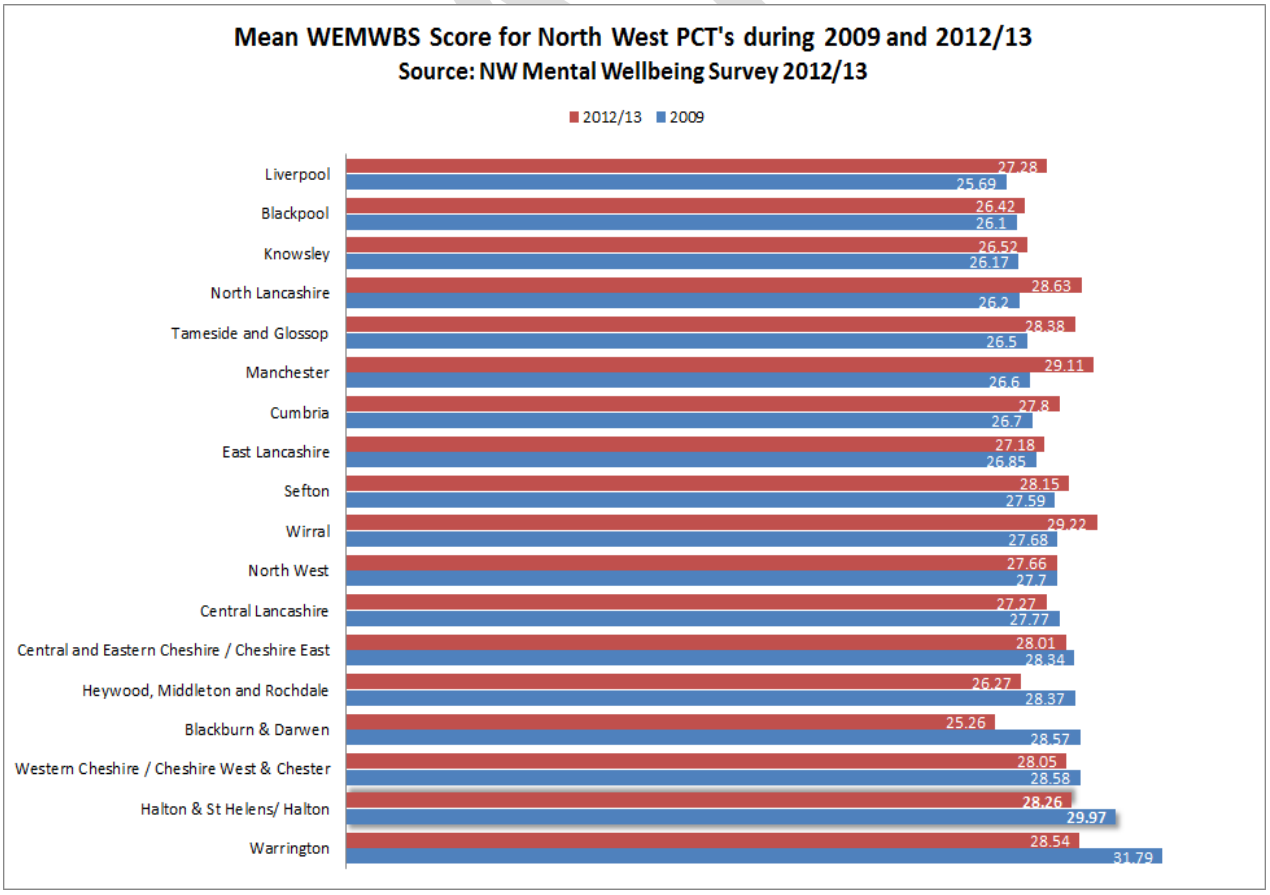
Much of the data available under the label mental health is in fact measuring a clinically diagnosed mental illness. There has been increasing interest nationally and locally in the concept of mental wellbeing. The Foresight report[75] defines mental wellbeing, or simply wellbeing, as:

> *"a dynamic state, in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others, and contribute to their economy. It is enhanced when an individual is able to fulfil their personal and social goals and achieve a sense of purpose in society."*

The North West Mental Wellbeing Survey points out that there is a clear distinction between mental wellbeing and mental illness. Mental health, or mental wellbeing, is something we all have and seek to improve. Mental illness or disorders affect up to one in four people. The determinants of one are not necessarily the same as the other[76].

Results from the 2009 North West mental Wellbeing Survey and the more recent 2012/13 survey are shown in Figure 28. Using a composite score of 7 questions on a 5-point Likert scale, known as WEMWBS (Warrick and Edinburgh Mental Wellbeing Score), boroughs could easily be compared to the North West average and also to one another.

Figure 28: NW mental wellbeing survey results



Although the overall wellbeing score for Halton is slightly lower than the previous result for Halton & St Helens PCT, it is nevertheless above the North West average and higher than others in the Liverpool City Region, apart from Wirral.

7.8.2. Evidence of effective interventions in the community pharmacy setting

No relevant studies on the early detection or depression were found in the literature review undertaken. A report by the Department of Health on the public health role of pharmacists, acknowledges this lack of an evidence base, suggesting that it is not beyond the scope of community pharmacists to have a role in mild to moderate mental ill health. For example, customers purchasing products to reduce stress and anxiety, such as sleeping products, could be offered support and advice from appropriately training pharmacists such as signposting or referral to local services[77]. This role in detecting the early signs and symptoms of mental health problems and providing information on how to deal with them is supported by a joint pharmacy report in which they conclude that there is a potential role for pharmacy staff to offer support and advice in relation to mental health issues[78]. Studies have also shown that the community pharmacist can make a valuable contributions to community mental health teams (CMHTs).[79;80;81]

7.8.3. Local provision

Mental Health is a local Joint Health & Wellbeing Strategy (JHWBS) priority. The focus of the JHWBS is one of wellbeing, prevention and early detection across the life course. This is in line with the national mental health strategy.

The community pharmacy is an ideal place for the public to obtain information on all forms of mental health conditions, and in particular ways in which they can access support and services to improve their wellbeing. As seen from the evidence, appropriately trained pharmacy staff can play a role in signposting and referral and there is the potential to link them to Health & Wellbeing Services and other provision of support. As such, and based on the evidence, it would be appropriate to include mental health and wellbeing as one of the six health education campaigns pharmacies should support each year as part of their essential services, national contract.

Conclusions

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

7.9. Substance Misuse

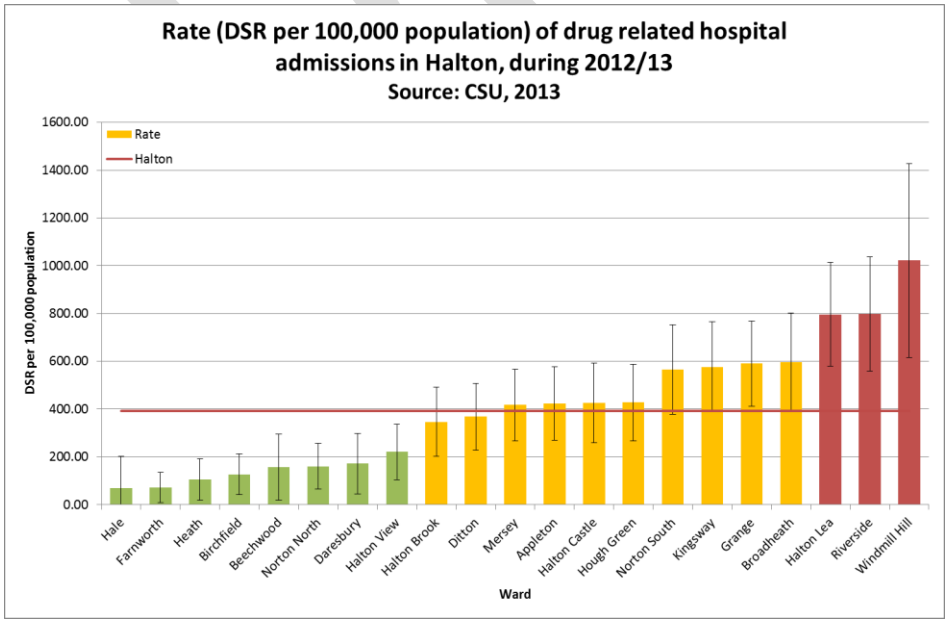
7.9.1. Level of Need

Data taken from the Halton Drugs Strategy 2014/18 showed:

- Prevalence estimates of opiate and crack/cocaine use indicates a higher rate per 1,000 population in Halton than nationally. The estimated prevalence of injecting drug use is slightly below the national average.
- During 2012/13 there were 655 individuals in contact with structured drug treatment.
- The percentage of people, in Halton, using heroin as the primary drug during 2012/13 is lower than the England and North West percentages. Due to this, the percentage of people using cocaine and cannabis as their primary drug in Halton is higher than England and the North West.
- The balance of males and females has remained constant for a number of years in Halton. Of the total population of people in treatment during 2012/13, 26% were female and 74% male. This is very similar to the national (27% female and 73% male) and North West (28% female and 72% male) picture.
- In Halton during 2012/13, 93% of people were 'successfully retained in effective treatment' compared with 87% in 2010/11. This means that the Halton 2012/13 percentage was significantly higher compared to the North West and England.
- In Halton, the percentage of people successfully leaving treatment is also continuing to improve – 65% in 2012/13 compared with 45% in 2011/12. During 2010/11 and 2011/12 the Halton percentage was similar to the England and North West percentages, however, in 2012/13 the Halton value was significantly higher.

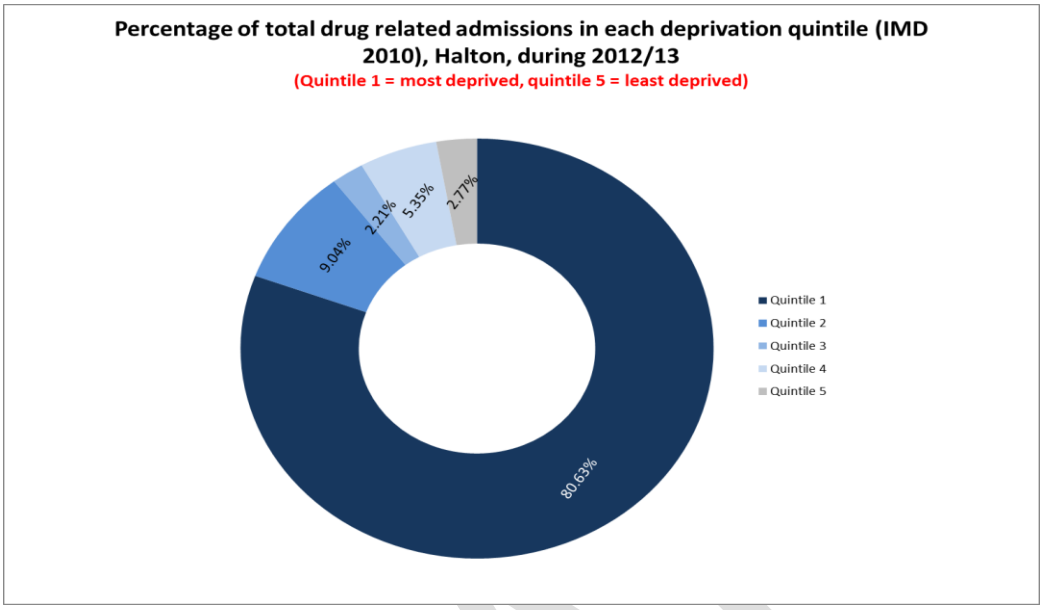
Rates of drug-related hospital admissions vary significantly across the borough. The overall directly age standardised rate (DSR) for 2012/13 was 400 per 100,000 population, ranging from less than 100 per 100,000 to over 1,000 per 100,000.

Figure 29: Drug-related hospital admissions by electoral ward, 2012/13



There is a strong relationship between deprivation and hospital admissions as Figure 30 shows, with over 80% of admissions being for people from the most deprived parts of the borough.

Figure 30: Drug-related admissions by deprivation, 2012/13



7.9.2. Evidence of effective interventions in the community pharmacy setting

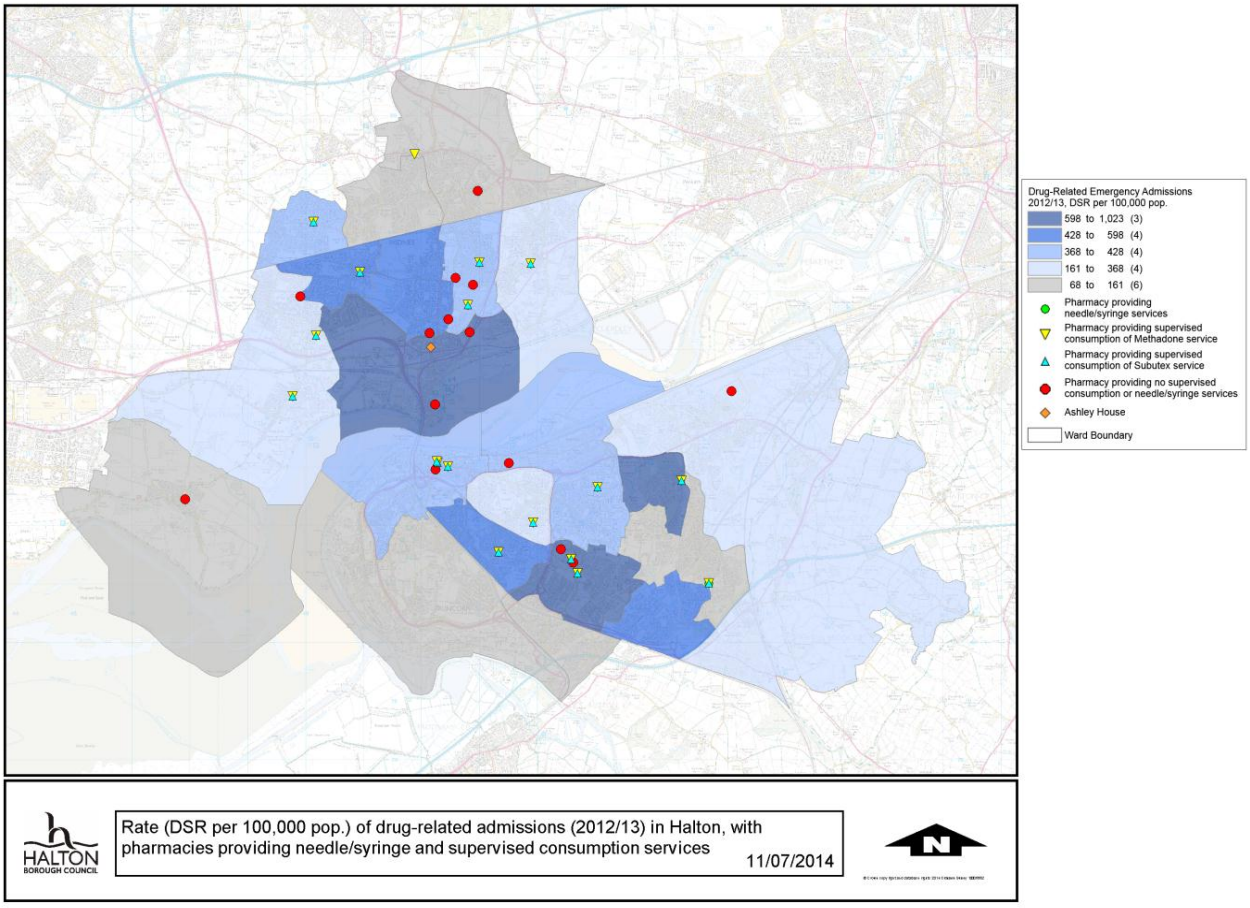
NICE guidance on the optimum provision of Needle & Syringe Programmes[82] places community pharmacies at the heart of the provision of these programmes. Research also demonstrates that community pharmacy-based supervised methadone administration services can achieve high attendance rates and are acceptable to clients[83]. NICE guidelines recommend that each new treatment of opiate dependence be subject to supervised administration for the first three months or a period considered appropriate by the prescriber. The rationale for this recommendation is to provide routine and structure for the client, helping to promote a move away from chaotic and risky behaviour. This service requires the pharmacist to supervise the consumption of prescribed medicines at the point of dispensing in the pharmacy – ideally within a private consultation room, and ensuring that the dose has been administered to the patient[84].

7.9.3. Local provision

There are two aspects to currently commissioned pharmaceutical services to substance misuse clients. These are supervised administration of methadone (or similar medication) and needle and syringe provision services. Both needle and syringe provision and supervised administration are fundamental harm reduction services. Supervised administration is a service that can only be provided by a pharmacy following dispensing of an appropriate diamorphine substitute such as methadone. It is not part of the essential tier of the pharmacy contract but greatly reduces harm by reduction of diversion of prescribed methadone onto an illicit market and protection of vulnerable individuals from overdose. Needle and syringe provision services are also provided by specialist services but pharmacies are a good choice of provider due to excellent access and existing client relationships.

18 Pharmacies are currently commissioned to provide supervised administration, with all but one of these providing both methadone and subutex (one provides methadone only). Community pharmacy provision and other community healthcare provision of both supervised administration and needle & syringe exchange is shown in Map 12. The service requires the pharmacist to supervise the consumption of prescribed medicines (methadone or buprenorphine), at the point of dispensing in the pharmacy within a private consultation room, and ensuring that the dose has been administered to the patient. 1 pharmacy currently provides needle & syringe exchange.

Map 12: Supervised consumption and needle & syringe programme provision



The community pharmacy is also an ideal place for the public to obtain information on all forms of substance misuse, and in particular ways in which they can access support and services. This should include information on the misuse of prescription and non-prescription substances and also the misuse of steroids which is increasing locally.

Conclusions

- Provision of needle & syringe exchange is mainly through the community drugs service run by CRI with one pharmacy providing this service. Provision is adequate
- There is adequate provision of supervised administration services provided by community pharmacies across the borough

7.10. Older People

7.10.1. Level of Need

As people get older the chances of developing long-term conditions increases. As these worsen they are likely to impact on a person's ability to carry out all the daily activity they would like to. This is especially likely if the person has multiple conditions. Data from the last Census shows that Halton has a higher proportion of its population living with Long-term health problem or disability that limit their daily lives a lot or a little than both the North West and England.

Table 7: Percentage of the population with long-term health problem or disability, 2011 Census

	Population	Day-to-day activities limited a lot	Day-to-day activities limited a little	Day-to-day activities not limited
Halton	125,746	11.6%	9.8%	78.6%
North West	7,052,177	10.4%	10.0%	79.8%
England	53,012,456	8.3%	9.3%	82.4%

Source: Office of National Statistics, 2013

This data also shows that in Halton, as elsewhere the number of the population with such conditions increases with age

Table 8: Number of Halton residents with long-term health problem or disability, by age group, 2011 Census

	Age Group									
	All ages	0 to 15	16 to 24	25 to 34	35 to 49	50 to 64	65 to 74	75 to 84	85 and over	65+
limited a lot	13,970	417	340	615	1,978	4,302	2,911	2,396	1,011	6,318
limited a little	12,154	574	501	741	2,042	3,658	2,451	1,758	429	4,638
limited a little or a lot	26,124	991	841	1,356	4,020	7,960	5,362	4,154	1,440	10,956
not limited	98,750	23,930	13,551	14,424	22,526	17,372	4,926	1,758	263	6,947

Source: Census 2011, Office of National Statistics 2013.

The level of ill health in the borough means that Halton experiences a lower than average level of healthy life expectancy at 65 (Table 9). The level is statistically significantly lower than the England average. Halton people aged 65 and over live only 37.4% (females) and 40.9% (males) of their later years in good health, a lower proportion than is seen across England as a whole.

Table 9: Healthy Life expectancy (HLE), 2010/12

	HLE at 65 (years)	LE at 65 (years)	Proportion of life 65+ in 'Good' health (%)	Statistical significance
England males	9.2	18.6	49.7	
Halton males	7.0	17.0	40.9	Sig Low
England females	9.7	21.1	46.1	
Halton females	7.2	19.3	37.4	Sig Low

Source: Office of National Statistics, 2013

Falls amongst those aged 50+ and 65+ is a local Health & Wellbeing Board priority and is a significant cause of infirmity and loss of independence in later life. National comparator data for 2012/13 shows Halton's rate was statistically significantly worse than that of England and was also higher than the North West average.

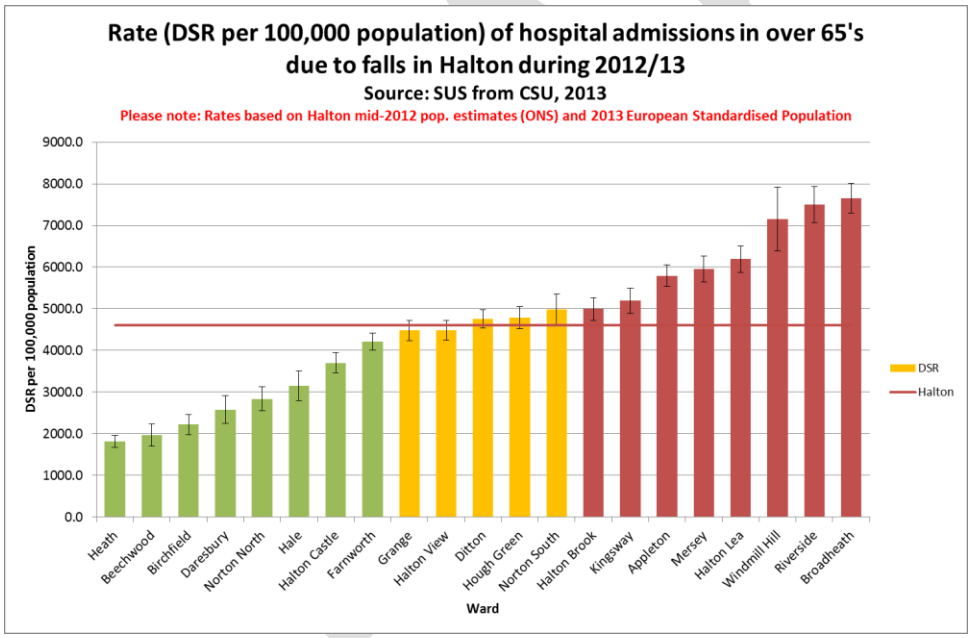
Table 10: 65s and over hospital admissions due to falls, Directly Standardised Rate per 1,000 population, 2012/13

	Number of Admissions	Resident Population	Rate	Significance Compared to England
Halton	624	19,603	3293.49	Higher
North West	28,594	1,221,740	2279.69	Higher
England	192,695	9,056,508	2001.01	

Source: Public Health England, 2014

Local ward level data for 2012/13 (Figure 31) shows that rates vary across the borough from just over 1,500 per 100,00 population aged 65+ to over 6,000 per 100,000.

Figure 31: Hospital admissions due to falls amongst Halton residents aged 65+, by electoral ward, 2012/13



It is estimated that, if all older people were immunised against influenza, almost 5,000 additional lives might be saved each year in England. Studies show influenza immunisation among older people is cost-effective. Older people, as a vulnerable group, are eligible for NHS flu immunisation, and are included in groups that may be offered flu vaccine. The national targets are based on World Health Organisation (WHO) targets. The WHO target for influenza vaccination for those aged 65 years and over is 75%. Everyone aged 65 and over should be actively contacted and offered flu vaccine[85].

A qualitative study by Evans et al 2007[86] shows that many older people do not feel vulnerable to influenza and this affects their likelihood of taking up the immunisation. Both

refusers and defaulters overstated adverse effects from influenza vaccine so this is a potential target for an intervention. Individual prompts, particularly from GPs, seemed to be the most significant motivators to attend for immunisation. However, whilst influential, other research suggests that the messages healthcare workers give need to be sensitive to the reasons for non-uptake and people's views about their health.[87;88]

7.10.2. Evidence of effective interventions in the community pharmacy setting

Community pharmacy-based services assessing older women's risk of osteoporosis were well received and were able to identify women at different levels of risk[89]. Those that followed women up post intervention found they had made lifestyle changes such as increased calcium in the diet, increased physical activity and relevant medication.[90;91;92.]

Influenza vaccination is a key intervention to protect older people's health. Research has shown that immunisation services can be safely provided in community pharmacy settings[93], that the review of medication records is a useful tool in flagging up those 'at risk' and inviting them to take part in the programme[94]. Such programmes are also well received by both patients and doctors[95] .

Medicines reviews for the elderly are both perceived favourably by participants[96] and can help reduce prescribing costs[97]. However, it is unclear if such interventions are cost effective as cost of the interventions were not detailed.

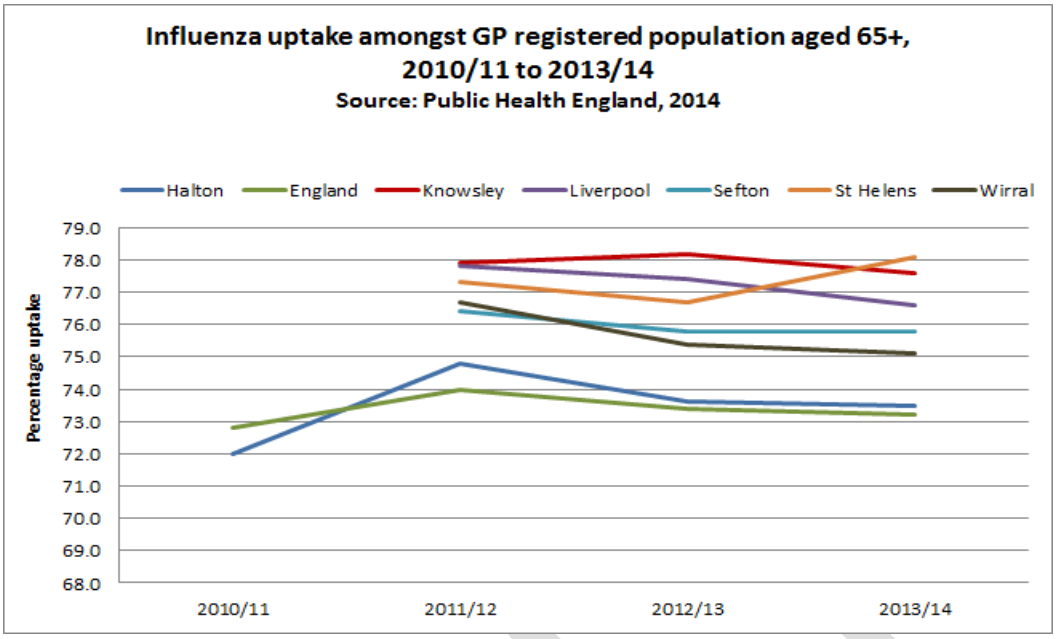
NICE guidance on medicines management in care homes was published March 2014[98]. It states that helping residents to help look after and take their medicines themselves is important in enabling residents to retain their independence. Care home staff should assume residents are able to look after and manage their own medicines when they move into a care home, unless indicated otherwise. An individual risk assessment should be undertaken to determine the level of support a resident needs to manage their own medicines.

The guideline considers all aspects of managing medicines in care homes and recommends that all care home providers have a care home medicines policy. The policy should ensure that processes are in place for safe and effective use of medicines in the care home. Sections of the guideline provide recommendations for different aspects of managing medicines covered by the care home medicines policy.

7.10.3. Local provision

Since April 2013 Public Health England became responsible for immunisations and vaccinations programmes, including influenza. Locally the annual, seasonal influenza vaccination programme is implemented through GP practices. Figure 32 shows that, for those over the age of 65, Halton has not reached the 75% uptake target for the last 4 years. This is also the case across England as a whole. However, Merseyside boroughs have been meeting the target, although several of them have seen slight dips for the last years compared to previous years.

Figure 32: Flu vaccination uptake for those aged 65+



Some pharmacies do provide flu vaccinations as a non-commissioned service which patients pay for directly. There are plans to conduct a restricted trial for one year for the provision of the NHS influenza vaccination via community pharmacies for at risk people aged under-65. However, the 65+ NHS programme will remain via GPs only.

See also 7.4.3. Planned care: medicines use reviews.

One pharmacy in Widnes and one in Runcorn are commissioned to provide advice to care homes. The Halton Care Homes Project identified issues around 'polypharmacies' with high percentages of residents on 6 or more medications. Whilst this is often necessary, multiple medications are more likely to cause significant side effects such as falls and physiological as well as psychological and cognitive complications. Despite this audits of the care homes showed that many residents had not had their medication reviewed to ensure they were on the minimum effective and efficient combination of drugs to meet their needs. The employment of a pharmacist and pharmacy technician aims to review each person starting with those on the highest numbers of drugs.

9 pharmacies are commissioned to provide Domiciliary Medicines Administration Records (domMAR), 5 in Widnes and 4 in Runcorn. These are listed in Appendix 4. This ensures that care workers who provide level 2 support with medicines to service-users do so in accordance with regulations and best practice so that it is done safely[xii]. This may be care at home to a child or adult who needs assistance, or in a care home or institutional setting. Therefore this service does not just apply to older people. domMAR is a pre-printed administration record.

xii See for example guidance from the Royal Pharmaceutical Society https://www.rpharms.com/social-care-settings-pdfs/the-handling-of-medicines-in-social-care.pdf Accessed 11 July 2014

Conclusions

- As part of the borough plans for influenza vaccinations, community pharmacies could have a role to play provided they are given appropriate training and systems are established for data collection and reporting

7.11. Palliative Care

7.11.1. Level of Need

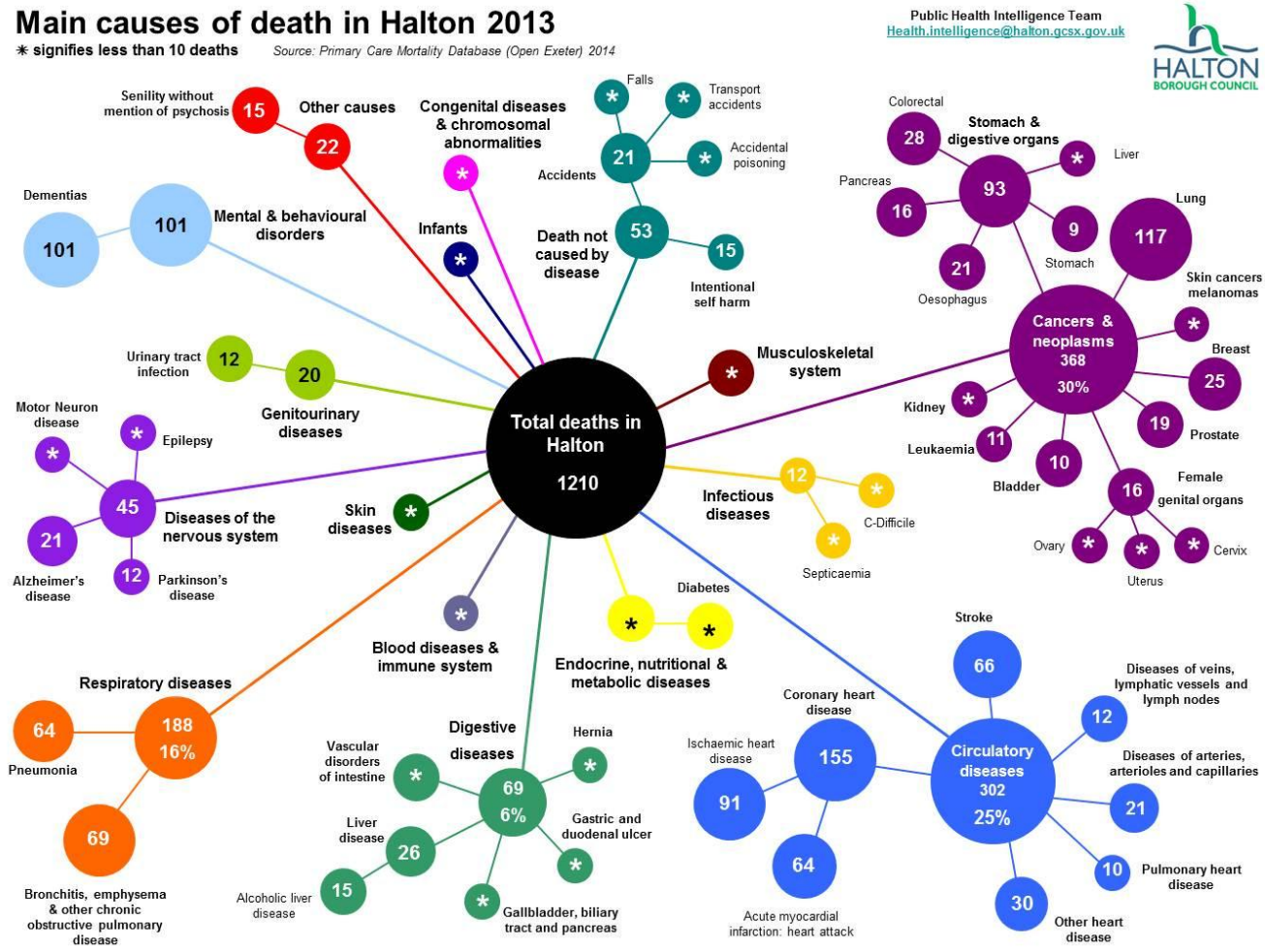
The Department of Health *End of Life Care Strategy*[99] states that patients should have access to:

• rapid specialist advice and clinical assessment-through 24/7 telephone helplines and rapid access to home care
• 9-5 access to specialist nurses – 7 days a week including bank holidays
• High quality care in the last days of life
• coordinated care and support, ensuring that patients' needs are met- in hospices and care home with palliative care beds

Coordinated care will be delivered through multi agency training including the 'gold standards framework' and the Six Steps programme. Pharmacists play a vital role in for patients who have stipulated their preferred priorities of care and wish to die at home

In Halton, cancers account for the largest single cause of death in the borough, at 30%. The second highest cause is disease of the circulatory system at 25%, with a further 16% of people dying from a respiratory disease.

Figure 33: Main causes of death in Halton 2013



Most research into people's preference for place of death has been undertaken with cancer patients. This has found that 50-70% would like to die at home.[100]There has been slow but gradual increase in patients dying at home who request to do so. Deprivation, availability of appropriate home care and whether the individual is living with relatives or alone are all factors in determining the likelihood of a home death[101;102].

Place of death has been determined by examination of local mortality files. Table 9 shows that the majority of Halton residents die in hospital. However, whilst more men die at home than in residential, nursing or care homes, the reverse is so for women.

Table 11: Place of death during 2013, by gender

Place of Death*	Male	Female
Hospital	276	308
Residential/Nursing/Care Home	76	138
Hospice	56	51
Home	151	131

*There was a total of 22 deaths in other locations

Source: Primary Care Mortality Database, 2014

7.11.2. Evidence of effective interventions in the community pharmacy setting

Palliative care is designed to provide pain relief and improve the quality of life of patients with life-threatening illness. The number of patients with chronic, slowly debilitating conditions has risen so even where patients die in a hospital or other care institution many will live in their own homes with the need to manage the condition before this happens. NICE guidance on palliative care showed that, amongst other things, there was inadequate access to pharmacy services outside normal working hours[103] so local schemes should seek to address this issue. Pharmacists are a vital part of the multidisciplinary team supporting an individual and their family during this time, ensuring that medications are assessed and the effectiveness of medications is reviewed and needs change.[104]

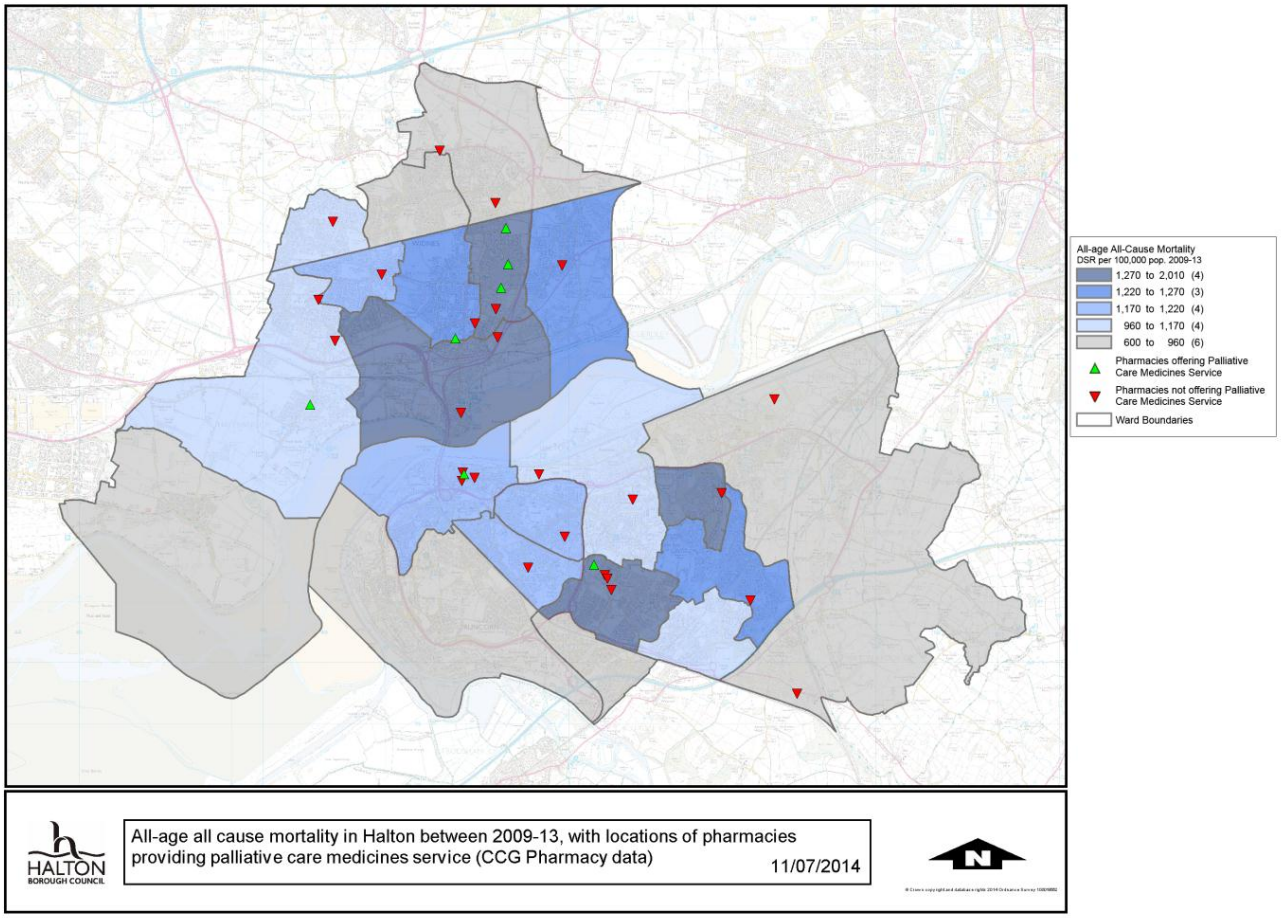
7.11.3. Local provision

There are currently 7 pharmacies that provide the On Demand Availability of Palliative Care Medicines service. The aim of the service is to improve access to palliative care medicines when they are required. The pharmacies were historically selected based on opening hours and geographical spread. 100 hour pharmacies are ideally placed to provide this service as they can provide enhanced access as requests for palliative care medicines may be both urgent and unpredictable.

Pharmacies that provide the service maintain a stock of a locally agreed range of palliative care medicines and commit to ensuring continuity of supply so that users of this service have prompt access to these medicines during the opening hours of the pharmacy. Pharmacists are able to support users, carers and clinicians by providing information and advice.

To help ensure patient care is joined-up and to improve accessibility, a list of participating pharmacies and the Pharmacy Palliative Care Drug Formulary is shared with providers of Out of Hours care, Walk-in-Centres, specialist palliative care nurses and district nursing teams.

Map 13: Community pharmacy palliative care drugs service provision



The On Demand Availability of Palliative Care Medicines service is being reviewed during 2014-15. The formulary is to be reviewed to ensure it is fit for purpose and delivers the aims of the service – a pan Mersey approach to reviewing this service is likely to be taken to improve cross border issues of palliative care drug availability. The geographical spread of service provision is also to be reviewed to ensure adequate access across the locality.

Conclusions
• This service provides convenient access and can only be provided by community pharmacy • This service is primarily designed to provide access to infrequent and unpredictably required specialist drugs • There is currently no evidence to suggest that more provision is required. There is evidence to suggest that the geographical spread and formulary needs to be reviewed – this is already underway 2014-15. Hence provision is adequate as it stands at the moment but following a review this may change

Appendix 1: Policy Context

'A Vision for Pharmacy in the New NHS'

In the last five years, the pace of change for NHS community pharmaceutical services has probably been more rapid than at any other time in the last 60 years. In that same period, community pharmacy has featured more prominently in how to improve services, how its potential can be more widely recognised by the NHS and by other health professionals, and how its ability to respond innovatively and creatively can be better utilised. That is what was intended when the Department of Health launched *A Vision for Pharmacy in the New NHS* in July 2003, that identified and aligned the ambitions for pharmacy alongside the wider ambitions for the NHS as a whole.

The current policy context shaping the direction of pharmacy services has its roots in the publication of '*Choosing Health*' published by the Government in 2004. This programme of action aimed to provide more of the opportunities, support and information people want to enable them to improve their health.

'Choosing Health Through Pharmacy'

As part of the *Choosing Health* programme, the Government made a commitment to publish a strategy for pharmaceutical public health which expanded the contribution that pharmacists, their staff and the premises in which they work can make to improving health and reducing health inequalities.

This strategy recognised that pharmacists work at the heart of the communities they serve and they enjoy the confidence of the public. Every day, they support self-care and provide health messages, advice and services in areas such as diet, physical activity, stop smoking and sexual health.

A New Contractual Framework

As part of the *Vision for Pharmacy* a new community pharmacy contractual framework was put in place in April 2005. It comprises three tiers of services – essential, advanced and local enhanced services.

- Essential services are those which every pharmacy must provide, including dispensing.

- Advanced services are those which, subject to accreditation requirements, a pharmacy contractor can choose to provide. At present, there are three advanced services, Medicines Use Reviews (MUR), Appliance Use Reviews (AURs) and Stoma Appliance Customisation (SAC). In MURs and AURs the pharmacist discusses with the patient their use of the medicines or appliances they are prescribed and whether there are any problems that the pharmacist can help resolve. For SAC the aim is to ensure proper use and comfortable fitting of the stoma appliance and to improve duration of usage thereby reducing waste.

- Local enhanced services, such as health and lifestyle advice or help for substance misusers, are commissioned locally by PCTs direct with contractors.

Community pharmacies are remunerated through this national contractual framework, the majority of the income to community pharmacy is made through fees, allowances and retained purchasing profit which is controlled at a national level to provide an agreed return on investment to pharmacy contractors. In return pharmacy contractors must provide certain specified services at agreed times. Around 85% of community pharmacy income nationally comes from NHS services. A growing source of income to community pharmacies comes from providing enhanced services commissioned by PCTs. Pharmacies provide both NHS funded care and services that are paid for directly by the patient. Some community pharmacies provide these non-NHS services to our population. These include:

- Over the counter medication, including supply of emergency hormonal contraception and smoking cessation
- Measurements like blood pressure, weight and height
- Diagnostic tests like cholesterol and blood glucose

'Our health, our care, our say'

This White Paper in January 2006 set out a new strategic direction for improving the health and well-being of the population. It focused on a strategic shift to locate more services in local communities closer to people's homes. This recognised the vital role that community pharmacies provide in providing services which support patients with long term conditions and make treatment for minor illnesses accessible and convenient.

'NHS Next Stage Review'

The final report set out a vision of an NHS that gives patients and the public more information and choice, works in partnership and has quality of care at its heart – quality defined as clinically effective, personal and safe. The changes that are now being taken forward, locally and nationally, will see the NHS deliver high quality care for all users of services in all aspects, not just some. It will see services delivered closer to home, a much greater focus on helping people stay healthy and a stronger emphasis on the NHS working with local partners. Pharmacy has a key role to play in delivering this vision, particularly as a provider of services which prevent ill-health, promote better health for all and improve access to services within communities.

'Pharmacy in England - Building on strengths delivering the future'

In April 2008 the government set out its plans in this Pharmacy White Paper and subsequently a consultation was undertaken on the proposed changes to the regulations for pharmacy.

This White Paper sets out a vision for improved quality and effectiveness of pharmaceutical services, and a wider contribution to public health. Whilst acknowledging good overall provision and much good practice amongst providers, it revealed several areas of real concern about medicines usage across the country which it seeks to address through a work programme which will challenge and engage PCTs, pharmacists and the NHS.

It identifies practical, achievable ways in which pharmacists and their teams can improve patient care in the coming years. It sets out a reinvigorated vision of pharmacy's potential to contribute further to a fair, personalised, safe and effective NHS. This vision demonstrates how pharmacy can continue, and expand further, its role in an NHS that focuses as much on prevention as it does on treating sick people, helping to reduce health inequalities, supporting healthy choices, improving quality and promoting well-being for patients and public alike.

This White Paper has put forward a broad range of proposals to build on progress over the last three years which has succeeded in embedding community pharmacy's role in improving health and well-being and reducing health inequalities. An overview is set out below in Figure 1. This includes proposals for nationally commissioned additions to the contract in future years for how pharmacies will, over time:

- offer NHS funded treatment for many minor ailments (e.g. coughs, colds, stomach problems) for people who do not need to go to their local GP;
- provide specific support for people who are starting out on a new course of treatment for long term conditions such as high blood pressure or high cholesterol;
- be commissioned based on the range and quality of services they deliver.

Figure 34: Pharmacy White Paper – Summary

Building on strengths – delivering the future
The Aims of the White Paper, Pharmacy in England

Supporting healthy living and better care
Community pharmacies will become 'healthy living' centres providing a primary source of information for healthy living and health improvement.

Pharmacy will be integrated into public health initiatives such as stop smoking, sexual health services and weight management, or offer screening for those at risk of vascular disease – an area where there are significant variations in access to services and life expectancy around the country.

Better, safe use of medicines
Safe medication practices should be embedded in patient care by identifying, introducing and evaluating systems designed to reduce unintended hospital admissions related to medicines use.

Identifying specific patient groups for MURs, using MURs and repeat dispensing to identify and reduce the amount of unused medicines and including pharmacists in care pathways for longterm conditions are all examples of this.

Access and choice
Community pharmacies improve access and choice through more help with medicines. This will be realised by developing MURs, repeat dispensing, access to urgent medicines, emergency supply and working with hospitals on medicine reconciliation.

Integration and interfaces
Community based pharmaceutical care will be developed which will involve creating new alliances between hospital and community pharmacists as well as primary care pharmacists and pharmacy technicians.

Quality
Underpinning all of this in the White Paper and the other policy drivers mentioned earlier is continual improvement in quality. This is a recurring theme throughout all the policy drivers currently influencing the development of community pharmacy. This refers to staff, premises and services alike. PCTs have a responsibility to ensure continuous quality by monitoring the community pharmacy services against the strategic tests.

"Healthy lives, healthy people",

The public health strategy for England (2010) says: "Community pharmacies are a valuable and trusted public health resource. With millions of contacts with the public each day, there is real potential to use community pharmacy teams more effectively to improve health and wellbeing and to reduce health inequalities." This will be relevant to local authorities as they take on responsibility for public health in their communities.

In addition, Community pharmacy is an important investor in local communities through employment, supporting neighbourhood and high street economies, as a health asset and long term partner.

Equity and excellence: Liberating the NHS (2010)

> "Information, combined with the right support, is the key to better care, better outcomes and reduced costs. Patients need and should have far more information and data on all aspects of healthcare, to enable them to share in decisions made about their care and find out much more easily about services that are available. Our aim is to give people access to comprehensive, trustworthy and easy to understand information from a range of sources on conditions, treatments, lifestyle choices and how to look after their own and their family's health".

Community pharmacy is at the forefront of self-care, health promotion and is ably qualified to assist people to manage long term conditions, the vast majority of which are managed via the use of medication. Advanced services under the contract should be maximized to ensure patients get access to the support that they need.

October 2011 - Market entry by means of pharmaceutical needs assessments and quality and performance (market exit)

The NHS Act 2006 required the Secretary of State for Health to make Regulations concerning the provision of NHS pharmaceutical services in England. The Health Act 2009 amended these provisions by providing that PCTs must develop and publish local pharmaceutical needs assessments (known as "PNAs"); and PCTs would then use their PNAs as the basis for determining entry to the NHS pharmaceutical services market.

The Health Act 2009 also introduced new provisions which allow the Secretary of State to make regulations about what remedial actions PCTs can take against pharmacy and dispensing appliance contractors who breach their terms of service or whose performance is poor or below standard.

The first set of Regulations dealing with the development and publication of PNAs, the NHS (Pharmaceutical Services and Local Pharmaceutical Services)(Amendment) Regulations 2010 (S.I. 2010/914) were laid on 26 March 2010 and came into force on 24 May 2010.

Later the National Health Service (Pharmaceutical Services) Regulations 2012 ("the 2012 Regulations") and draft guidance came into force concerning the remaining provision under the Health Act 2009.

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

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

Appendix 2: Abbreviations Used

AAACM	All Age All-Cause Mortality Rate
AUR	Appliance Use Review
BI	Brief Intervention
CATC	Care at the Chemist
CCG	Clinical Commissioning Group
CPAF	Community Pharmacy Assurance Framework
COPD	Chronic Obstructive Pulmonary Disease
CVD	Cardio Vascular Disease
domMAR	Domiciliary Medicines Administration Record
DSR	Directly Standardised Rate
EHC	Emergency Hormonal Contraception
GP	General Practice / General Practitioner
GUM	Genito-urinary Medicine
HBC	Halton Borough Council
HIV	Human Immunodeficiency Virus
HLE	Healthy Life Expectancy
HSCIC	Health and Social Care Information Centre
HWB	Health and Wellbeing Board
ID	(English) Indices of Deprivation
IMD	Index of Multiple Deprivation
JHWBS	Joint Health and Wellbeing Strategy
JSNA	Joint Strategic Needs assessment
LAPHT	Local Authority Public Health Team
LARC	Long-acting reversible contraception
LE	Life Expectancy
LMC	Local Medical Committee
LPC	Local Pharmaceutical Committee
LPS	Local Pharmaceutical Services
LSOA	Lower Super Output Area - is a geographic hierarchy designed to improve the collection, analysis and reporting of small area statistics in England, they have an av. Population of 1,500
MUR	Medicines Use Review
NHS	National Health Service
NHSE	NHS England
NICE	National Institute for Health and Clinical Excellence
NMS	New Medicines Service
NRT	Nicotine Replacement Therapy
ONS	Office of National Statistics
PCDG	Pharmacy Contracts and Development Group
PCT	Primary Care Trust
PGD	Patient Group Direction
PHE	Public Health England

PNA	Pharmaceutical Needs Assessment
PSNC	Pharmaceutical Services Negotiating Committee
QOF	Quality Outcomes Framework
RCT	Randomised control trial
SAC	Stoma Appliance Customisation
STI	Sexually Transmitted Infection
TIA	Transient Ischaemic Attack
WEMWBS	Warrick and Edinburgh Mental Wellbeing Score
WHO	World Health Organisation

Appendix 3: Community Pharmacy addresses and opening hours

Name	Address 1	Address 2	Postcode	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	100 hour pharmacy
RUNCORN											
Asda Pharmacy	West Lane	Runcorn	WA7 2PY	**08:00 - 23:00**	**07:00 - 23:00**	**07:00 - 23:00**	**07:00 - 23:00**	**07:00 - 23:00**	**07:00 - 22:00**	**10:30 - 16:30**	Y
Boots	90 Forest Walk	Halton Lea Shopping Centre	WA7 2GX	**09:00 - 17:30** (09:00-13:00; 14:00-17:30)	**09:00 - 17:30** (09:00-13:00; 14:00-17:30)	**09:00 - 17:30** (09:00-13:00; 14:00-17:30)	**09:00 - 17:30** (09:00-13:00; 14:00-17:30)	**09:00 - 17:30** (09:00-13:00; 14:00-17:30)	**09:00 - 17:30** (09:00-11:30)	Closed	
Boots	Hallwood Health Centre	Hospital Way	WA7 2UT	**08:30 - 18:30** (09.00-13.00; 14.00-18.00)	**08:30 - 18:30** (09.00-13.00; 14.00-18.00)	**08:30 - 18:30** (09.00-13.00; 14.00-18.00)	**08:30 - 18:30** (09.00-13.00; 14.00-18.00)	**08:30 - 18:30** (09.00-13.00; 14.00-18.00)	Closed	Closed	
Boots Pharmacy	21 High Street	Runcorn	WA7 1AP	**09:00 - 17:30** (09.00-17.00)	**09:00 - 17:30** (09.00-17.00)	**09:00 - 17:30** (09.00-17.00)	**09:00 - 17:30** (09.00-17.00)	**09:00 - 17:30** (09.00-17.00)	**09:00 - 13:00**	Closed	
Boots Pharmacy	Castlefields Primary Care Centre	Castlefields	WA7 2HY	**08:00 - 19.00** (09.00-12.00; 13.00-17.30)	**08:00 - 19.00** (09.00-12.00; 13.00-17.30)	**08:00 - 19.00** (09.00-12.00; 13.00-17.30)	**08:00 - 18.30** (09.00-12.00; 13.00-17.30)	**08:00 - 18.30** (09.00-12.00; 13.00-17.30)	**08:00 - 12.30** (09.30-12.00)	Closed	
Co-Operative Pharmacy	11 Grangeway		WA75LY	**09:00 - 18:00** (09.00-13.00; 14:00-16: 00)	**09:00 - 18:00** (09.00-13.00; 14:00-16: 00)	**09:00 - 18:00** (09.00-13.00; 14:00-16: 00)	**09:00 - 18:00** (09.00-13.00; 14:00-16: 00)	**09:00 - 18:00** (09.00-13.00; 14:00-16: 00)	09:00 - 13:00	Closed	
Lloyds Pharmacy	5-6 Granville Street	Runcorn	WA7 1NE	**08:00 - 22:30**	**08:00 - 22:30**	**08:00 - 22:30**	**08:00 - 22:30**	**08:00 - 22:30**	**08:00 - 22:30**	**09:30 - 22:30**	Y
Lunt's	51-53 Church Street	Runcorn	WA7 1LQ	**09:00 - 17:30** (09.00-13.00;	**09:00 - 17:30** (09.00 - 17.00)	**09:00 - 17:30** (09.00 - 17.00)	**09:00 - 17:30** (09.00 - 17.00)	**09:00 - 17:30** (09.00 - 17.00)	**09:00 - 13:00**	Closed	
Murdishaw Pharmacy	Gorsewood Road	Murdishaw	WA7 6DA	**08:30 - 18:00** (08.45-13.00; 14.00-17.45)	**08:30 - 18:00** (08.45-13.00; 14.00-17.45)	**08:30 - 18:00** (08.45-13.00; 14.00-17.45)	**08:30 - 18:00** (08.45-13.00; 14.00-17.45)	**08:30 - 18:00** (08.45-13.00; 14.00-17.45)	Closed	Closed	
St Paul's Pharmacy	49 High Street	Runcorn	WA7 1AH	**08:45 - 18:00** (09.00-13.00; 14:00 - 18:00)	**08:45 - 18:00** (09.00-13.00; 14:00 - 18:00)	**08:45 - 18:00** (09.00-13.00; 14:00 - 18:00)	**08:45 - 18:00** (09.00-13.00; 14:00 - 18:00)	**08:45 - 18:00** (09.00-13.00; 14:00 - 18:00)	Closed	Closed	
Superdrug Pharmacy	89 Forest Walk	Halton Lea	WA7 2GX	**08.30-17.30** (09.00-17.00)	**08.30-17.30** (09.00-17.00)	**08.30-17.30** (09.00-17.00)	**08.30-17.30** (09.00-17.00)	**08.30-17.30** (09.00-17.00)	09:00 - 17:30 (13:30 - 14:30)	Closed	
Wise Pharmacy Ltd	27 Hillcrest	Runcorn	WA7 2DY	**09.00-17.30** (09.00-17.00)	**09.00-17.30** (09.00-17.00)	**09.00-17.30** (09.00-17.00)	**09.00-17.30** (09.00-17.00)	**09.00-17.30** (09.00-17.00)			
Wise Pharmacy Ltd	Windmill Hill Shopping Centre	Windmill Hill Avenue West	WA7 6QZ	**08:45 - 18:00** (09.00-17.00)	**08:45 - 18:00** (09.00-17.00)	**08:45 - 18:00** (09.00-17.00)	**08:45 - 18:00** (09.00-17.00)	**08:45 - 18:00** (09.00-17.00)	09:00 - 12:00	Closed	

Bold = total hours; (in brackets) = core hours; **Bold only** = core and total hours the same

Name	Address 1	Address 2	Postcode	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	100 hour pharmacy
WIDNES											
Appleton Village Pharmacy	Appleton village		WA8 6EQ	**07:00 - 23:00**	**07:00 - 23:00**	**07:00 - 23:00**	**07:00 - 23:00**	**07:00 - 23:00**	**08:00 - 22:00**	**10:00 - 16:00**	**Y**
Asda Pharmacy	Widnes Road		WA8 6AH	**08:00 - 23:00**	**07:00 - 23:00**	**07:00 - 23:00**	**07:00 - 23:00**	**07:00 - 23:00**	**07:00 - 22:00**	**10:00 - 16:00**	**Y**
Boots Pharmacy	Unit 7 Widnes Shopping Park	High Street	WA8 7TN	**09:00 -20:00** (09:00-14:00; 15:00-17:30)	**09:00 -20:00** (09:00-14:00; 15:00-17:30)	**09:00 -20:00** (09:00-14:00; 15:00-17:30)	**09:00 -20:00** (09:00-14:00; 15:00-17:30)	**09:00 -20:00** (09:00-14:00; 15:00-17:30)	**09:00 -19:00** (09:00-14:30)	**11:00 17:00**	
Cohens Chemist	222a Liverpool Road	Ditton	WA8 7HY	**09:00 - 17:30** (09:00-17:00)	**09:00 - 17:30** (09:00-17:00)	**09:00 - 17:30** (09:00-17:00)	**09:00 - 17:30** (09:00-17:00)	**09:00 - 17:30** (09:00-17:00)	Closed	Closed	
Cookes Ltd	76 Albert Road	Widnes	WA8 6JT	**09:00 - 18:00** (09:00 - 13:00; 14:00 - 18:00)	**09:00 - 18:00** (09:00 - 13:00; 14:00 - 18:00)	**09:00 - 18:00** (09:00 - 13:00; 14:00 - 18:00)	**09:00 - 18:00** (09:00 - 13:00; 14:00 - 18:00)	**09:00 - 18:00** (09:00 - 13:00; 14:00 - 18:00)	**09:00 - 13:00**	Closed	
Co-Operative Pharmacy	Peel House Medical Plaza	Peel House Lane	WA86TN	**08:30 - 18:30** (09:00-13:00; 14:00-18:00)	**08:30 - 18:30** (09:00-13:00; 14:00-18:00)	**08:30 - 18:30** (09:00-13:00; 14:00-18:00)	**08:30 - 18:30** (09:00-13:00; 14:00-18:00)	**08:30 - 18:30** (09:00-13:00; 14:00-18:00)	Closed	Closed	
Ditton Pharmacy	203 Hale Road			**09:00 - 18:00** (09:00 - 13:00; 14:00 - 18:00)	**09:00 - 18:00** (09:00 - 13:00; 14:00 - 18:00)	**09:00 - 18:00** (09:00 - 13:00; 14:00 - 18:00)	**09:00 - 18:00** (09:00 - 13:00; 14:00 - 18:00)	**09:00 - 18:00** (09:00 - 13:00; 14:00 - 18:00)	Closed	Closed	
Hale Village Pharmacy	3 Ivy Farm Court	Hale Village	L24 4PG	**09:00 - 18:00** (09:00-13:00; 14:00-17:30)	**09:00 - 18:00** (09:00-13:00; 14:00-17:30)	**09:00 - 18:00** (09:00-13:00; 14:00-17:30)	**09:00 - 18:00** (09:00-13:00; 14:00-17:30)	**09:00 - 18:00** (09:00-13:00; 15:00-17:30)	**09:00 - 12:30**	Closed	
Lloyds Pharmacy	Hough Green Health Park	45-47 Hough Green Road	WA8 4NS	**08:45-19:30** (09:00-13:00; 14:30-18:00)	**08:45-18:00** (09:00-13:00; 14:30-18:00)	**08:45-18:00** (09:00-13:00; 14:30-18:00)	**08:45-18:00** (09:00-13:00; 14:30-18:00)	**08:45-18:00** (09:00-13:00; 14:30-18:00)	**09:00-13:00** (09:00-12:30)	Closed	
McDougalls's Pharmacy	Widnes Health Care Resource Centre	Oaks Place		**09:00 - 19:00** (09:00-12:30-; 13:30-18:30)	**09:00 - 19:00** (09:00-12:30-; 13:30-18:00)	**09:00 - 19:00** (09:00-12:30-; 13:30-18:00)	**09:00 - 17:00** (09:00-13:00; 14:00-17:00)	**09:00 - 19:00** (09:00-12:30-; 13:30-18:30)	**09:00 - 17:00**	Closed	
Nicholson's Pharmacy	17 Queens Avenue	Ditton	Widnes	**09:00 - 13:00; 14:00 - 18:00**	**09:00 - 13:00; 14:00 - 18:00**	**09:00 - 13:00; 14:00 - 18:00**	**09:00 - 13:00; 14:00 - 18:00**	**09:00 - 13:00; 14:00 - 18:00**	**09:00 - 11:30**	Closed	
Rowlands Pharmacy	11 Farnworth Street		WA8 9LH	**09:00 - 13:00; 13:20-17:30** (09:00-13:00; 14:00-17:30)	**09:00 - 13:00; 13:20-17:30** (09:00-13:00; 14:00-17:30)	**09:00 - 13:00; 13:20-17:30** (09:00-13:00; 14:00-17:30)	**09:00 - 13:00; 13:20-17:30** (09:00-13:00; 14:00-17:30)	**09:00 - 13:00; 13:20-17:30** (09:00-13:00; 14:00-17:30)	**09:00 - 11:30**	Closed	
Strachan's Chemist	445 Hale Road		WA8 8UU	**09:00 - 18:00** (09:00-13:00; 14:00-18:00)	**09:00 - 18:00** (09:00-13:00; 14:00-18:00)	**09:00 - 18:00** (09:00-13:00; 14:00-18:00)	**09:00 - 18:00** (09:00-13:00; 14:00-18:00)	**09:00 - 18:00** (09:00-13:00; 14:00-18:00)	**09:00 - 13:00**	Closed	
Tesco In-store Pharmacy	Ashley Retail Park	Lugsdale Road	WA8 7YT	**08:00 - 22:30**	**06:30 - 22:30**	**06:30 - 22:30**	**06:30 - 22:30**	**06:30 - 22:30**	**06:30 - 22:00**	**11:00 - 17:00**	**Y**
Upton Rocks Pharmacy	12a Cronton Lane		WA8 5AJ	**09:00 - 18:00** (09:00-13:00; 14:00-17:30)	**09:00 - 18:00** (09:00-13:00; 14:00-17:30)	**09:00 - 18:00** (09:00-13:00; 14:00-17:30)	**09:00 - 18:00** (09:00-13:00; 14:00-17:30)	**09:00 - 18:00** (09:00-13:00; 15:00-17:30)	**09:00 - 13:00** (09:00 - 12:30)	Closed	
West Bank pharmacy	8a Mersey Road	West Bank	WA8 0DG	**09:00 - 13:00; 14:00 - 18:00**	**09:00 - 13:00; 14:00 - 18:00**	**09:00 - 13:00; 14:00 - 18:00**	**09:00 - 13:00; 14:00 - 18:00**	**09:00 - 13:00; 14:00 - 18:00**	Closed	Closed	
Widnes Late Night Pharmacy	Peel House Lane		WA8 6TE	**08:00 - 23:00**	**08:00 - 23:00**	**08:00 - 23:00**	**08:00 - 23:00**	**08:00 - 23:00**	**08:00 - 23:00**	**10:00 - 20:00**	**Y**
Wise Pharmacy Ltd	204 Warrington Road		WA8 0AX	**09:00 - 17:30** (09:00 - 17:00)	**09:00 - 17:30** (09:00 - 17:00)	**09:00 - 17:30** (09:00 - 17:00)	**09:00 - 17:30** (09:00 - 17:00)	**09:00 - 17:30** (09:00 - 17:00)	**09:00 - 12:00**	Closed	
DISTANCE SELLING 'INTERNET' PHARMACIES											
Calea UK Ltd, Cestrian Court	Pharmacy Services Dept	Cestrian Court, Eastgate Way	WA7 1NT	**09:00 - 17:30** (09.00-17.00)	**09:00 - 17:30** (09.00-17.00)	**09:00 - 17:30** (09.00-17.00)	**09:00 - 17:30** (09.00-17.00)	**09:00 - 17:30** (09.00-17.00)	Closed	Closed	
Wise Pharmacy Ltd	Unit 7. Jenson Court	Jensen Court	WA7 1SQ	**09:00 - 17:00**	**09:00 - 17:00**	**09:00 - 17:00**	**09:00 - 17:00**	**09:00 - 17:00**	Closed	Closed	
Rowlands Pharmacy	Whitehouse Industrial Estate	Rivington Road	WA7 3DJ	**08:45 - 17:15** (08.45-12.30: 13.00-17.15)	**08:45 - 17:15** (08.45-12.30: 13.00-17.15)	**08:45 - 17:15** (08.45-12.30: 13.00-17.15)	**08:45 - 17:15** (08.45-12.30: 13.00-17.15)	**08:45 - 17:15** (08.45-12.30: 13.00-17.15)	Closed	Closed	
Bold = total hours; (in brackets) = core hours; **Bold only** = core and total hours the same											

Appendix 4: Community Pharmacy services

Name	100hrs	Ward Location	Post Code	CONSRM	MUR	NMS	Advice to Care Homes	EHC	CATC	SCESS	NSEX	SUPCON-M	SUPCON-S	PALL-SH	PALL-GD	DOM-MAR
Runcorn																
Asda Pharmacy, West Lane, Runcorn	Y	Halton Lea	WA7 2PY	Yes	Yes	Yes		Yes	Yes	Yes						Yes
Boots Pharmacy, Halton Lea Shopping Centre, Runcorn		Halton Lea	WA7 2GX	Yes	Yes	Yes			Yes	Yes		Yes	Yes			
Boots Pharmacy, Castlefields Primary Care Centre, Runcorn		Halton Castle	WA7 2ST	Yes	Yes	Yes				Yes		Yes	Yes			
Boots Pharmacy, Hallwood Health Centre, Runcorn		Halton Lea	WA7 2UT	Yes	Yes	Yes						Yes	Yes			
Boots Pharmacy, 21 High Street, Runcorn		Mersey	WA7 1AP	Yes	Yes	Yes	Yes		Yes			Yes	Yes			Yes
Co-Operative Pharmacy, 11 Grangeway, Runcorn		Grange	WA7 5LY	Yes	Yes	Yes		Yes	Yes	Yes		Yes	Yes		Yes	
Lloyds Pharmacy, 5-6 Granville Street, Runcorn	Y	Mersey	WA7 1NE	Yes	Yes	Yes			Yes	Yes		Yes	Yes	Yes		
N C & B Lunt, 51-53 Church Street, Runcorn		Mersey	WA7 1LQ	Yes	Yes	Yes		Yes	Yes	Yes		Yes	Yes			Yes
Murdishaw Pharmacy, Gorsewood Road, Runcorn		Murdishaw	WA7 6ES	Yes	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes			
St Paul's Pharmacy, 49 High Street, Runcorn		Mersey	WA7 1AH	Yes	Yes	Yes		Yes	Yes	Yes				Yes		Yes
Superdrug Pharmacy, Halton Lea Shopping Centre		Halton Lea	WA7 2BX	Yes	Yes	Yes										
Wise Pharmacy Ltd, 27 Hillcrest, Runcorn		Halton Brook		Yes	Yes	Yes			Yes	Yes		Yes	Yes			
Wise Pharmacy Ltd, Windmill Hill Shopping Centre, Runcorn		Windmill Hill	WA7 6QZ	Yes	Yes	Yes			Yes	Yes		Yes	Yes			Yes

Name	100hrs	Ward Location	Post Code	CONSRM	MUR	NMS	Advice to Care Homes	EHC	CATC	SCESS	NSEX	SUPCON-M	SUPCON-S	PALL-SH	PALL-GD	DOM-MAR
Widnes																
Appleton Village Pharmacy	**Y**	Appleton	WA8 6EQ	Yes	Yes	Yes										
Asda Pharmacy, Widnes Road, Widnes	**Y**	Kingsway	WA8 6AH	Yes	Yes	Yes										
Boots Pharmacy, Unit 7, Widnes Shopping Centre		Appleton	WA8 7TN	Yes	Yes	Yes			Yes	Yes		Yes	Yes			
Ditton Pharmacy, 203 Hale Road, Widnes		Ditton	WA8 8QB	Yes	Yes	Yes						Yes	Yes			
Cohens Chemist, 22a Liverpool Road, Widnes		Broadheath	WA8 7HYes	Yes	Yes	Yes		Yes		Yes		Yes	Yes	Yes		Yes
Cookes Ltd, 76 Albert Road, Widnes		Appleton	WA8 6JT	Yes	Yes	Yes		Yes	Yes	Yes				Yes	Yes	
Co-Operative Pharmacy, Peel House Medical Plaza, Widnes		Appleton	WA8 6TN	Yes	Yes	Yes		Yes	Yes	Yes		Yes	Yes		Yes	
Hale Village Pharmacy, 3 Ivy Farm Court, Widnes		Hale	L24 4AG	Yes	Yes	Yes			Yes	Yes				Yes		Yes
Lloyds Pharmacy, Hough Green Health Park, Widnes		Hough Green	WA8 4NJ	Yes	Yes	Yes			Yes	Yes		Yes	Yes			
McDougalls's Pharmacy, Health Care Resource Centre, Widnes		Kingsway	WA8 7GD	Yes	Yes	Yes			Yes	Yes				Yes		Yes
Nicholson's Pharmacy, 17 Queens Avenue, Widnes		Ditton	WA8 8HR	Yes												
Rowlands Pharmacy, 11 Farnworth Street, Widnes		Farnworth	WA8 9LX		Yes	Yes			Yes							
Strachan's Chemist, 445 Hale Road, Widnes		Ditton	WA8 8UU	Yes	Yes	Yes		Yes	Yes	Yes		Yes	Yes	Yes	Yes	
Tesco In-store Pharmacy, Ashley Retail Park, Widnes	**Y**	Riverside	WA8 7YT		Yes	Yes										
Upton Rocks Pharmacy, 12a Cronton Lane, Widnes		Farnworth	WA8 5AJ	Yes	Yes	Yes	Yes		Yes			Yes		Yes		Yes
West Bank pharmacy, 8a Mersey Road, Widnes		Riverside														
Widnes Late Night Pharmacy*, Peel House Lane, Widnes	**Y**	Appleton		Yes	Yes			Yes	Yes	Yes				Yes		

Name	100hrs	Ward Location	Post Code	CONSRM	MUR	NMS	Advice to Care Homes	EHC	CATC	SCESS	NSEX	SUPCON-M	SUPCON-S	PALL-SH	PALL-GD	DOM-MAR
Widnes																
Wise Pharmacy Ltd, 204 Warrington Road, Widnes		Halton View	WA8 0AX		Yes	Yes			Yes	Yes		Yes	Yes			

* - information taken from records as pharmacy questionnaire not available

KEY	
CONSRM:	Consulting room
MUR:	Medicines Use Review
NMS:	New Medicines Service
EHC:	Emergency Hormonal Contraception
CATC:	Care at the Chemist
SCESS:	Smoking Cessation
NSEX:	Needle Syringe Exchange
SUPCON-M:	Supervised Consumption - Methodone
SUPCON-S:	Supervised Consumption - Subutex
PALL-SH:	Palliative Care - Stock Holder
PALL-GD:	Palliative Care - Guarenteed Dispenser
DOM_MAR:	Domicilliary Medicine Administration Records

Appendix 5: Cross border Community Pharmacy service provision

No. on map 7	Pharmacy	Address	Postcode	EHC	Supervised Consumption	NRT	MUR's	Care at the Chemist (Minor Ailments)	open weekends	Opening Hours
KNOWSLEY										
1	Boots	Cables Retail Park	L34 5NQ	y	n	y	y	y	7-9 Sat 10.30-4.30 Sun	7.-11.
2	Rowlands	Eccleston St, Prescot	L34 5QH	y	y	y	y	y	9-1 Sat	9.-6.
3	Neils Parmacy	32 Molyneix Drive Prescot	L35 5DY	y	y	y	y	y		9.-6
4	Tesco Pharmacy	Cables Retail Park	L34 5NQ	n	n	y	y	y	8-8 Sat 10-4 Sun	8.-8.
5	Boots	Whiston health centre	L35 3SX	n	y	y	y	y	1/2 day Sat	8.30-6.30
LIVERPOOL										
6	Greencross Pharmacy	West Speke Health Centre	L24 3TY	y	y	y	y	y		9-6pm
7	Lloyds Pharmacy	The Garston Urban Village Hall	L19 8JZ	n	n	y	y	y	9-5pm Sat	9-6pm Mon-Tues Thurs-Fri, 9-5pm Wed
8	Rowlands Pharmacy	Speke Health Centre	L24 2XP	n	y	y	y	y		8-6pm
9	Rowlands Pharmacy	Somerfield Store	L19 2NJ	n	y	y	y	y		08:45-6:45pm
10	Rowlands Pharmacy	15 Penketh Drive	L24 2WZ	n	y	y	y	y	9-5pm Sat	9-6pm
11	Lloyds Pharmacy	4 Woodend Avenue	L25 0PA	n	y	y	y	y	9-1pm Sat	08:30-6pm
12	Lloyds Pharmacy	109 East Millwood Road	L24 6TH	n	y	y	y	y		08:30-6pm
13	Boots	Unit 9, Mersey Retail Park, Speke	L24 8QB	y	y	y	y	y	9:30-7pm Sat, 11-5pm Sun	9-9pm

No. on map 7	Pharmacy	Address	Postcode	EHC	Supervised Consumption	NRT	MUR's	Care at the Chemist (Minor Ailments)	open weekends	Opening Hours
WARRINGTON										
14	Rydale Pharmacy	18 Chapel Ln	WA5 4HF	n	y	n	n	n	9-12pm Sat	9-1pm 2:15-6pm
15	Boots Gemini	910 Boulevard, Gemini	WA5 7TY	y	y	n	y	n	9-8pm Sat, 11-5pm Sun	9-9pm
16	Lloyds, Penketh	Penketh Medical Centre	WA5 2EY	y	y	n	y	n	9-5:30pm Sat	8:30-6:15pm
17	Safehands Healthcare	Barrow Hall Lane	WA5 3AE	n	y	n	y	n		8:30-6 Mon, Tues, Wed & Fri, 8:30-1pm Thurs
ST HELENS										
18	Lloyds, Rainhill	473 Warrington Road	L35 4LL	y	y	y	y	y		
19	Longsters Pharmacy	578 Warrington Road, Rainhill	L35 4LZ	y	y	y	y	y		
20	Rowlands	Unit 1 & 2 Four Acre Precinct		y	y	y	y	y		
22										

(please note this information is correct as of August 2014. Different PNA production schedules mean not all information in this Appendix may be up-to-date at time of consultation)

Appendix 6: Pharmacy Premises and Services Questionnaire

A questionnaire to gather information from all pharmacies was devised as a collaborative exercise with Merseyside local authority PNA leads and NHSE, Merseyside area team. It was conducted using the online tool Survey Monkey with any follow-ups needed being sent out electronically by email. Below is the communication and questions asked.

Each Local Authority has a statutory duty to produce a Pharmaceutical Needs Assessment – Public Health are currently drafting the new version and for this to be informative and to meet guidelines we are asking local community pharmacists to complete the following questionnaire. Your responses are integral to help inform the current re-write which will then be subject to a full, formal public consultation.

1. Contract Details		
1.1	**Name of Contractor**	
1.2	**Trade Name**	
1.3	**Pharmacy Address**	
1.4	**Name of person completing survey**	
1.5	**Telephone Number**	
1.6	**Which Local Authority are you based in?**	**Halton** ☐ **St. Helens** ☐ **Knowsley** ☐ **Liverpool** ☐ **Sefton** ☐ **Warrington** ☐
1.7	**Website address**	
1.8	**Provide estimates of which LA residents represent your major customer bases (e.g. Liverpool 20%, Sefton 80%)**	

2. Services			Tick all that apply
2.1	Which of these Advanced Services do you currently provide?	Medicine Use Review	
		New Medicines Service	
		Appliance Use Review	
		Stoma Customisation	
2.2	Does the Pharmacy dispense:	Stoma Appliances	
		Incontinence Appliances	
		Dressings	

2.3	Which of these locally commissioned services do you currently commissioned to provide? (Please tick). *This survey relates to a number of Local Authority Areas so the services listed here may not be available in your locality.*	Tick all that apply
	Advice to care Homes	
	Chlamydia Screening	
	Emergency Hormonal Contraception	
	Minor Ailments e.g. Care at the Chemist	
	Smoking Cessation	
	Needle/Syringe Exchange	
	Supervised Administration of Methadone	
	Supervised Administration of Subutex	
	Supply of Palliative Care Medicines : Stock holder Guaranteed dispenser	
	Anticoagulant Monitoring	
	Gluten Free Food Supply	
	Weight Management	
	Domiciliary Medicine Administration Records (MAR)	
	NHS (Cardiovascular) Health Checks	
	NHS Emergency Medicines Service	
	NHS Seasonal Influenza Vaccination Service	

3.	Dispensing/Other Services Does the pharmacy provide any of the following?		Tick all that apply
3.1	Collection of prescriptions from surgeries		
3.2	Delivery of dispensed medicines:	Free of charge on request	
		Chargeable	
		Selected patient groups only Criteria…..	
		Selected areas only Criteria…..	
3.3	Provision of Monitored Dosage Systems (MDS) to patients living in their own home		
3.4	Under what circumstances would you supply an MDS container to a person	If the patient is eligible under the 2010 Equality Act (formally the DDA) and the	

	living in their own home?	pharmacy considers it reasonable adjustment	
		At the request of the surgery	
		At the request of a family member	
		At the request of a care worker/agency	
3.5	**Provision of non-commissioned services** The safe and efficient supply of medicines, including the additional (non-commissioned) support services provided by pharmacies for:	their housebound patients and older people,	
		people with learning disabilities	
3.6	**Provision of non-commissioned services** Do you provide any other services which are not commissioned by either NHS England, your local CCG or local public health team?	Please list additional services you provide:	

4. Accessibility (tick all that apply)			**Tick all that apply**
4.1	**Can customers legally park within 50 metres of the pharmacy?**		
4.2	**Is there a bus stop within walking distance of the pharmacy?**		
	If yes how long does the walk take	Less than 2 minutes	
		2-5 minutes	
		More than 5 minutes	
4.3	**Can disabled customers park within 10 metres of the pharmacy?**		
4.4	**Is the entrance to the pharmacy suitable for wheelchair access unaided?**		
4.5	**Are all areas of the pharmacy floor accessible by wheelchair?**		
4.6	**Do you have any other facilities in the pharmacy aimed at supporting disabled people access your service?**	Automatic door assistance	
		Bell at front door	
		Disabled toilet facility	
		Hearing loop	
		Sign language	
		Large print labels/leaflets	
		Wheelchair ramp access	
		Other, please state	
4.7	**Are you able to offer support to people whose first language is not English?**		
	If so how?	Use of interpreter/language line	
		Staff at pharmacy speak languages other than English (please indicate)	
		Other, please state	
4.8	**Are you able to provide advice and support if a customer wishes to speak to a person of the same sex?:**	**At all times**	
		By arrangement	

5. Premises and Consultation Facilities				
5.1	**Is there a consultation area available that meets the criteria for Medicine Use Reviews where a patient and pharmacist can sit down together, talk at a normal speaking volume without being over heard by customers or staff and is clearly signed as private consultation?**		**Yes**	**No**
	On the premises	None		
		Available with wheelchair access		
		Planned within the next 12 months		
		Other, please state		
5.2	**Do the premises have toilets that patients can access for screening e.g. for chlamydia & pregnancy testing?**			

Thank you for taking the time to complete this questionnaire

Appendix 7: Public Local Pharmacy Services Questionnaire

During April and May 2014 the public health team conducted a survey at a local health & wellbeing event and online. It asked local residents to give their feedback on their local pharmacy. The online version of the survey was sent out via a wide range of networks including Halton & St Helens Voluntary Action, Healthwatch, Halton Local Strategic Partnership groups and networks, Halton Children's Trust, Halton Clinical Commissioning Group engagement network, Halton OPEN (Older People's Network) and others. 97 responses were received. A press release was also issued to the local paper. The online survey was open for four weeks. The following is the communication sent out and questionnaire.

Pharmacy Services in Halton - Have your say

Halton Borough Council wants to hear the public's views on local pharmacy services.

As part of the Council's new Public Health responsibilities, it is required to produce an assessment of local pharmacy services.

A questionnaire is available on the Council website seeking residents' views on the helpfulness and location of pharmacies, and the frequency with which Halton people make use of them. The survey also asks residents how they normally get to their chosen pharmacy, and what is their most important consideration when choosing a pharmacy.

Director of Public Health, Eileen O'Meara said:

"The local pharmacy is often the first place residents will turn to when they have a concern about their health or that of their family. It is for this reason that it is important we look into the needs of Halton's population and how pharmacies can meet these needs. I would ask everyone to get involved and respond to this important survey, to help us shape the future of the service."

The questionnaire is anonymous and should only take a few minutes to complete.

Results from the survey will be used to inform a review of the needs of the local population and the ease of access to local pharmacy services, and will be made available later in the year.

LOCAL SURVEY OF COMMUNITY PHARMACY SERVICES

A pharmacy or Chemist is a place you would use to get a prescription dispensed or buy medicines or ask a pharmacist for advice. A pharmacist is the most qualified person in the pharmacy to dispense and sell medicines and give advice.

How easy it is to use your usual pharmacy?

1. When did you last use a pharmacy to get a prescription, buy medicines or to get advice? *Please tick one*

☐$_1$ In the last week ☐$_2$ In the last two weeks ☐$_3$ In the last month
☐$_4$ In the last three months ☐$_5$ In the last six months ☐$_6$ Not in the last six months

2. How did you get to the pharmacy? Please tick all that apply

☐$_1$ Walking ☐$_2$ Public transport ☐$_3$ Car ☐$_4$ Taxi ☐$_5$ Other

3. Thinking about the location of the pharmacy, which of the following is most important to you?

Please tick one:

☐$_1$ It is close to my doctor's surgery
☐$_2$ It is close to my home
☐$_3$ It is close to other shops I use
☐$_4$ It is close to my children's school or nursery
☐$_5$ It is easy to park nearby
☐$_6$ It is near to the bus stop / train station
☐$_7$ None of these
☐$_8$ Other - please write in the box below

4. How easy is to get to your usual pharmacy?

Please tick one

☐1 It is very easy - within my walking distance
☐2 It is quite easy - within a short bus ride or car journey
☐3 It is not easy - I can only get there by car but I can get there
☐4 It is not easy at all - I have no car and can't get there easily
☐5 It is very difficult - but my pharmacy will deliver medicines if I need them
☐6 It is very inconvenient for me to get to a pharmacy and can cause a problem for me

5. If you have a "blue badge" for disabled persons, can you park within approximately 10 yards/ 10 metres (or 30 feet) of the pharmacy?
☐1Yes ☐2 No☐3 Don't know

6. In the last 12 months have you had any problems finding a pharmacy to get a medicine dispensed, to get advice or to buy medicines?
☐1 Yes☐2 No **Go to Q7**

If Yes, what was your main reason for going to the pharmacy?

Please tick one:
☐1 To get medicine(s) on a prescription ☐2 To buy medicine(s) from the pharmacy
☐3To get advice at the pharmacy ☐4 Other, please state _____

Please tell us what was the problem in finding a pharmacy?

7. Are you satisfied with the opening hours of your pharmacy?
☐1 Yes ☐2 No

If no, please say why

About the last time you found your usual pharmacy, or the one closest to you, closed

8. What day of the week was it?
Please tick one:
☐1

to ☐$_2$ ☐$_3$ ☐$_4$ Bank Holiday
☐$_5$ Can't remember

9. What time of the day was it? _____ Am/Pm, or☐$_5$ Can't remember

About any medicines you receive on prescription and dispensed by your usual, or local pharmacy

10. Did you get a prescription the last time you used a pharmacy?
☐$_1$ Yes **Go to Q11** ☐$_2$ No **Go to Q16** ☐$_3$ Can't remember **Go to Q16**

11. Did someone explain how long your prescription would take to be prepared?

☐$_1$ Yes ☐$_2$ No, but I would have liked to have been told ☐$_3$ No, but I did not mind
☐$_4$ Can't remember

12. If 'yes' was this a reasonable period of time?
☐$_1$ Yes ☐$_2$ No

13. Did you get all the medicines that you needed on this occasion?
☐$_1$ Yes **Go to Q16** ☐$_2$ No **Go to Q14** ☐$_3$ Can't remember **Go to Q16**

14. What was the main reason for not getting all your medicines on this occasion?

Please tick one:
☐$_1$ The pharmacy had run out of my medicine
☐$_2$ My GP had not prescribed something I wanted
☐$_3$ My prescription had not arrived at the pharmacy
☐$_4$ Some other reason

15. How long did you have to wait to get the rest of your medicines?

Please tick one
☐$_1$ Later the same day ☐$_2$ The next day ☐$_3$ Two or more days ☐$_4$ More than a week

16.One other question, about anytime you may receive a prescription when discharged from hospital or when attending an out-patient <u>at the hospital</u>, would you like to be able to have the choice to get your prescription filled (dispensed) at your local pharmacy as well as at the hospital pharmacy?

☐$_1$ Yes☐$_2$ No

About times when you needed a consultation, or wished to talk to the pharmacist in the pharmacy

17. Have you had a consultation with the pharmacist in the last 12 months for any health related purpose?

☐$_1$ Yes ☐$_2$ No **Go to Q20**☐$_3$ Can't remember **Go to Q20**

18. Where did you have your consultation with the pharmacist?

Please tick one
☐$_1$ At the pharmacy counter
☐$_2$ In the dispensary or a quiet part of the shop

☐4 In a separate room
☐5 Over the telephone **Go to Q20**
☐6 Other

19. How do you rate the level of privacy you have in the consultation with the pharmacist?
Please tick one:
☐1 Excellent ☐2 Very good ☐3 Good ☐4 Fair ☐5 Poor ☐6 Very Poor

About what you feel pharmacies should be able to offer you

20. Please tell us how you would describe your feelings about pharmacies.
Please tick one:
☐1 I wish pharmacies could provide more services for me
☐2 I am satisfied with the range of services pharmacies provide ☐3 Don't know

21. Which if any of the services below do you think should be available locally through pharmacies

Tick one box in each row:

a. To get **treatment of a minor illness** such as a cold instead of my doctor (free of charge if you don't pay for prescriptions)	Yes ☐	No ☐	Not sure ☐
b. Advice on stopping smoking and/or vouchers for nicotine patches/gum etc.	Yes ☐	No ☐	Not sure ☐
c. Advice on contraception and **supply of "morning after" pill free of charge**	Yes ☐	No ☐	Not sure ☐
d. Weight management services and advice on diet/exercise for weight management	Yes ☐	No ☐	Not sure ☐
e. Tests to check blood pressure, cholesterol, whether I might get diabetes or other conditions	Yes ☐	No ☐	Not sure ☐
f. Advice and treatment for drug and alcohol abuse	Yes ☐	No ☐	Not sure ☐
g. Review of medicines on repeat prescription with advice on when it is best to take them, what they are for and side-effects to expect	Yes ☐	No ☐	Not sure ☐

22. Is there anything you particularly value as a service from pharmacies?

23. Is there anything else, or any service that you feel could be provided by local pharmacies?

Finally please provide some details about yourself

24.Are you? ☐Male ☐Female

25. How old are you?
☐1 16-20 years ☐2 21-30 years ☐3 31-40 years ☐4 41-50 years ☐7 51-59 years
☐5 60- 70 years ☐6 71 years or over

26. Please tell us the first 4 letters/numbers of your postcode | | | | |

27. Which ethnic group do you belong to? (Please tick the appropriate box)

☐$_1$ White British ☐$_2$ Black Caribbean ☐$_3$ Black African ☐$_4$ Black other

☐$_5$ Asian ☐$_6$ Indian ☐$_7$ Pakistani ☐$_8$ Bangladeshi

☐$_9$ Irish traveller ☐$_{10}$ European ☐$_{11}$ Other

Thank you for you for taking the time to fill in this questionnaire.

Appendix 8: Formal Consultation Letter and Questionnaire

Appendix 9: Formal Consultation Response

(to be completed following end of 60-day consultation period)

Appendix 10: References

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Dear Sir / Madam

Pharmaceutical Needs Assessment (PNA) Consultation
Invitation to Participate

During the reorganisation of the NHS the responsibility for production of the Pharmaceutical Needs Assessments (PNAs) transferred to the Health and Wellbeing Boards (HWB) which are hosted by local authorities.

Halton Health and Wellbeing Board (HWB) is developing a new PNA. This is a statutory HWB responsibility, as set out under the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013(SI 2013 No. 349).

A PNA is a document which records the assessment of the need for pharmaceutical services within a specific area. As such, it sets out a statement of the pharmaceutical services which are currently provided, together with when and where these are available to a given population. The same Regulations require NHS England to use the PNA to consider applications to open a new pharmacy, move an existing pharmacy or to commission additional services from pharmacy.

The HWB has established a PNA Task & Finish Group to oversee the development of the new PNA. This group includes membership from our partner organisations, Healthwatch and the Local Pharmaceutical Committee.

As part of the development process, the Regulations require that the HWB undertakes a formal consultation on a draft of its PNA. The key outcomes for this consultation are:

- To encourage constructive feedback from a variety of stakeholders
- To ensure a wide range of primary care health professionals provide opinions and views on what is contained within the PNA

Taking this into account, we would like to invite you to participate in this consultation, which will run from Monday 22 September 2014 to Monday 24 November 2014:

- The draft PNA can be found on our website by via the following link
  (link to be added)
- **All responses must be in writing.** A consultation response form has been developed to facilitate comment and feedback. This may be accessed on the same website via the following link:
- Submitting responses: You may choose one of the following options to submit your response:
  - Complete the survey online
  -
  - Complete the form at the end of this letter and return it electronically via email to: Lynne.Woods3@halton.gov.uk
  - complete the form and return it by post to the following address: **Public Health and Public Protection Department, Halton Borough Council, Runcorn Town Hall, Heath Road, Runcorn, Cheshire, WA7 5TD**

Halton Borough Council has decided to run this consultation electronically in order to limit the environmental impact of this consultation. However, if you require a paper version of the PNA, please contact Lynne Woods on 0151 511 6855 who will arrange to provide this within 14 days of your request.

All feedback received by 24 November 2014 will be collated and presented to the PNA Task & Finish Group, for consideration on behalf of the HWB. A consultation report will be included within the final PNA document. This will provide an overview of the feedback received and set out how the comments have been acted upon. An updated PNA including consultation process and responses will be presented to the HWB in January 2015 and published shortly afterwards.

We look forward to receiving your feedback on the draft PNA.

Yours faithfully

Eileen O'Meara
Director of Public Health
PNA Sponsor, Halton Health & Wellbeing Board
Halton Borough Council

Halton Pharmaceutical Needs Assessment
Consultation Response Form

(note all section numbers refer to the main document)

1. Has the purpose of the PNA been explained sufficiently within section 1 of the draft PNA document?

Yes ☐ No ☐ Not sure ☐

If "No", please explain why in the box below:

2. Does Section 2 clearly set out the scope of the PNA?

Yes ☐ No ☐ Not sure ☐

If "No", please explain why in the box below:

3. Does Section 4 & 6 clearly set out the local providers of pharmaceutical services and local context?

Yes ☐ No ☐ Not sure ☐

If "No", please explain why in the box below:

4. Does the information in Sections 5 & 7 provide a reasonable description of the services which are provided by pharmacies in Halton?

Yes ☐ No ☐ Not sure ☐

If “No”, please explain why in the box below:

5. Are you aware of any pharmaceutical services currently provided which have not been included within the PNA?

Yes ☐ No ☐ Not sure ☐

If “Yes”, please explain why in the box below:

6. Do you think the pharmaceutical needs of the population have been accurately reflected in the PNA?

Yes ☐ No ☐ Not sure ☐

If “Yes”, please let us know which service(s) in the box below:

7. Do you agree with the key findings about pharmaceutical services in Halton?

Yes ☐ No ☐ Not sure ☐

If “No” please explain why in the box below:

8. Do you agree with the assessment of future pharmaceutical services as set out in sections 6.4?

Yes ☐ No ☐ Not sure ☐

If “No”, please explain why in the box below:

9. ***Community pharmacies & Dispensing Appliance Contractor only.*** Please can you review the information in Appendix 3 (Opening Hours) and Appendix 4 (Service Provision) for accuracy? If you identify any issues please provide details

	Is the information Accurate?				If "No", please provide details:
Opening Hours	Yes	☐	No	☐	
Service Provision	Yes	☐	No	☐	

10. If you have any further comments, please enter them in the box below (question applies to all):

11. About you - please can you provide the following information:

(if responding on behalf of an organisation or pharmacy please fill in the details below. If you are responding as an individual you do not need to fill this information in but you can do so if you wish))

Name	
Job Title	
Pharmacy Name Or Organisation (	
Address	
Telephone No.	
Please confirm that you are happy for us to store these details in case we need to contact you about your feedback?	Yes ☐ No ☐

Please return this feedback form:

- Via email to: Lynne.Woods3@halton.gov.uk

- Via post to the following address: **Public Health and Public Protection Department, Halton Borough Council, Runcorn Town Hall, Heath Road, Runcorn, Cheshire, WA7 5TD**

(to be added: equal opportunities page)

REPORT TO: Health and Wellbeing Board

DATE: 17th September 2014

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Wellbeing

SUBJECT: Halton Health Profile 2014.

WARDS: Borough wide

1.0 PURPOSE OF THE REPORT

1.1 The purpose of this report is to present the Health and Wellbeing Board with information relating to Halton's Health Profile 2014 and provides analysis regarding the findings from a local perspective.

RECOMMENDATION: That

1. **the Board note progress in health outcomes and programmes established to address areas of concern; and**

2. **feedback comments to the Director of Public Health**

2.0 SUPPORTING INFORMATION

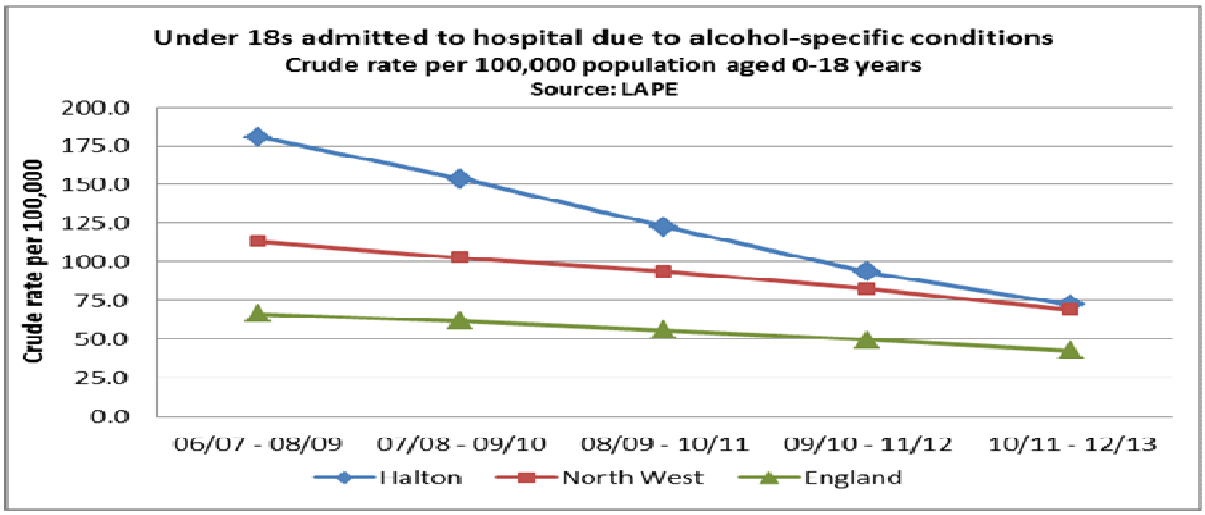
2.1 Every year the Department of Health releases a health profile of Halton which compares it to the England average. It is designed to help local government and health services understand their community's needs, so that they can work to improve people's health and reduce health inequalities.

2.2 The Halton Health Profile 2014 shows that half of all local residents live in the most deprived areas in England. Given the direct relationship between poverty and poor health it is unsurprising that Halton's health statistics are worse than the national average. Using a traffic-light rating system, the profile ranks those better than the England average as green, those similar to the England average as amber and those performing worse than the England average as red.

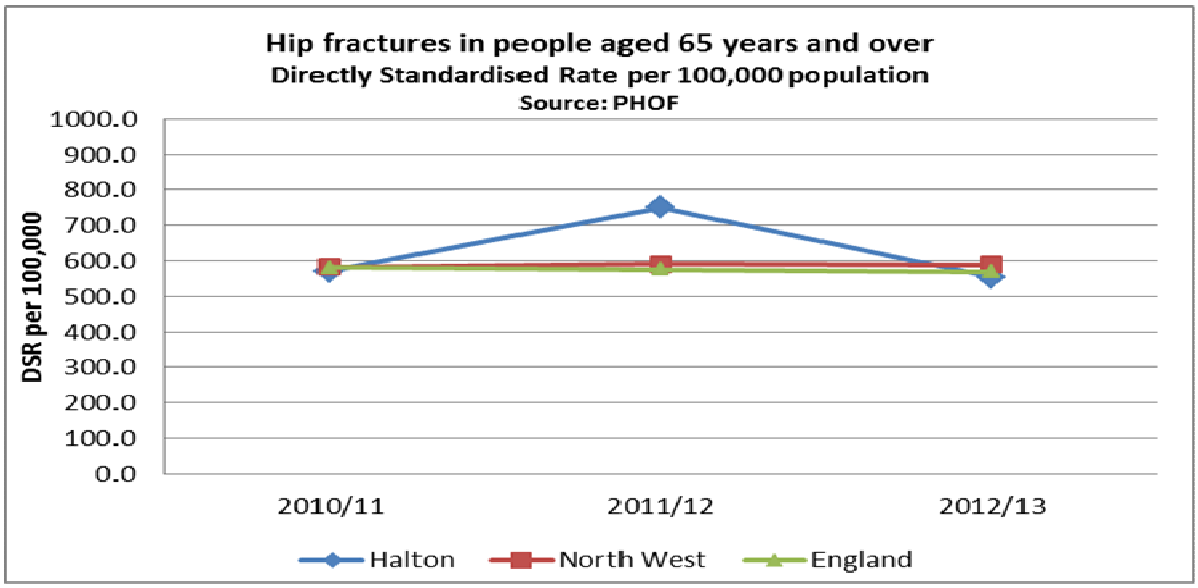
2.3 Halton's profile can be seen in the Appendix which shows that although Halton is not better than the England average in the majority of indicators it has improved against the previous year's figures in 15 out of 27 comparable indicators, remained static for 7 and worsened in 5.

Halton progress and challenges.

2.4 The data for Halton shows that if we compare the 2013 profile with the 2014 profile we have made very good progress in the Health and Wellbeing Board priority areas of reducing harmful levels of drinking, improved mental health and reducing falls in older people. This is reflected in the drop in *Alcohol specific stays (under 18s)* and *Hospital stays for alcohol related harm (adults).* As well as a big reduction in *Hospital stays for self harm* and *Hip fractures in over 65s.*

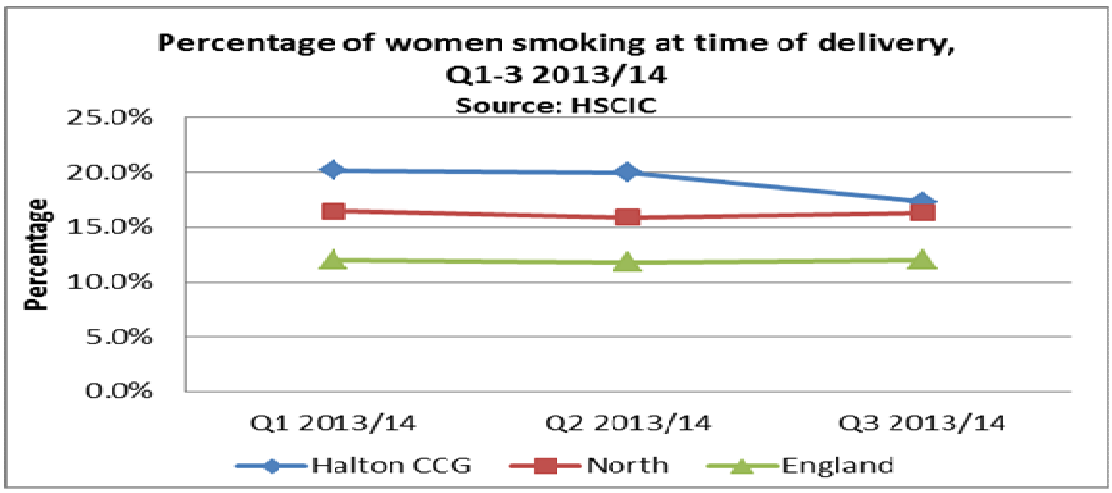


Hospital admissions due to alcohol specific conditions (under 18s). Halton has reduced from the worst in England to the North West average.

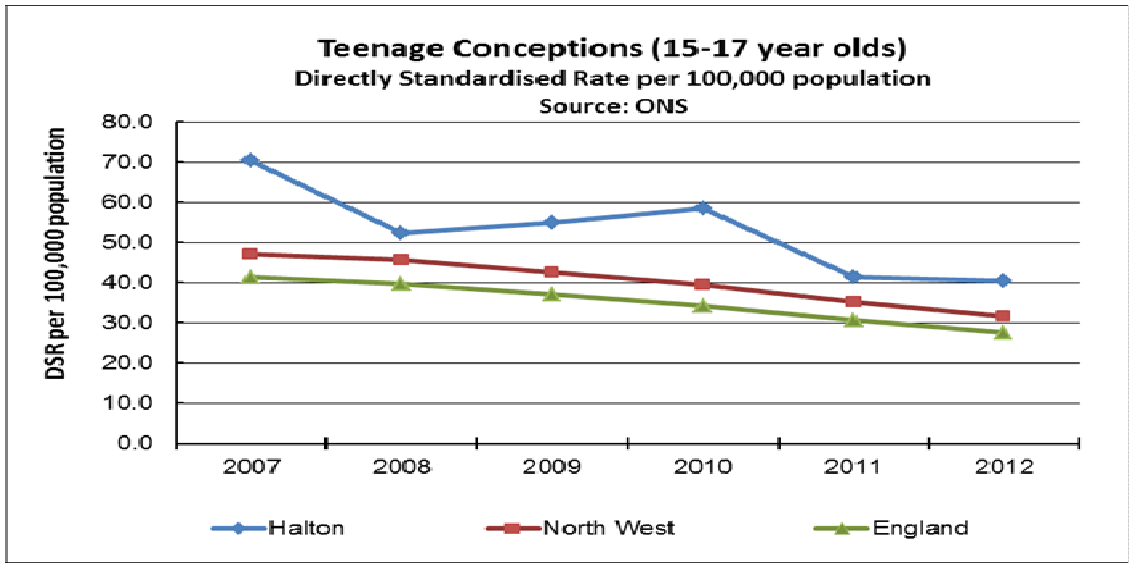


Hip fractures in people aged 65+ in Halton were similar in 2012/13 to 2010/11. The rate did increase in 2011/12 but the decrease in 2012/13 means that the Halton rate is now once again similar to England the North West.

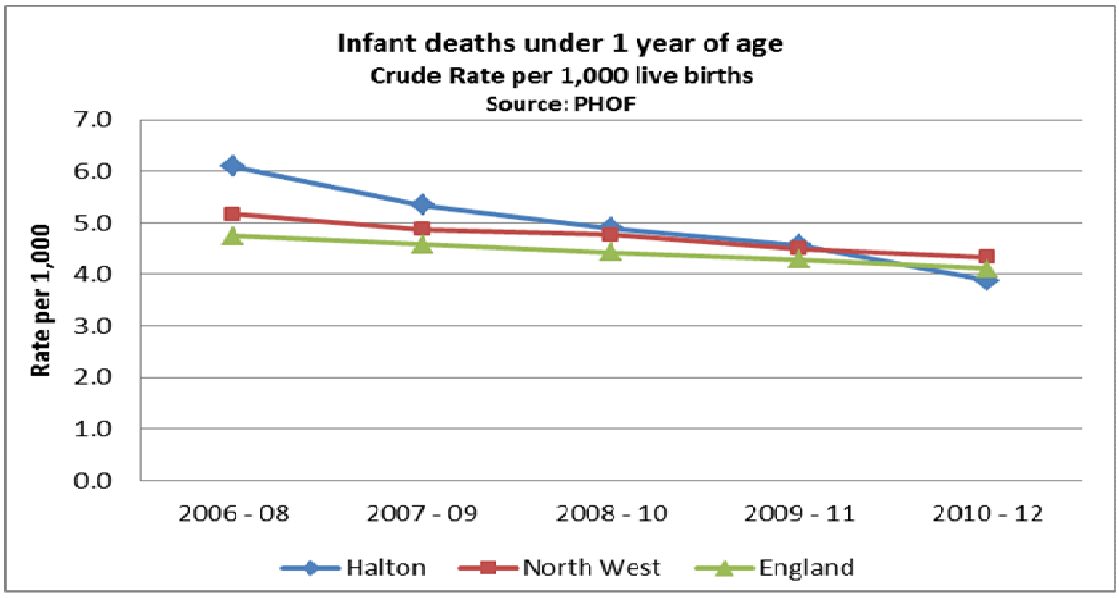
2.5 Halton has also improved in terms of smoking in pregnancy, increasing the number of mothers who breastfeed, reducing teen pregnancy, reducing drug misuse, reducing the number of TB cases, increasing male lives, reducing infant mortality and reducing the number of people who die from cancer.



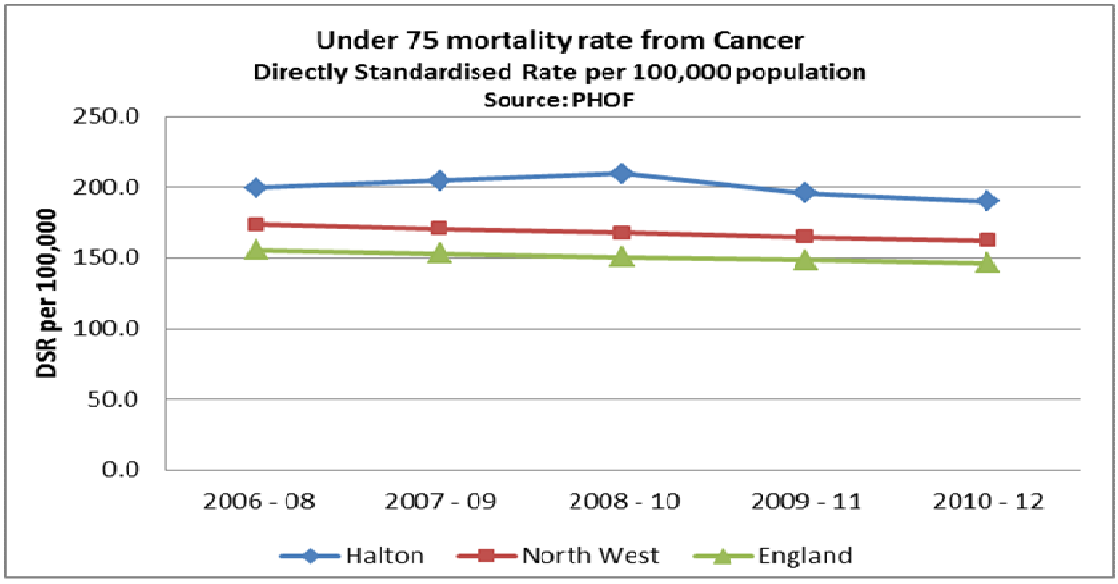
Halton's Smoking at time of delivery rate has now reduced to the North average.



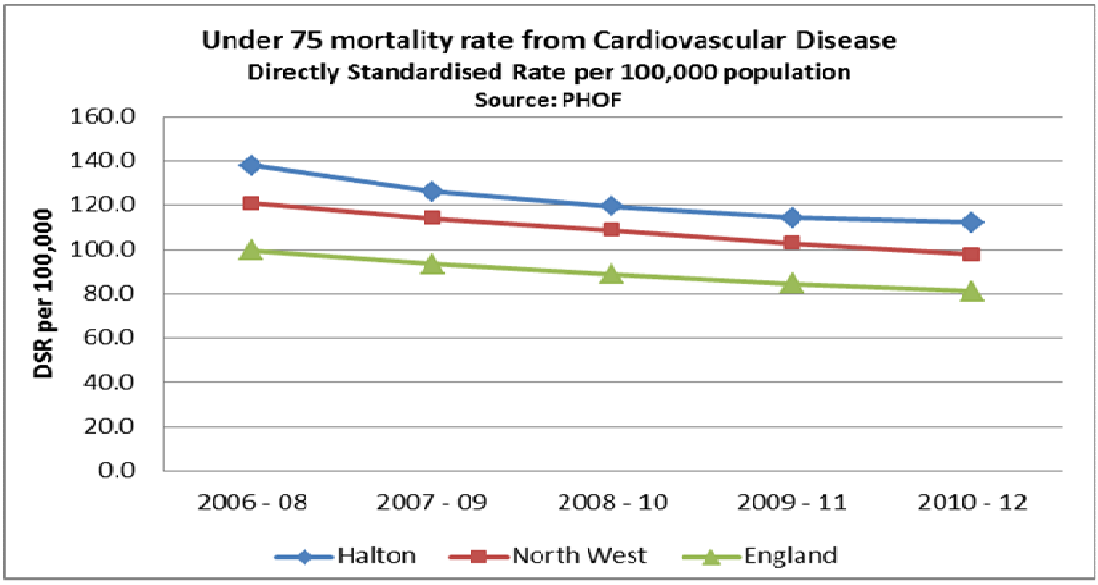
Halton's teen pregnancy rate has reduced significantly.



The infant mortality rate in Halton has continued to decrease since 2006-10. Due to this, the rate is now slightly lower than the national and regional averages.



The under 75 cancer mortality rate for Halton decreased between 2008-10 and 2010-12, however, it remains higher than England and the North West.

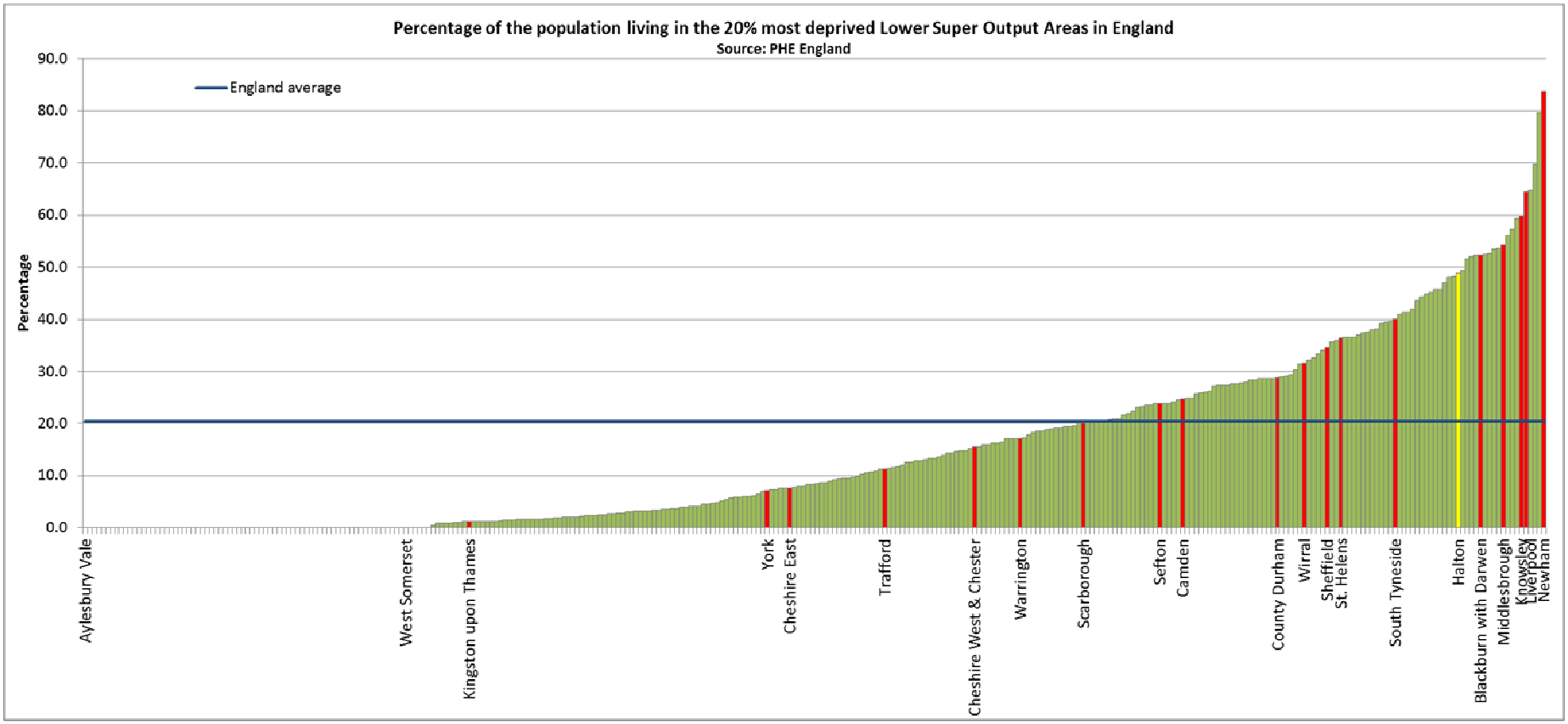


Under 75 mortality from CVD has decreased in Halton since 2006-08. This means that the gap between Halton and England decreased between 2006-08 and 2010-12

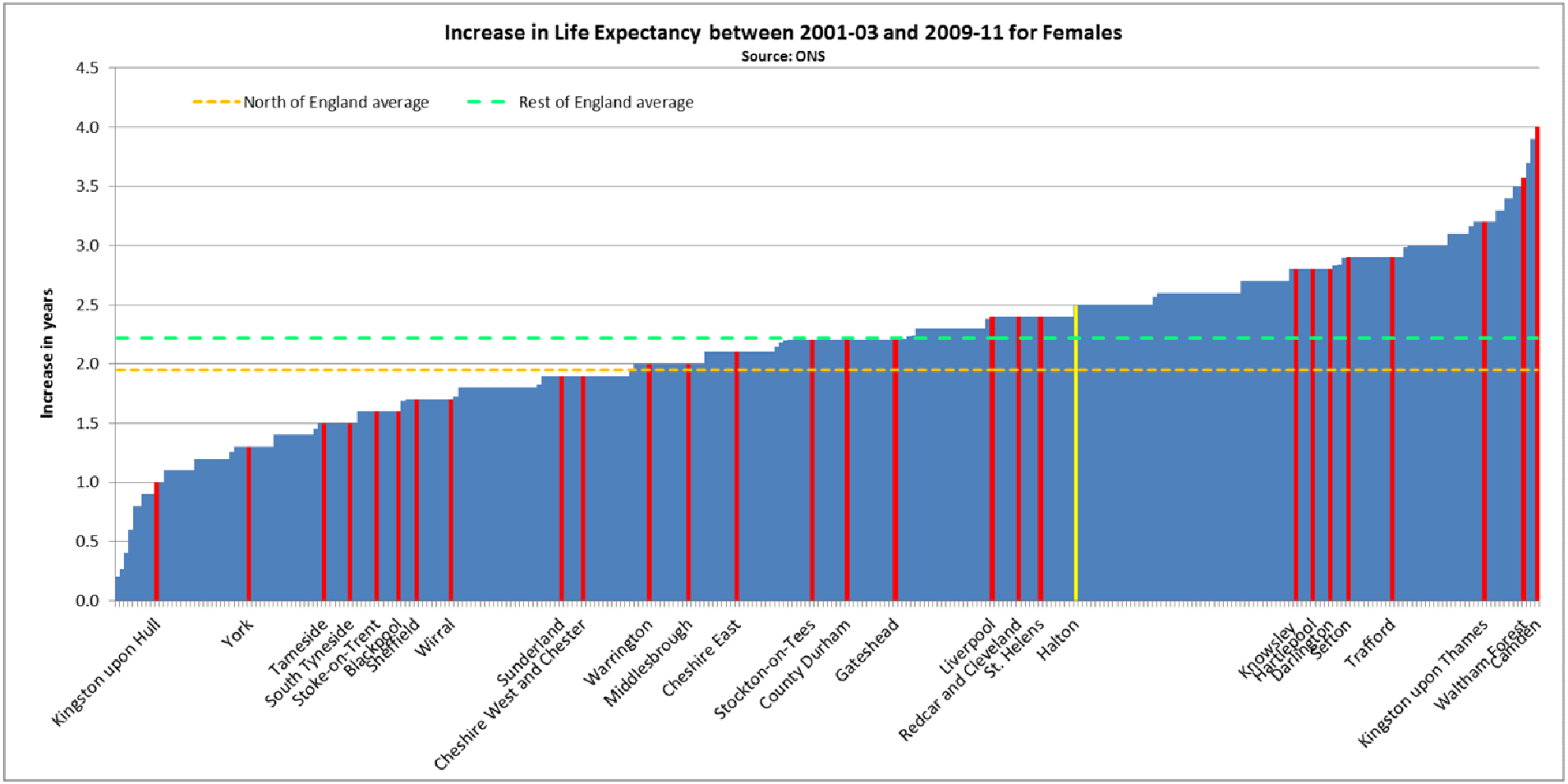
2.6 Halton has not made progress this year against reducing levels of deprivation, statutory homelessness, violent crime, obesity and reducing long term unemployment. The number of people diagnosed with diabetes has increased but given there is national under diagnosis of this disease this could be considered a good thing.

2.7 Compared to the rest of England Halton has high levels of deprivation. However, progress has been made in terms of reducing health inequalities and improving life expectancy.

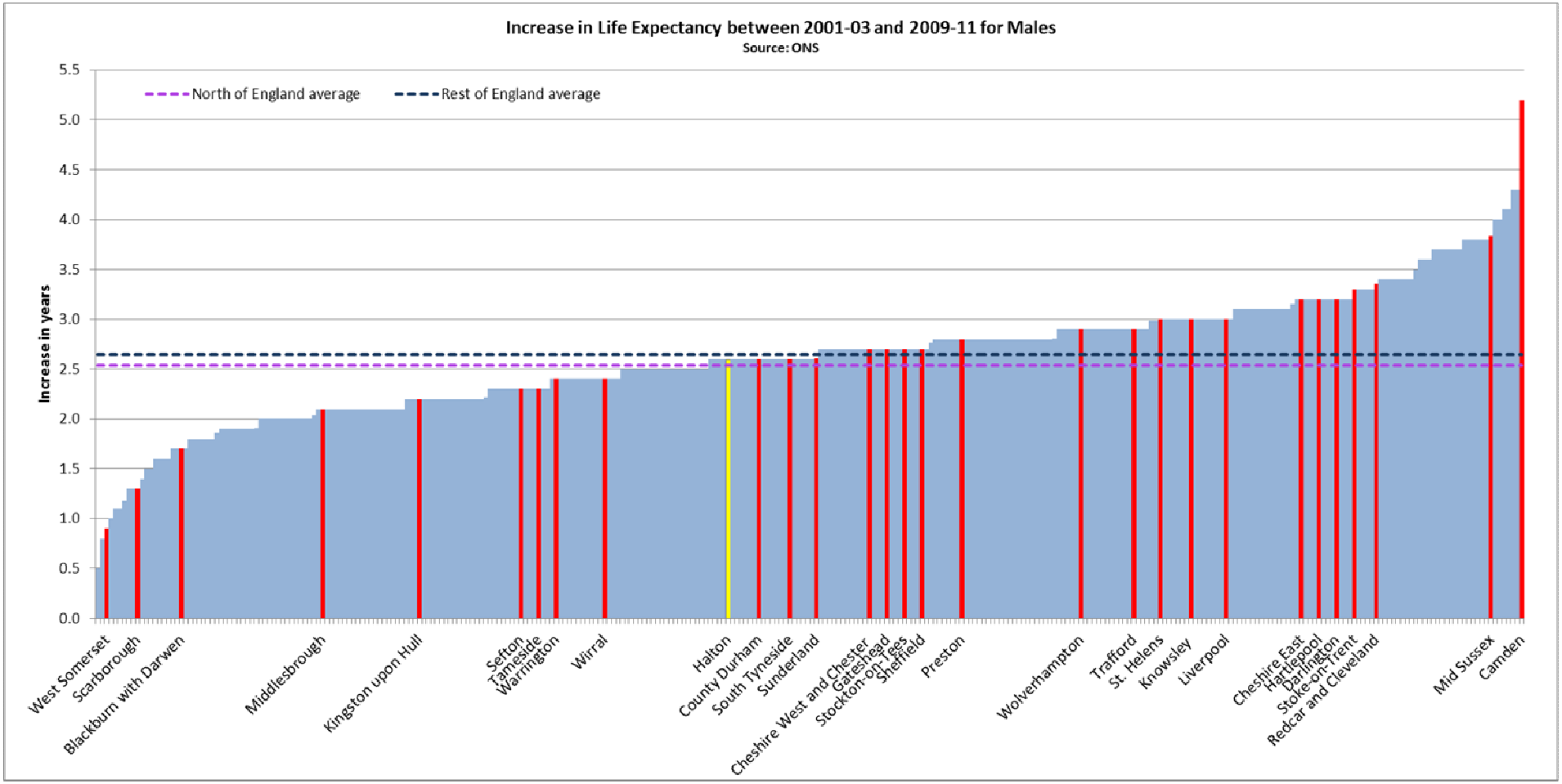
In England on average 20% of people live in deprived areas in Halton 48% of people live in deprived areas.

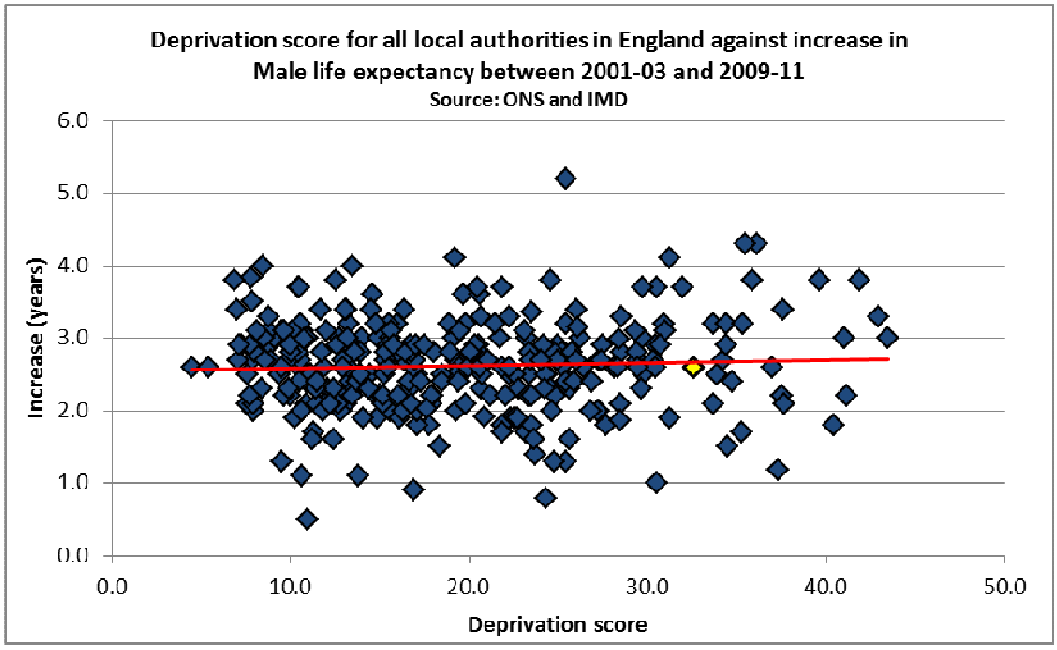


Despite high levels of poverty Halton has increased life expectancy for women by more than the England average and is closing the gap.

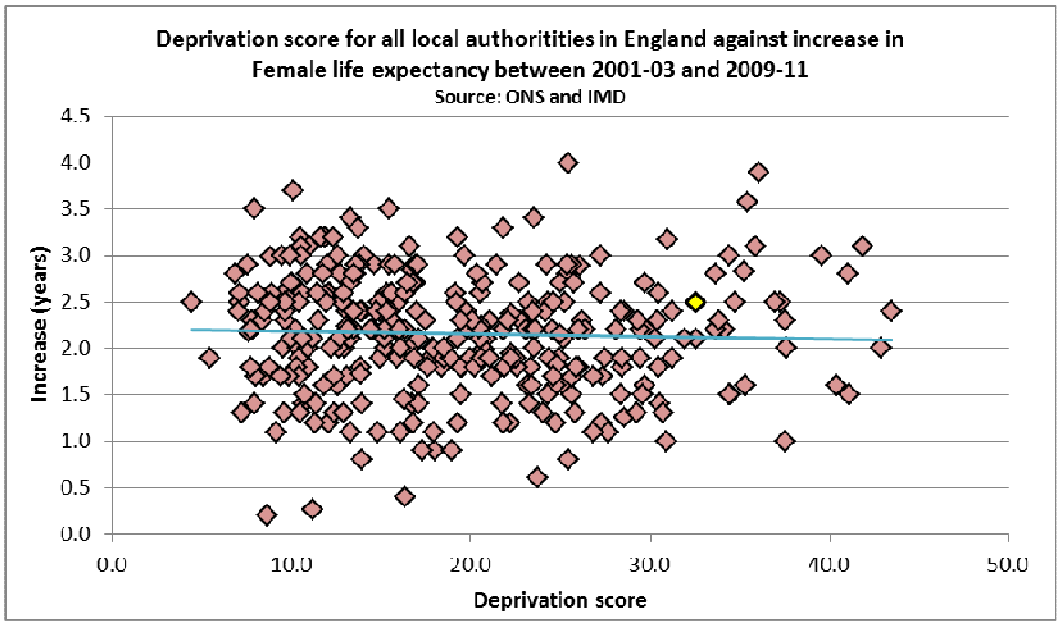


Life expectancy for men in Halton is below the England average and is improving at just under the same rate as the rest of England.





Each diamond represents a Local Authority and shows how each authority is progressing on life expectancy for men compared to their level of deprivation. This chart shows Halton, the yellow diamond, has made substantially more progress for its level of deprivation than most Local Authorities in England.



Each diamond represents a Local Authority and shows how each authority is progressing on life expectancy for women compared to their level of deprivation. This chart shows Halton, the yellow diamond, has made substantially more progress for its level of deprivation than most Local Authorities in England.

Programmes to address areas of concern.

2.8 Halton has a wide range of programmes that address deprivation, worklessness, child poverty, diabetes and obesity.

- Child Poverty Programme: Halton has a Child Poverty Strategy and Action Plan and is part of the City Region Child Poverty Commission. There is a wide range of work underway to address this area including Children's Centres Programmes, healthy eating, working with food banks, increasing breastfeeding, increasing free school meal uptake, plain packaging for cigarettes, smoking prevention, work with mums and tots, support for the New Shoots Food Coop, Credit Crunch Cooking, work with Housing Trusts around welfare reforms, Healthy Homes/ Warm Homes initiatives, work with the CAB and Supporting Residents at Risk of Home Repossession project.

- Back to work Programmes: Halton works with local residents to enable them to find work through Halton People into Jobs, an apprenticeship scheme, Welfare Rights Programme, Halton Housing Trust financial inclusion, Healthy and back to Work project.

- Child Social and Emotional Health Programmes: Halton has Prevention of Mental Health Conditions as a Health and Wellbeing Board priority. A new Mental Health Strategy and comprehensive Action Plan has recently been developed. There is a review of the CAHMS service underway, Adaction is employed to work with youngsters with addictions, teachers are trained to work with youngsters on developing confidence and self-esteem and counteracting bullying, an anti-cyber bullying project is in development, midwives are working with mothers to avoid post natal depression and parenting programmes for families in how to bond with babies and deal with toddlers.

- Diabetes Programme: Impaired Glucose Regulation project that picks up people at risk of developing diabetes and provides them with education, diet and exercise advice so they can avoid developing the condition. Diabetes Education Programme for patients with the condition to help them manage it, Expert Patient Programme so people become experts on their condition, Healthy Weight Fresh Start Programme enables people to lose weight and therefore be less at risk of developing diabetes, Healthy Weight in Pregnancy Programme works with overweight pregnant women who are at risk of developing gestational diabetes.

- Reducing Harmful Levels of Drinking Programme: Reduction in the levels of harmful alcohol consumption is a priority for Halton's Health and Wellbeing Board. It has an Action Plan which includes: training for all frontline staff in dealing with alcohol related issues from birth to old age, treatment services for adults and children, awareness raising via

campaigns, alcohol prevention programmes for all schools, mystery shopping via trading standards for underage sales, regulation of counterfeit alcohol, alcohol liaison nurse at hospitals A&E and advocacy on minimum unit pricing.

- Falls Programme: Falls is a priority for the Health and Wellbeing Board and a new Falls Strategy and Action Plan has recently been implemented which includes: exercise for older people to improve balance, training on falls prevention for frontline staff, development of new falls pathway.

3.0 POLICY IMPLICATIONS

The Halton Health Profile 2013 highlights a number of key health issues for Halton. The Health and Wellbeing Strategy together with a number of related strategies is already addressing many of the issues highlighted.

4.0 OTHER/FINANCIAL IMPLICATIONS

4.1 There are no direct financial implications as a result of this report. Actions identified within the Health and Wellbeing Strategy and associated strategies however, may have implications that will be reported to the relevant boards as they arise.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 **Children and Young People in Halton**
Improving the Health of Children and Young People is a key priority in Halton and will continue to be addressed through the Health and Wellbeing Strategy whilst taking into account existing strategies and action plans so as to ensure a joined-up approach and avoid duplication

5.2 **Employment, Learning and Skills in Halton**
The above priority is a key determinant of health. Therefore improving outcomes in this area will have an impact on improving the health of Halton residents

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

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5.4 **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.

There are also close links between partnerships on areas such as alcohol and domestic violence.

5.5 **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 should therefore, be a key consideration when developing strategies that examine the wider determinants of health and wellbeing.

6.0 RISK ANALYSIS

Developing strategies to address the issues outlined by Halton Health Profile 2013 in itself does not present a risk. However, there may be risks associated with the recommended actions. These will be assessed as appropriate. There are no financial risks associated directly with this report. The recommendations are not so significant that they require a full risk assessment.

7.0 EQUALITY AND DIVERSITY ISSUES

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

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

Document	Place of Inspection	Contact Officer
Halton Health Profile 2014	Council Website	Diane Lloyd

Appendix

The Halton 2014 Health Profiles have recently been released. The Chart below compares the 2013 Profile with the 2014 one and the arrows show whether we have improved or deteriorated against the England average.

Indicator Number	Indicator	Previous year	Signif to Eng	2014	2014 Signif to Eng	↑/↓/=
1	Deprivation	Not updated since 2010		48.8		
2	Children in poverty (under 16s)	27.3		26.7		↓
3	Statutory homelessness	0.2		0.3		↑
4	GCSE achieved (5A*-C inc. Eng & Maths)	59.0		62.5		↑
5	Violent crime (violence offences)	12.1		12.8		↑
6	Long term unemployment	13.6		13.7		=
7	Smoking status at time of delivery	21.1		18.9		↑
8	Breastfeeding initiation	51.1		52.3		↑
9	Obese children (Year 6)	23.8		23.9		=
10	Alcohol-specific hospital stays (under 18)	94.7		73.5		↓
11	Under 18 conceptions	41.5		40.4		↓
12	Smoking prevalence	22.2		22.6		↑
13	Percentage of physically active adults	Not comparable		49.8		
14	Obese adults	New indicator		35.2		
15	Excess weight in adults	New indicator		70.2		
16	Incidence of malignant melanoma	18.4		17.4		=
17	Hospital stays for self-harm	416.4		325.9		↓
18	Hospital stays for alcohol related harm	851.3		814.4		↓
19*	Drug misuse	9.8		8.4		↓
20	Recorded diabetes	7.0		7.2		↑
21	Incidence of TB	1.1		0.0		↓
22	Acute sexually transmitted infections	Not comparable		785.9		
23	Hip fractures in people aged 65 and over	750.3		553.1		↓
24	Excess winter deaths (three year)	8.7		9.5		↑
25	Life expectancy at birth (Male)	76.5		77.1		↑
26	Life expectancy at birth (Female)	80.7		80.6		=
27	Infant mortality	4.6		3.9		↓
28	Smoking related deaths	414.4		415.5		=
29	Suicide rate	8.8		7.8		↓
30	Under 75 mortality rate: cardiovascular	114.2		112.2		=
31	Under 75 mortality rate: cancer	195.9		190.2		↓
32	Killed and seriously injured on roads	32.6		32.1		=

For the definitions of the indicators please see the Health Profile

* new data released - 2014 column contains new rate

not significantly different to England average
significantly better than England average
significantly worse than England average

The figures show how Halton compares to England for each indicator. Some indicators are more robust than others, i.e. use good data sources based on big cohorts of people. Other indicators use small numbers or are modelled, the DH recommends "It is important to note that these estimates are modelled and published as 'experimental data' and should be used and interpreted with caution." This is the case for indicators 13, 14, and 15 as there is currently no reliable way of collecting this data on a big population basis.

REPORT TO: Health and Wellbeing Board

DATE: 17th September 2013

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Wellbeing

SUBJECT: NHS Health Check Programme

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To inform members of Halton's Health and Wellbeing Board of the progress of the NHS Health Check Programme and of ongoing and future developments with the programme.

2.0 RECOMMENDATION: That

1. the Annual Report on Health Checks is noted; and

2. the Board endorse the recommendations in the annual report, in particular

- **widespread promotion of Health Checks**
- **a health trainer available to every practice**
- **use of a bus to deliver Health Checks and community based approaches.**

3.0 SUPPORTING INFORMATION

3.1 Members will recall that a report on the NHS Health Check programme was presented to the Health and Wellbeing Board on 18th September 2013. NHS Health Checks is the government's flagship programme for the prevention of CVD, diabetes and kidney disease. The programme now also aims to reduce levels of alcohol related harm and raise awareness of the signs of dementia and where people can go for help.

4.0 Local delivery of NHS Health Checks

4.1 NHS Health Checks have been delivered in Halton for a number of years. However the programme was revamped in October 2013 to include dementia and alcohol and to remove elements of the Check which did not form part of the statutory programme. This was in response to feedback from GP practices that the programme was too unwieldly in its previous format and this was impacting on the number

of Health Checks that could physically be carried out.

4.2 Research undertaken by Health Inequalities Specialist Professor Chris Bentley reveals that 40% of Halton residents with long term conditions do not visit GP practices, hence, the importance of the programme in identifying these residents and enabling early treatment.

4.3 New Service Level Agreements were drawn up with GP practices to reflect the changes and a handbook was developed to assist GP practices deliver the programme. The EMIS web template was revised by one of the practice managers and rolled out to other practices. The revised programme has been promoted via individual visits to practices, attendance at Practice Managers' meetings and via presentations at related events e.g. the local launch of the IGR pathway.

4.4 Although currently the programme is exclusively delivered locally in GP practices other delivery mechanisms are now being developed.

4.5 All but one practice has signed up to the SLA. Officers are currently exploring this in order to get 100% coverage.

4.6 Over the past few months an approach has been trialled whereby Health Trainers from the Health Improvement Team have been based within GP practices for the purpose of carrying out Health Checks on behalf of the practice. The practice is still able to claim fees for each Health Check carried out in line with the SLA. This advantage of this approach is that patients can be signed up for appropriate lifestyle interventions there and then without the need for a referral by the practice or self-referral which carries with it a risk that the patient may not attend.

4.7 Local authorities are required to submit quarterly reports on the number of eligible people invited for a Health Check and the numbers of those who attend. This data is currently collected by St Helens and Knowsley NHS Hospitals Trust Health Informatics Service (HIS) under a local agreement with Halton CCG.

5.0 **NHS Health Checks 2013/14**

5.1 An annual report on the performance of NHS Health Checks in 2013/14 has been produced using information supplied by the HIS team. This is attached as Appendix A. In summary, the report reveals the following.

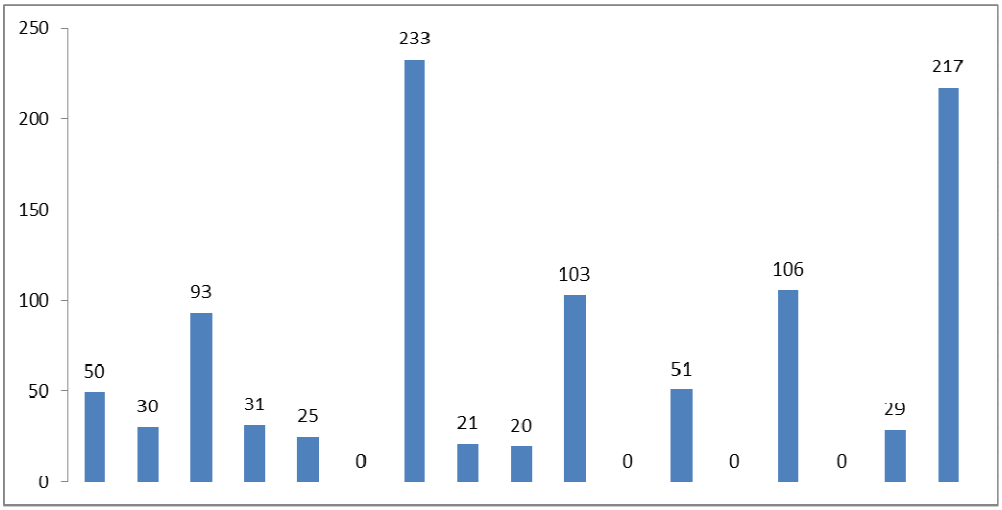
5.2 Of the 35,169 registered patients who were eligible (at quarter 4 2013/14), 5,217 were invited for a Health Check, equating to 14.83%. This falls someway short of the 20% that would be needed on an annual basis to ensure that every eligible person is invited once in a

five year period.

5.3 Of those invited 2,179 patients received a NHS Health Check giving a take up rate of 42%. Although there is no mandated target, the Department of Health has indicated that local authorities should be aiming for a take up rate of around 75% in line with current screening rates.

5.4 There is wide variation in the proportion of the eligible population invited and receiving a Health Check in each practice. Newtown Surgery and Castlefields Health Centre invited the highest proportions (63% and 41% respectively) while some surgeries invited only a small proportion of the eligible population. The table at the back of this report shows practice level information on the eligible population, numbers invited for and receiving a Health Check.

5.5 Similarly there is wide variation in take up rates as shown in the table below. However the take up figures suggest that there may be some under reporting of the number of people invited for a Health Check since some practices are recording take up rates exceeding 100 and even 200%. It is likely that this is due to opportunistic invitations not being recorded as such via the appropriate read code.



5.6 The report also highlights the issues that have arisen in obtaining data in an acceptable format from the HIS team. This is hindered by the fact that the Local Authority does not have a direct contractual relationship with the team and must communicate via the CCG.

5.7 In 2013/14 data on outcomes was fairly limited and related to all patients who received a Health Check not just those who were eligible for the NHS programme. The data that was available revealed that 8.5% of patients having a Health Check had a CVD risk score of 20 or above and 2.6% had hypertension. Numbers for other disease registers was relatively low. (see chart 8 in the report) These patients

have been added to practice disease registers and as a result are generating additional QOF points.

A wider range of outcome data will be available for 204/15 including lifestyle factors, demographics and referral information.

6.0 Recommendations

6.1 It is the vision of the Council to have a Health Trainer based in every practice for the purpose of supporting the Health Check programme. Options to achieve this could include training up Community Wellbeing Practice staff who are already based in practices.

6.2 The scheme would benefit from more widespread promotion. This could include posters and powerpoint presentations for surgery waiting areas (these are in development), advertising in public areas e.g. buses, libraries, carers and community centres and use of social marketing.

6.3 We are in the process of negotiations to secure the use of a bus for the purposes of carrying out Health Checks within the community. These would be carried out by Health Trainers from the Health Improvement Team. This would enable a more targeted approach in high risk areas or areas where there appears to have been little Health Check activity. There are some practical issues to be sorted e.g. customising the bus so that it appeals to the target audience and the development of data sharing protocols which will be particularly important when the Health Improvement Team staff transfer to the Council.

6.5 There is a need to provide support to practices on the use of read codes and ensure that all invitations are recorded regardless of how the patient has been invited for the Health Check. This is particularly important to ensure that data submitted to Public Health England is accurate.

6.6 Other future developments in the pipeline include the following:

Undertaking an options appraisal in relation to the data collection element of the programme;

Looking at the feasibility of offering NHS Health Checks to Council staff and elected Members.

Identifying community venues for NHS Health Checks delivered by health trainers

7.0 POLICY IMPLICATIONS

The Health and Social Care Act 2012 placed a statutory duty on local authorities to make arrangements for the delivery of NHS Health

Checks in their area.

8.0 OTHER/FINANCIAL IMPLICATIONS

Halton has a budget for the delivery of Health Checks.

9.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

9.1 Children and Young People in Halton

While Health Checks are specifically for people aged 40 to 74, it is anticipated that there will be indirect benefits to children and young people as a result of their parents and other family members being supported to lead a healthier lifestyle and/or prevent or delay the onset of ill health.

9.2 Employment, Learning & Skills in Halton

Improving the health of individuals can have a positive impact on their long term employability.

9.3 A Healthy Halton

Health Checks are a key tool in the identification, early detection and prevention of a range of health issues and can help to promote healthier lifestyles, thereby contributing to the aims and objectives of Halton's Health and Well Being Strategy.

9.4 A Safer Halton

None directly

9.5 Halton's Urban Renewal

None directly

10.0 RISK ANALYSIS

10.1 NHS Health Checks are a statutory requirement for local authorities. Failure to offer Health Checks in a locality could result in damage to the authority's reputation and impact on future funding levels.

10.2 There is a need to develop data sharing protocols in relation to delivery of NHS Health Checks in the community to ensure there is no breach of data protection legislation.

11.0 EQUALITY AND DIVERSITY

An Equality Impact Assessment has been completed for the delivery of NHS Health Checks. The assessment revealed two potential negative impacts.

The first relates to the fact that GPs are unlikely to invite pregnant women for Health Checks due to the high probability of temporarily misleading results. However provided they remain eligible pregnant women can be invited once the baby is born. In any case pregnant

women are in regular contact with their GP so that any potential health issues are likely to be picked up.

The second relates to the fact that traditionally a disproportionately high proportion of Gypsies and Travellers do not register with GPs. To mitigate this impact it is proposed that pro active engagement is carried out with the Gypsy and Travelling community through the Council's Gypsy and Traveller Co-ordinator and site wardens with a view to the Halton Health and Well Being service offering health screenings on site carried out by Health Trainers.

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

Department of Health/Public Health England draft Guidance on NHS Health Checks.

Appendix A

Halton Borough Council
NHS Health Checks
Annual review 2013/14

1.0 Purpose

The purpose of this report is to review the delivery of NHS Health Checks in Halton during 2013/14 and to make recommendations as to the future operation of the service.

2.0 National context

The NHS Health Check programme is a public health programme for people aged 40-74 which aims to keep people well for longer. It is a risk assessment and management programme which aims to prevent or delay the onset of diabetes, heart and kidney disease and stroke. Together these conditions account for a third of the difference in life expectancy between the most deprived areas and the rest of the country.

The programme now also aims to reduce levels of alcohol related harm and raise awareness of the signs of dementia and where people can go for help. Everyone attending a NHS Health Check will have their alcohol consumption risk assessed. In addition, people aged 65-74 will be informed of the signs and symptoms of dementia and sign posted to memory clinics if needed.

As Health Checks is a public health programme aimed at preventing disease, people who have been previously diagnosed with the following are excluded as they should already be being managed and monitored through existing care pathways:

- Cardiovascular disease;
- Coronary heart disease;
- Chronic kidney disease (CKD);
- Diabetes;
- Hypertension;
- Atrial fibrillation;
- Transient ischaemic attack;
- Hypercholesterolaemia;
- Heart failure;
- Peripheral heart disease;
- Stroke.

Also excluded are people:

- Being prescribed statins;
- Who have previously had an NHS Health Check or any other check undertaken through the health service in England and found to have a 20% or higher risk of developing cardiovascular disease over the next 10 years.

Since 1st April 2013 the provision of NHS Health Checks has been a mandatory requirement for local authority Public Health teams. The Department of Health requires that every person who is eligible for a NHS Health Check will be invited every five years.

Local authorities are expected to monitor the delivery of NHS Health Checks in their area and to report progress on a quarterly basis. While there are no formal targets for take up of the programme, authorities are expected to seek continuous improvement in take up rates. The Department of Health has indicated that authorities should aspire to achieve take up rates that are comparable with other screening programmes (around 75%).

3.0 Local context

The delivery of NHS Health Checks in Halton pre dates the transition of Public Health functions to local authorities. Previously they were delivered as an NHS Local Enhanced Service to the GP contract and were badged as "Health Check Plus" as they included additional questions to the standard Health Check. A 2013 survey of GP practices revealed that most found the Health Checks Plus too time consuming to complete and this was impacting upon the number of checks they were able and/or willing to complete.

In view of this the Health Check was streamlined, a new Health Checks Handbook was produced and new Service Level Agreements were drawn up with GP practices for delivery of the programme. Practices can claim up to £20 for each completed Health Check. This includes £1 for each invite (regardless of whether this is by letter, phone call or opportunistic), £18 for the Health Check itself and £1 for electronic recording of each Health Check.

Only one practice, has not signed up to the programme and this is currently being explored. One other practice has only recently signed up so although there were no returns for the 2013/14 programme, results are expected to come through for the latest quarter.

Also prior to April 2013, agreements had been drawn up with a number of pharmacies and Bridgewater's Health Improvement Team to supplement the GP based service by offering Health Checks Plus in community settings. However, despite this being listed as an option on invitation letters no patients came forward for community Health Checks.

As non NHS organisations local authorities do not have access to patient identifiable information. Consequently data monitoring on the number of people invited for and receiving a Health Check (for both eligible and non-eligible patients) is completed by St Helens and Knowsley NHS Trust Health Informatics Service (HIS) as part of a contract with Halton CCG. The HIS team has access to GP data systems and so is able to extract data using read codes. The data is then aggregated and shared with Halton CCG and HBC Public Health on a quarterly basis. The service also provides monthly data on the outcomes from the NHS Health Check (there is a 3 month time lag from the HC being completed to allow for data recording), however, the outcome data also records the outcomes from Health Checks completed on non-eligible patients. Nonetheless we have included the outcome data in this report for information purposes.

The fact that there is no direct contractual relationship between the Council and the HIS service has caused significant difficulties over the past 12 months as all requests for information or changes to reporting requirements have to be communicated and agreed by the CCG.

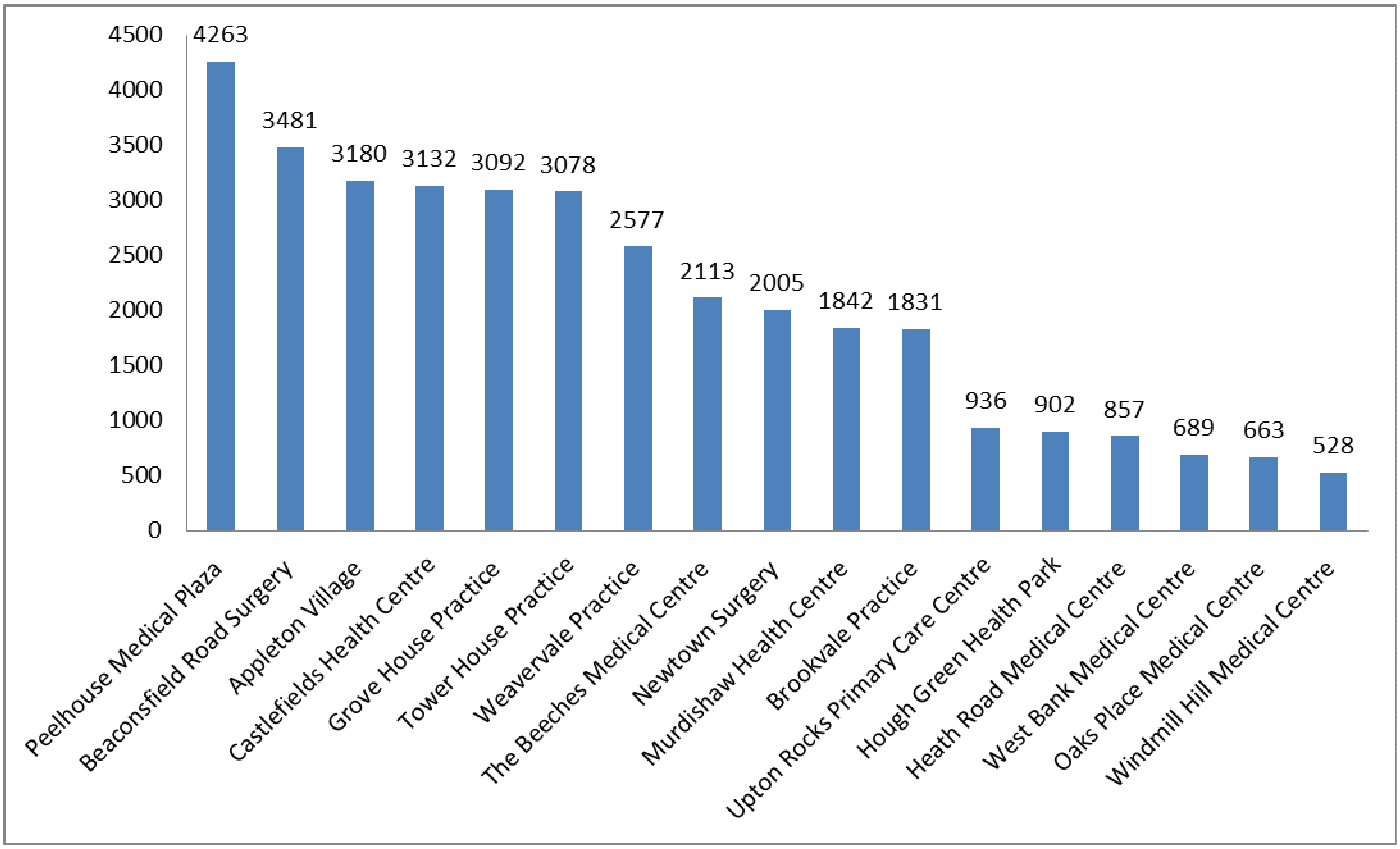
In a bid to boost capacity to carry out Health Checks Halton's Health Improvement Team has offered practices the option to have Health Trainers situated within the practice for a portion of the week to carry out the Health Checks on behalf of the practice. Several practices have recently taken up this offer.

4.0 NHS Health Checks programme 2013/14

4.1 Eligible Population

According to GP practice records at quarter 4 2014, 35,169 patients were eligible for a NHS Health Check. There is wide variation in eligible populations with Peelhouse Medical Plaza having the highest eligible population and Windmill Hill the least.

Chart 1 – NHS Health Checks – Eligible population per practice at quarter 4 2013/14



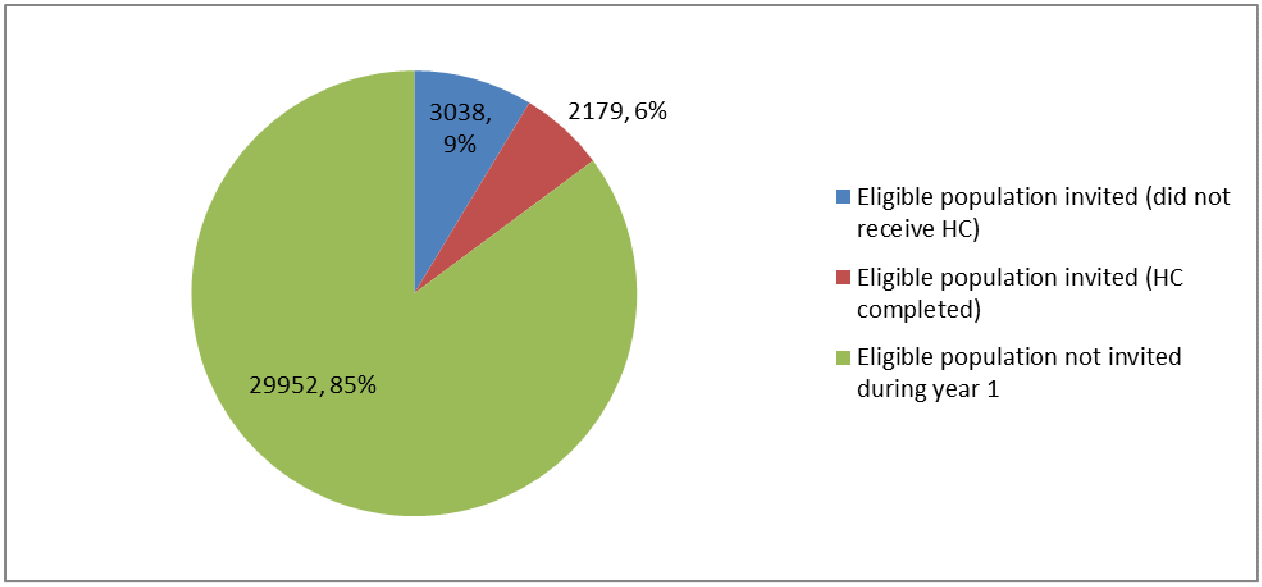
Source: St Helens and Knowsley NHS Trust Health Informatics Service data returns 2013/14

4.2 Eligible patients invited/received a Health Check

During 2013/14 5,217 eligible patients were invited for a NHS Health Check equating to 14.83% of the eligible population. This falls some way short of the Department of Health target to invite 20% of the eligible population per year (thus every eligible person should receive an invite over a five year period). However, there are concerns arising from the practice level data that not all invitations are currently being recorded as such. This will be explored in more detail later in the report.

Of those invited 2,179 patients received a NHS Health Check giving a take up rate of 42%. Chart 2 illustrates the number of people invited for a Health Check (including those who received a check and those who didn't) during the year and the number of people still to be invited (according to official statistics) over the next four years.

Chart 2 – NHS Health Checks – Status of eligible population at end of year 1 (2013/14)



4.3 Health Checks by quarter

Charts 3 and 4 illustrate the quarterly fluctuations in the number of NHS Health Check invitations and completions and the corresponding take up rate with fewer invitations issued leading up to Christmas (although there is a much higher take up rate) and the number of invitations/completions peaking in the first 3 months of 2015.

Chart 3 – NHS Health Checks 2013/14 – invitations and completions by quarter

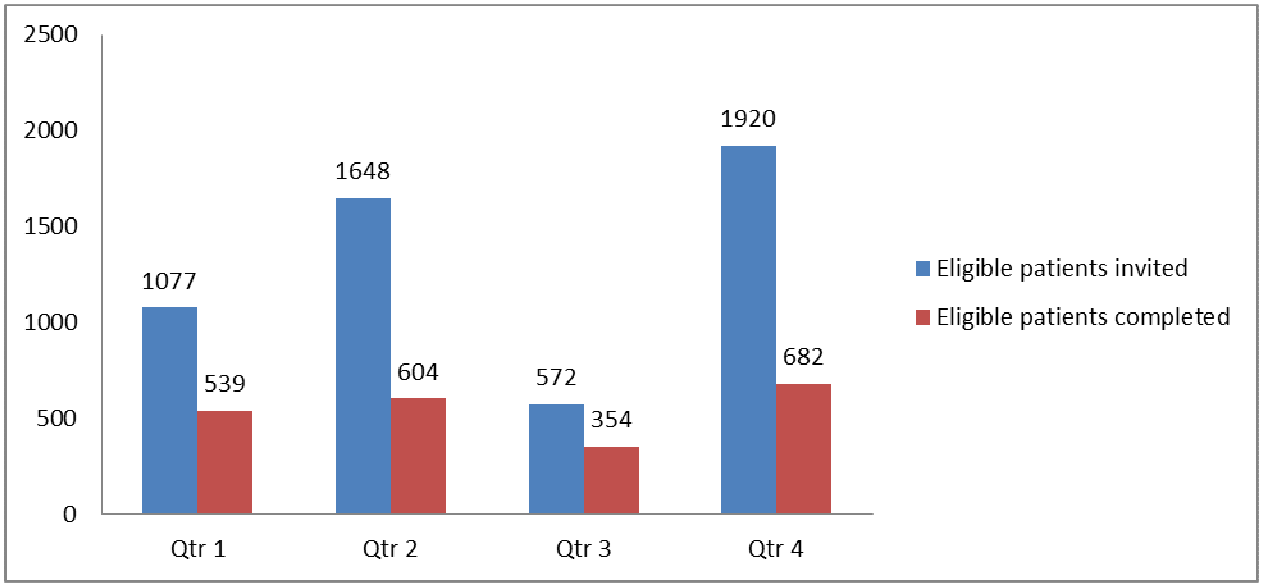
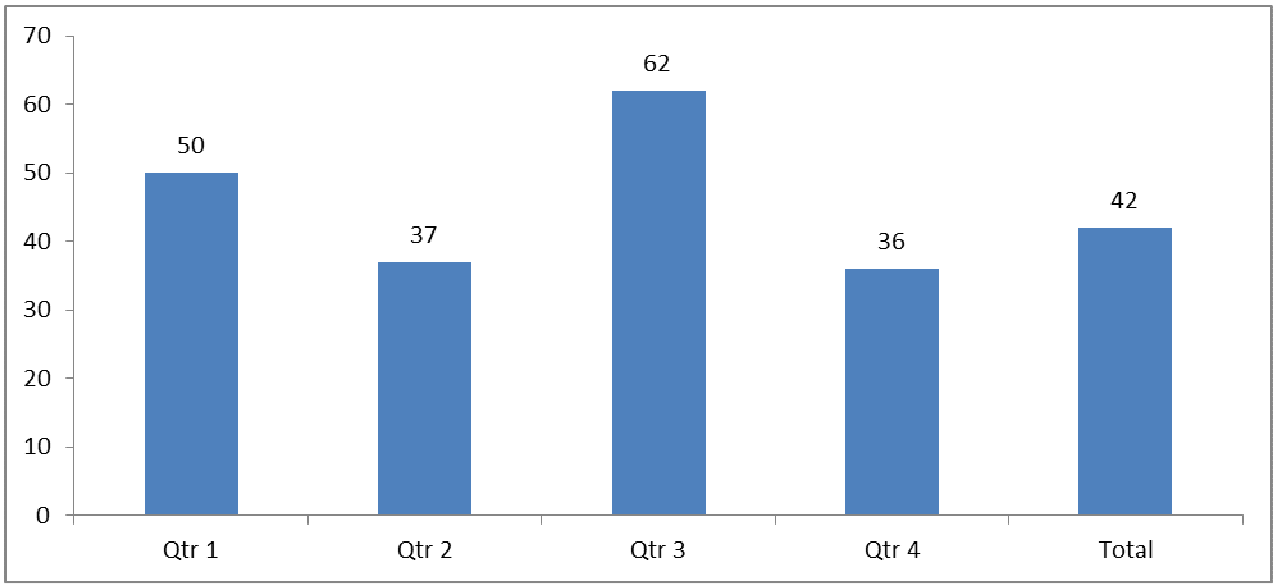


Chart 4 – NHS Health Checks 2013/14 – Take up rates per quarter



4.4 NHS Health Checks delivered per practice

Chart 5 overleaf illustrates that, despite all practices being signed up to deliver NHS Health Checks, some have embraced the programme more than others. Castlefields Health Centre and Newton Surgery invited by far the most patients resulting in the most Health Checks being carried out.

The chart also reveals that some practices claim to have carried out more Health Checks than they have issued invitations to patients. Although this is technically possible as some patients may be responding to invitations issued the previous year, it is more likely that there has been some underreporting of the number of invitations, particularly where there is a large differential possibly due to opportunistic health checks not being recorded as an invitation. Consequently the data reported to Public Health England on the number of Health Check invitations is likely to underestimate the true figure and, therefore, progress towards the 20% annual target is likely to be higher than official statistics suggest.

Chart 6 illustrates the proportion of the eligible population that has been invited for and has received a NHS Health Check in each practice.

Chart 5 – NHS Health Checks 2013/14 – Eligible patients invited/Health Checks completed

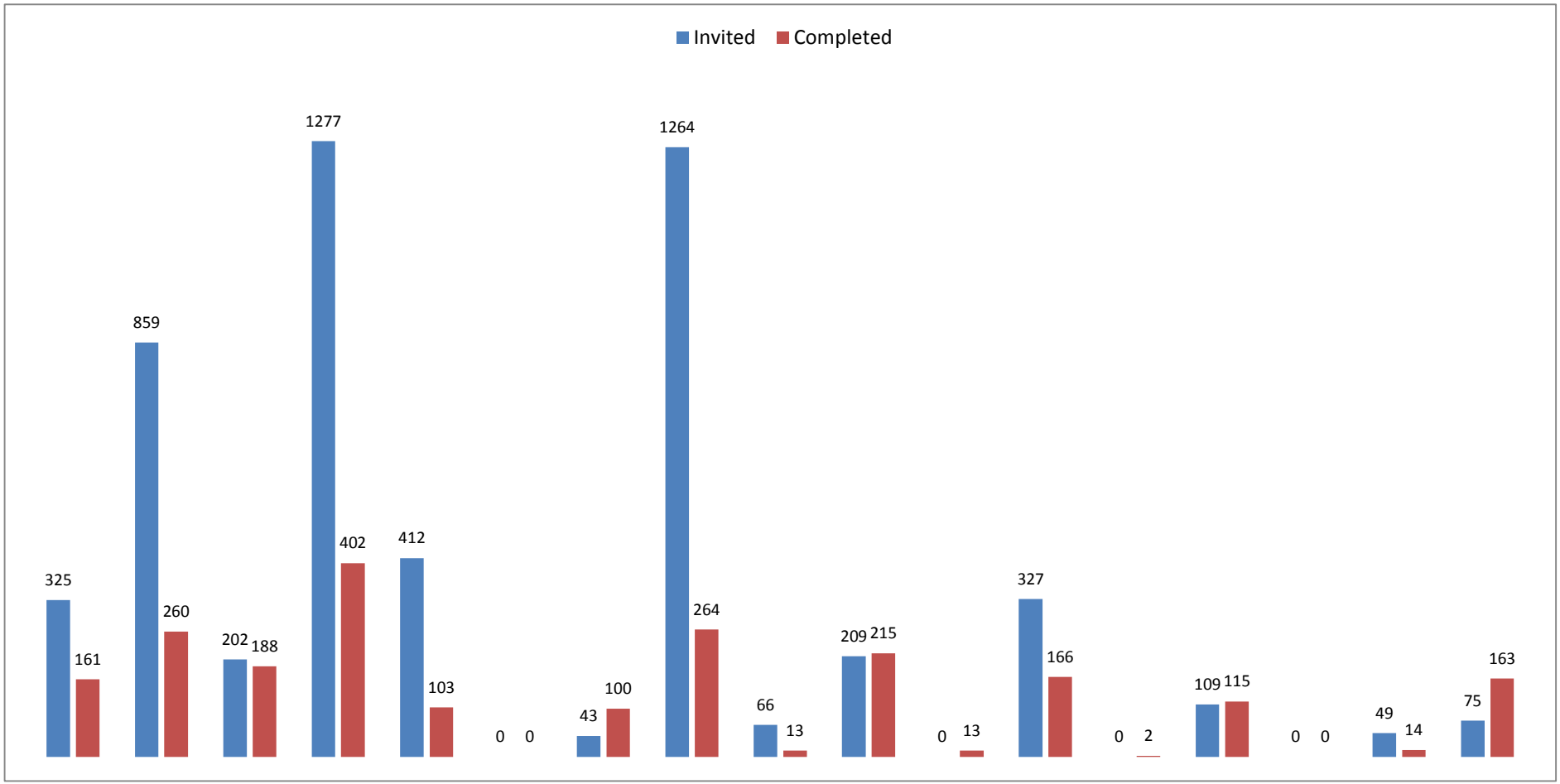
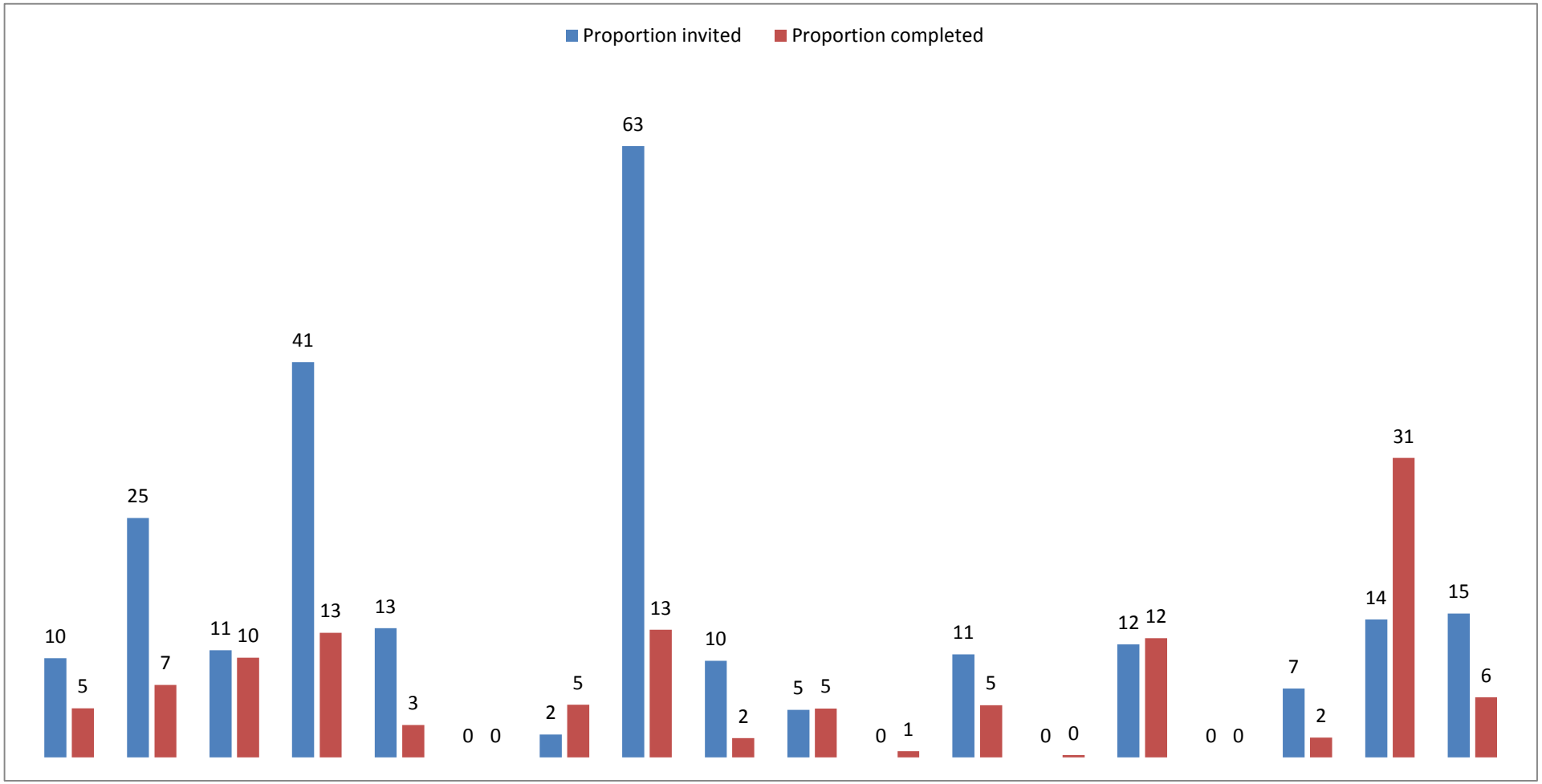


Chart 6 – NHS Health Checks 2013/14 – Proportion of eligible population invited/completed



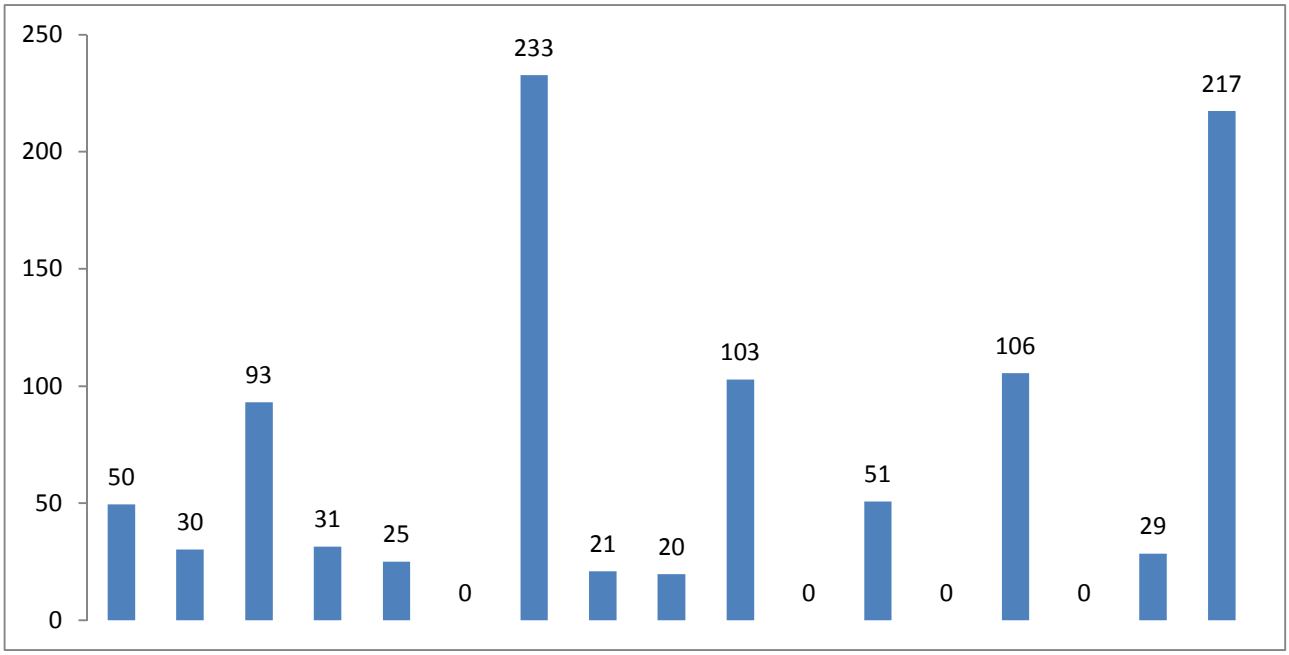
4.5 Take up rates per practice

Chart 7 illustrates the take up rates for Health Check invitations for each practice. It can be reasonably assumed that those practices with higher take up rates offer more opportunistic health checks while those with much lower rates are likely to send more postal or other remote invitations. One example of this is Brookvale practice with a take up rate of 93% where a Health Trainer has been in place to carry out opportunistic screens for some time.

Rates for those practices with over 100% take up are of course skewed since they claim to have carried out more Health Checks than invitations.

While a high take up rate is positive, ideally a mixture of invitation methods should be used – both remote and opportunistic to attempt to engage those people who do not regularly attend their GP practice.

Chart 7 – NHS Health Checks 2013/14 – take up rate (%) per practice



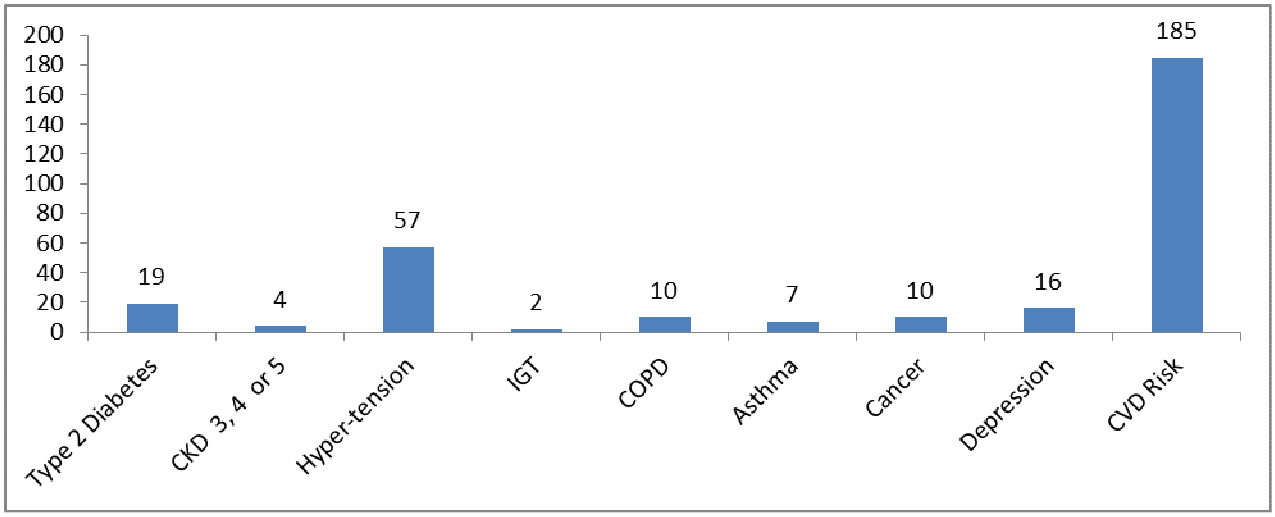
4.6 Outcomes

St Helens and Knowsley NHS Trust Health Informatics Service compile data on the number of people receiving a Health Check who are subsequently signed up to a disease register at their GP practice within a three month period following the Health Check. Unfortunately the outcome data collected relates to anybody who has had a Health Check and not just those patients who are eligible under NHS guidelines (and for whom the authority commissions the programme.) However the data does

give an indication of the potential outcomes from the programme and the difference this can make for individuals.

Please note that data for Health Checks completed in March 2014 is not available since the outcome reporting system has been changed, consequently the data below relates to April 2013 until February 2014 only.

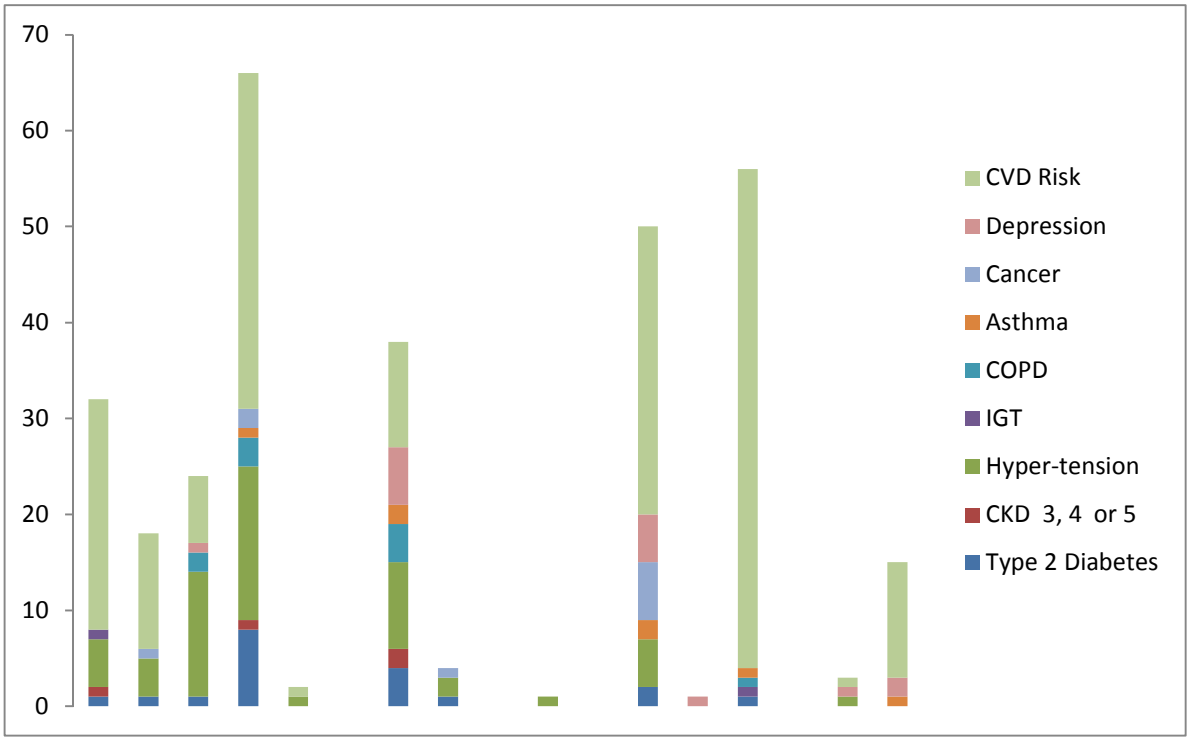
Chart 8 –Outcomes in 3 months following a Health Check



Around 8.5% of people attending for a Health Check were identified as having a CVD risk and 2.6% has having hypertension. The numbers identified for other disease registers are relatively low, however, for the patients involved this early intervention resulting from the Health Check could be life changing and could lead to savings in treatment costs in the long run.

Chart 9 below illustrates the outcomes of Health Checks for each practice. It has to be remembered that not all of these were eligible patients in terms of the NHS Health Check programme so this may include an element of targeting according to risk.

Chart 9 – Outcomes from all Health Checks completed in 2013/14 per practice



5.0 Recommendations

Based on data from 2013/14 there is clearly a need to increase the number of invitations sent to eligible patients and improve the take up rate for the programme. Options to do this are currently being explored.

For example, since March 2014 Health Trainers have established a presence in four GP practices for the purpose of carrying out Health Checks and there are plans to roll this out to two other practices in the near future. This builds on the experience of Brookvale practice where there has been a Health Trainer clinic since 2013 (not necessarily just for Health Checks). The advantages of this approach is that it does not take up the time of practice staff, it ensures a consistent approach to how the Health Check is carried out and it allows patients to sign up for a relevant lifestyle programme there and then without the need for referral either by the practice or self referral and thereby minimises the number who do not attend. It is too early to assess the impact of this approach, however, this will be monitored over the current financial year and reviewed to assess whether any changes are necessary.

The possibility of having the use of a bus to carry out Health Checks is also being explored. This would enable targeted checks in areas to even out the number of Health Checks being carried out across the Borough. It is expected that Health Trainers would use the bus to carry out Health Checks. Further work still needs to be done to progress this, specifically in terms of developing data sharing protocols with GP practices. This will be particularly important when the Health

Improvement Team is transferred to the Council as Health Trainers will then be Council staff and no longer covered by the data sharing arrangements within the NHS.

It is clear that some practices are embracing the programme more than others and therefore there is a need to engage with those with low or no invitations to explore how we can support them further e.g. through the use of the Health Trainer approach.

There is also a need to reiterate the importance of using read codes appropriately to ensure that the full information, particularly on the number of invitations, is captured.

In terms of promoting the programme officers are currently developing a powerpoint presentation that can be used on display monitors in practice waiting rooms and posters have been printed for display in surgeries, libraries, Council offices, community and carers centres etc

Outcome data for 2013/14 was relatively limited. However Council staff have worked with the Health Informatics Service and Halton CCG to extend the range of outcome data to include lifestyle and demographic information, whether dementia has been covered and whether the patient has been referred to a lifestyle service. This will enable a much more complete assessment of the value of the programme in future years.

As described earlier there have been some issues in terms of managing the relationship with the Health Informatics Service which provides supporting data resulting from having no direct contractual relationship with the Council. St Helens has recently tendered for an IT provider to manage the IT and data elements of the programme. It is something that the authority may wish to consider in the future based on St Helens experience with a private provider.

Appendix A

NHS Health Checks Summary of year 1 data

Practice Name	Eligible population	Annual eligible population	Invited for a Health Check Year 1		Received a Health Check Year 1		Take up rate (number received as a proportion of number invited)
			Number	Proportion	Number	Proportion	
		636	325	10	161	5	50
		696	859	25	260	7	30
		366	202	11	188	10	93
		626	1277	41	402	13	31
		618	412	13	103	3	25
		171	0	0	0	0	0
		368	43	2	100	5	233
		401	1264	63	264	13	21
		133	66	10	13	2	20
		853	209	5	215	5	103
		423	0	0	13	1	0
		616	327	11	166	5	51
		180	0	0	2	0	0
		187	109	12	115	12	106
		515	0	0	0	0	0
		138	49	7	14	2	29
		106	75	14	163	31	217
	35169	7034	5217	15	2179	6	42

REPORT TO: Health and Wellbeing Board

DATE: 17th September 2013

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Wellbeing

SUBJECT: Hypertension – a joint approach

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To inform members of Halton's Health and Wellbeing Board of the identification of Hypertension as a priority through the champs approach to prioritising areas for healthcare action and the implications for Halton.

2.0 RECOMMENDATION: That the Board note

1. **that Hypertension is a key cause of premature mortality in Halton;**

2. **there is underdiagnoses of hypertension nationally and in Halton; and**

3. **endorse the future plans for action in the area of Hypertension**

3.0 SUPPORTING INFORMATION

3.1 Champs is a collaborative service, where nine local authority public health teams work together to enable greater access to public health expertise and advice in Cheshire and Merseyside.

3.2 Local public health teams, under the leadership of their Director of Public Health, are fundamental to the delivery of the Champs public health collaborative service and are leading on key areas of work to improve health and wellbeing for their populations. They are supported in this by the Champs support team which enable local teams to work together effectively to achieve better quality services, increased value for money and improved health outcomes for the local populations of Cheshire and Merseyside. The team is the engine room to facilitate co-operation, knowledge transfer, contacts, networking and development for colleagues working in public health.

3.3 Champs is collaborating with local NHS partners across Cheshire and

Merseyside in order to support joint programmes of work for population health care. Given the competing demands and to support the delivery of this objective the Champs healthcare leads group require clear priorities that are objectively defined.

3.4 A project took place to identify and agree the priorities that will be used to inform the work plan for healthcare public health. It was led by a Public Health Consultant from Halton. This paper outlines the process used and the local implications of this.

4.0 **Prioritisation**

Using a two stage approach data was collected and compared to chosen priorities of healthcare partner organisations including 12 Clinical Commissioning Groups, nine Health and Wellbeing Boards, Strategic Clinical Networks and Public Health England

4.1 The methodology used has been recognised nationally and the process is being presented at a national conference. An abstract on the prioritisation approach has been accepted as a poster to the PHE conference in 17-18th September 2014. (See Appendix1)

4.2 **Findings from Prioritisation**

Three local priorities matched those generated by the data: mental illness (highest cost to NHS), cancer (largest cause of premature mortality) and unplanned/urgent care (high rate of 30 day re-admissions). These concur with Halton CCGs priorities.

The review highlighted priorities not chosen by partners. These are hypertension (largest disease register), liver disease (worst rate of premature mortality) and respiratory disease (large cause of hospital admissions). Much of the cause of liver disease relates to alcohol which is already a Halton HWB priority. A respiratory strategy is already in development locally. Hypertension was chosen as a key area for action at the last CCG primary care model development workshop in August.

4.3 The findings have been shared with a range of local partners which has in turn influenced the way in which the Champs team is developing its work plan. There has been early informal sharing of these findings with the relevant CCG commissioners during the writing of the Better Care Fund proposals as the public health consultant lead for this project was Halton based. Preliminary sharing of results with partners has been welcomed, with requests for additional support on priorities from the SCNs and the Merseyside Primary Care Strategic Forum. The latter has chosen to focus a stream of work on hypertension.

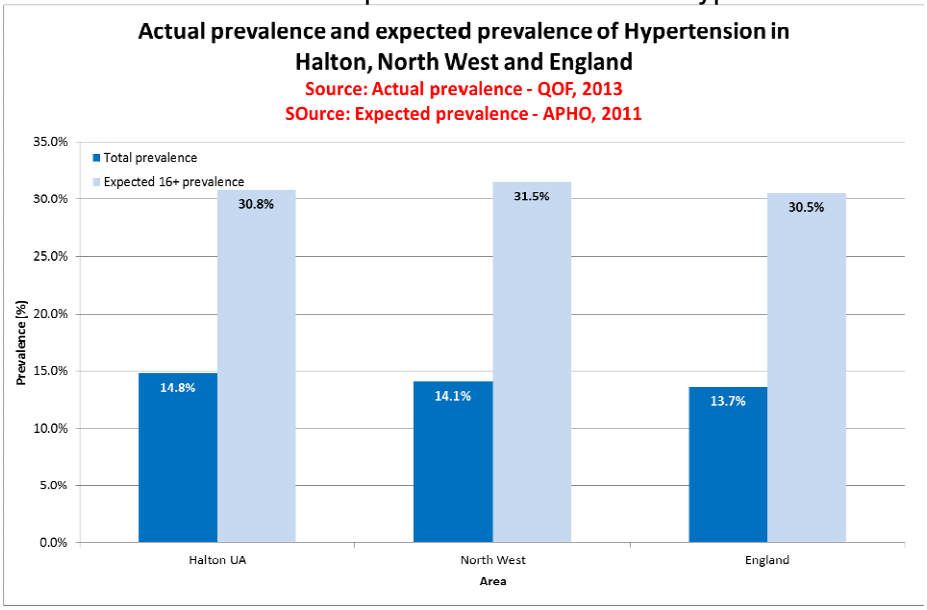
4.4 Hypertension was discussed as a key work stream at the CCG organised NHS IQ event in August. A working group has been formed to develop a system wide approach to tackling the issue.

5.0 Hypertension

5.1 There are currently 19,093 adults in Halton on primary care registers (QOF Registers) with hypertension. This represents 14.8% of the adult population.

5.2 There are an estimated 30.8 % people with Hypertension living in Halton. This means that about 20 000 adults have this condition but have not been diagnosed.

Chart 1. Actual versus Expected Prevalence of Hypertension



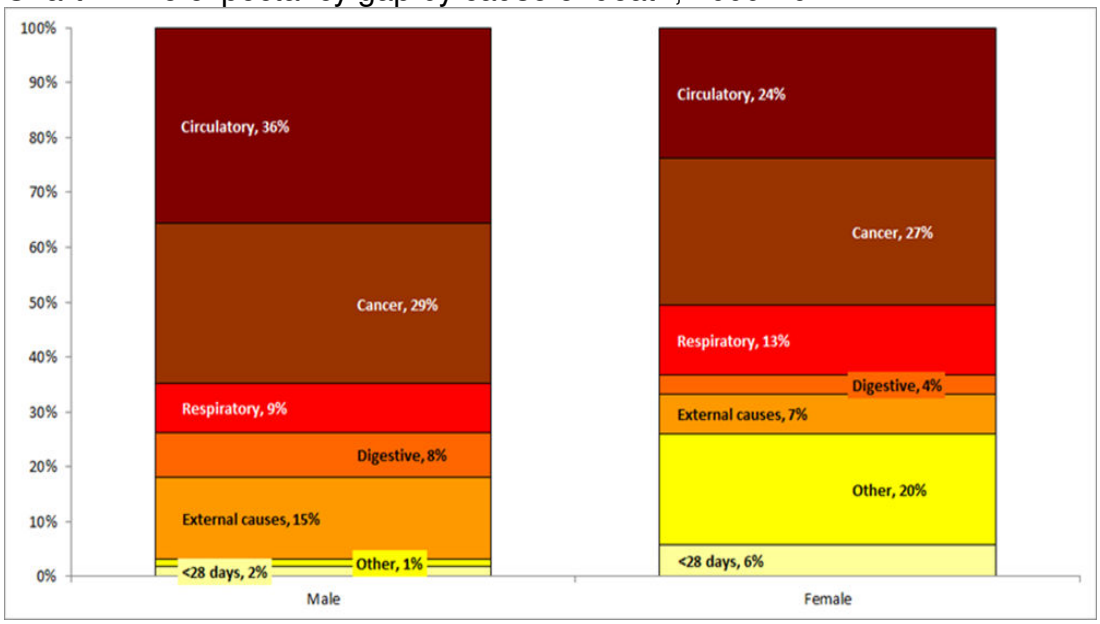
In chart 1 above the darker bar represents those with a diagnosis of hypertension and the lighter bar those who have hypertension but have not been diagnosed with it, this is the expected number based on modelled estimates.

5.3 Hypertension is a risk factor for cardiovascular disease which includes heart attacks and strokes. In addition certain behaviour such as drinking alcohol, high sugary and fatty food intake, smoking and poor physical activity increases the risk. There are some risk factors that are independent of behaviours such as age, sex, ethnicity and deprivation. Unfortunately across England 45% of hypertension remains undiagnosed until an acute event occurs.

5.4 Heart attacks and stroke (circulatory disease) is a leading cause of premature deaths locally. There are inequalities in how people are affected by heart attacks and stroke. The effect of deprivation increases the impact of the conditions by causing more deaths.

Chart 2 below is a scarf chart showing the breakdown of the life expectancy gap between Halton's most deprived quintile and Halton least deprived quintile. The life expectancy gap is the percentage increase in deaths between those who live in the lowest and highest areas of deprivation in Halton, caused by the main conditions listed below. From Chart 2 below, for men in Halton heart attacks and deaths occur 36% more in the most deprived groups and for women the figure is 24%

Chart 2. Life expectancy gap by cause of death, 2009-2011.



There appears to be variation between GP practices in identifying hypertension. For example, in Halton registered prevalence ranges from 8.8% to 17.6%. Chart 3 shows the % difference between the recorded diagnosis of hypertension and the modelled estimate in each practice.

Chart 3. Difference between expected and recorded prevalence

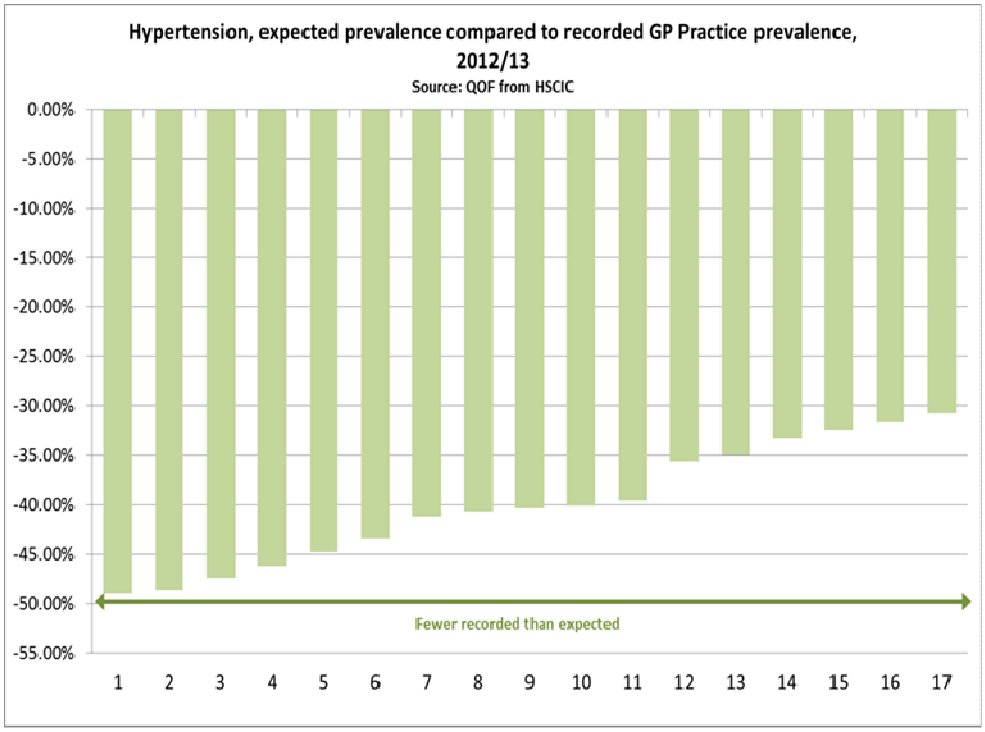
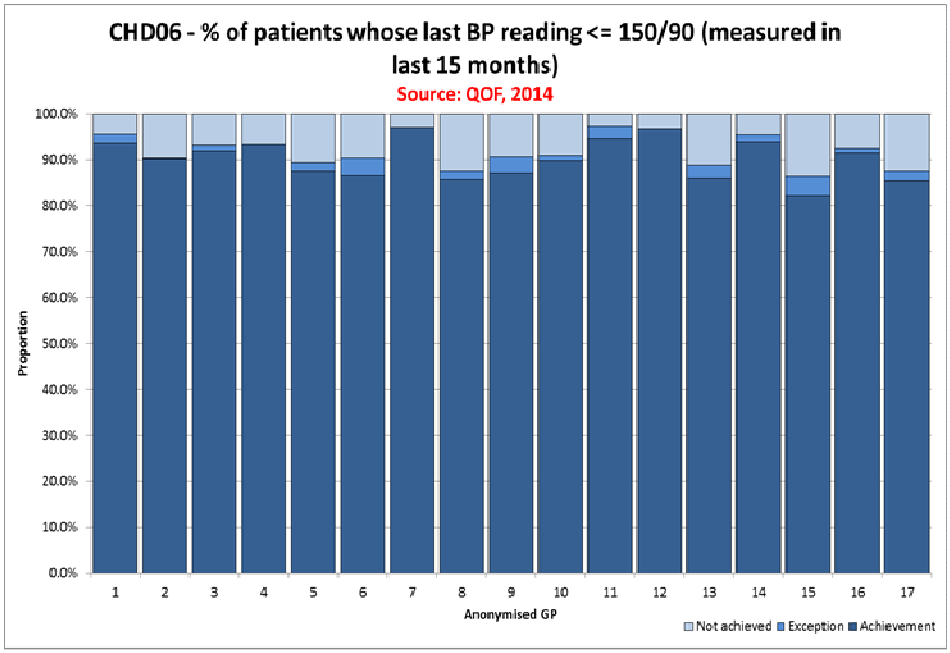


Chart 3 above shows for each practice the percentage difference between what modelling suggests is the number of people with hypertension and the number who are diagnosed with it. In Halton the range is from about 30-50% more people who should be on practice registers. This matches the national pattern.

The variation also extends to management of hypertension. The primary care registers for hypertension records how many patients have had a blood pressure check and if this is optimal in a set time period. Chart 4 shows the percentage of people on the registers that have had optimal blood pressure measurements in the preceding 15 month period which is shown by the dark bars, the lightest much smaller bars show the percentage who have had no checks in the prior 15 months and the other show the exceptions which is those who have been excluded for some reason. It should be remembered that an equally high number are not benefitting from the optimisation of treatment and care as they have not been identified as hypertensive in the first instance. It is important to note that some variation is natural and should be expected and that patient choice is often a factor.

Chart 4. Hypertension management of current population



6.0 **Future plans**

The prioritisation process has identified Hypertension as a work area for action across the region. There are two key opportunities for a system wide approach to tackling Hypertension: identification and treatment optimisation

6.1 **Identification**- finding the missing 20 000

Modelling indicates that about 20 000 additional people in Halton could have hypertension. Finding these people will enable them have access to a range of lifestyle and treatment options which could prevent the risk of further cardiovascular disease.

6.2 Working together to promote NHS Health Checks - Of the 2179 people who had a NHS HealthChecks last year 8.5% (185 people) had a CVD risk score of 20 or above and 2.6% (57people) had hypertension. This indicates that by conducting more checks it is likely that more people with hypertension will be found. But the case finding needs to be scaled up.

6.3 Targeted NHS Health Checks and systematic searches – There may also be an opportunity to target NHS Health Checks using computer searches to identify those who; have a high CVD risk, other long term conditions, a number of known risk factors e.g. obesity, high levels of drinking alcohol; patients with more than one high blood pressure reading without a diagnosis and therefore not on register, or those who have had a borderline high blood pressure.

6.4 Other opportunistic interventions – There are a range of other interventions that could be used. For example blood pressure monitors in practice reception areas; targeting other at risk groups e.g. flu clinics, outreach and or a public campaign.

6.5 Insight work is required to understand why people who may be

hypertensive are not presenting to primary care. This will enable the appropriate shaping of a publicity drive and future social marketing approaches. Key questions remain as to why a cohort of individuals do not attend primary care.

6.6 **Optimising Management**

Potential work areas include

- 'Deep Dive' from the Commissioning for Value/Right Care Team
- Audit of current management against NICE quality standards
- Developing locally agreed quality standards which reflect outcomes
- Develop a local network approach

All people with a diagnosis should as a minimum receive NICE recommended care and treatment. As mentioned earlier a CCG led working group has been formed and will be developing a system wide approach. A Halton cardiovascular disease strategy is in early development and the regional cardiovascular strategic clinical network and Merseyside primary care strategic forum have prioritised hypertension as a result of the Champs approach.

7.0 POLICY IMPLICATIONS

The prioritisation process identifies areas of work across Cheshire and Merseyside. Work programmes are being developed that will enable progress in local delivery of the national outcomes frameworks for the NHS and Public Health.

8.0 OTHER/FINANCIAL IMPLICATIONS

8.1 The diagnosis, treatment and follow-up of patients with hypertension is one of the most common interventions in primary care, accounting for approximately 12% of primary care consultation episodes. It is estimated that, in England alone, the cost of drugs used for lowering blood pressure is £840 million per year – almost 15% of the total annual cost of drugs in primary care.

8.2 The commissioning for value pack for CVD across Merseyside suggest that there are £830,000 opportunity costs that could be saved by reducing CVD related hospital admissions.

9.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

9.1 Children and Young People in Halton

None directly

9.2 Employment, Learning & Skills in Halton

Improving the health of individuals can have a positive impact on their long term employability.

9.3 A Healthy Halton

The early identification, early detection and prevention of a range of health issues including hypertension can contribute to healthier lives, thereby contributing to the aims and objectives of Halton's Health and Well Being Strategy.

9.4 A Safer Halton
None directly

9.5 Halton's Urban Renewal
None directly

10.0 RISK ANALYSIS

10.1 No risks identified.

11.0 EQUALITY AND DIVERSITY

No potential negative impacts are likely.

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

Appendix A

Poster

Establishing priorities for healthcare public health in Cheshire in Merseyside

I Onyia, RA du Plessis

Introduction: Champs is a collaborative service, where nine local authority public health teams work together to enable greater access to public health expertise and advice to the NHS in Cheshire and Merseyside. Key priorities were identified to determine the work plan for the healthcare public health component.

Objective: To use an evidence based approach to determine the 2014/15 priorities for the healthcare component and to determine the relevance of those of local NHS partners using easily accessible healthcare data.

Method: The documented priorities of 12 Clinical Commissioning Groups, nine health and wellbeing boards, Strategic Clinical Networks and Public Health England were reviewed and themed. Robust data and intelligence was collated from national and regional statistical websites on: risk factors, disease prevalence and premature mortality. Data was contrasted against the chosen priorities. We then developed a matrix to score the health conditions identified. (See matrix opposite).

Results: Chosen priorities varied with individual organisations, notably Type 2 diabetes was already a priority across Merseyside but not in Cheshire (fastest growing disease register). Three local priorities matched those generated by the data: mental illness (highest cost to NHS), cancer (largest cause of premature mortality) and unplanned/urgent care (high rate of 30 day re-admissions). The review also highlighted priorities not chosen by partners. These are hypertension (largest disease register), liver disease (worst rate of premature morality) and respiratory disease (large cause of hospital admissions). Preliminary sharing of results with partners has been welcomed.

Future considerations: The next stage is to review activities being undertaken locally and share advice on effective interventions relating to the chosen priorities and reducing associated health inequalities.

Matrix

Topic	Magnitude	Impact	Amenable to intervention	Equity	Cost/ Savings	Health Inequalities	Local Interest	Score
CVD Hypertension	5	5	4	5	4	4	4	45
CVD Stroke/ Transient Ischaemic Attack	3	3	4	4	4	3	3	34
CVD Type 2 Diabetes	5	5	5	5	5	4	4	45
CVD Acute Kidney Injury	3	3	4	3	4	3	3	34
CVD Hypercholesterolaemia	5	3	4	3	3	3	1	30
Cancer	5	5	4	4	3	5	5	45
Mental Illness	5	5	3	5	3	5	5	45
Liver Disease	4	5	5	5	5	5	3	42
Respiratory Disease	4	5	4	5	4	4	3	37
Accidents and Injuries	3	3	4	3	4	3	3	30

The Methodology

1a. Collate and understand local priorities from NHS and partner organisations

b. Thematically organise collected priorities- narrative based priorities - use condition/disease focus; systems; Marmot groupings

Check with colleagues, check and check again. New priorities arise constantly

2a. Collate population data from robust national sources- Public Health England (PHE); Longer Lives, NHS England: Reduce premature mortality, RightCare, Quality Outcome Framework (QOF)

2b. Obtain local data

Data needs to be robust, comparable and recent

3. Identify key trends to obtain data derived priorities

Compare narrative based priorities with data derived priorities

4. Note overlap but also identify gaps, check with partners, are these true gaps or have they been identified as areas of interest

5. Prioritisation

a. Build matrix and fill with list of priorities, use related data to populate each field to enable scoring, note gaps

b. Use measures to score each priority area (1-5 with higher score = higher priority)

c. Add scores to identify key priorities

6. Feedback to groups of interest - Strategic Clinical Networks (SCN); Clinical Commissioning Groups (CCG); Primary Care Forum; Directors of Public Health (DsPH), other Public Health (PH) strategic groups

working together to improve health and wellbeing in Cheshire & Merseyside

REPORT TO: Health & Wellbeing Board

DATE: 17th September 2014

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health & Wellbeing

SUBJECT: NHS support for Social Care

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To inform Members of the Heath & Wellbeing Board of recent announcements about NHS support for Social Care.

2.0 **RECOMMENDATION: That the Board approve the revised funding allocation as detailed in 5.3 & 5.4.**

3.0 **SUPPORTING INFORMATION**

3.1 Similar to previous years the Department of Health has allocated non-recurrent budget allocations to NHS England nationally, for transfer to Local Authorities to invest in social care services to benefit health, and to improve overall health gain.

3.2 This year, 2014, there are two components to the allocation; NHS transfer and Preparation for the Better Care Fund.

3.3 The payments are once again to be made via an agreement under Section 256 of the 2006 NHS Act, as agreed in previous years.

4.0 **CURRENT POSITION**

4.1 The Department of Health announced revised allocations and transfer arrangements for 2014/15. The funding transfer to Local Authorities will be carried out by NHS England and Halton will expect to receive; NHS transfer £2,396,355 and Preparation for the Better Care Fund £533,000. Total allocation £2,929,355.

4.2 A number of conditions must be satisfied, prior to the transfer of funding:

4.2.1 **Main Transfer:**

- The funding must be used to support Adult Social Care Services, which also has a Health benefit. However, beyond this broad condition, the Department wants to provide flexibility for local areas to determine how this investment in social services is best used.

- The Local Authority must agree with local Health partners how the funding is best used and the outcomes expected from this investment, as part of the wider discussions on the use of their total health and care resources.

- It is recommended that the Health and Well- Being boards are the most appropriate place to discuss the allocations, ensuring that there is regard to the JSNA and existing commissioning plans.

- Local Authorities must demonstrate how the funding transfer will make a positive difference to social care services and outcomes for service users, compared to service plans in the absence of the funding transfer.

- The funding may be used to support existing services or transformation programmes, where such services or programmes are of benefit to the wider health and care system, provide good outcomes for service users, and would be reduced due to budget pressures in local authorities without this investment.

- The funding may also be used to support new services or transformation, again where joint benefit with the health system and positive outcomes for service users have been identified.

- The Board will also have regard to the recommendations from “Caring for our future” White paper, which may require some small revenue costs.

- The Local Authority will be required to provide assurances to the NHS commissioning Board, that the conditions for funding transfer are being met.

4.2.2 **Preparing for the Better Care Fund:**

- The funding must be used to prepare for the implementation of pooled budgets in April 2015 and to make early progress against the national conditions and the performance measures set out in the local agreed plan.

- A condition of the transfer is that the local authority has agreed a completed Better Care Fund plan with its partner

CCG, and that this plan has been signed off by the Health and Well-Being Board.

5.0 FINANCIAL IMPLICATIONS

5.1 As a Council with Adult Social Care Responsibilities, Halton Borough Council faces a number of challenges over the next 2 years related to some of the unique circumstances within the Borough, including:

- Efficiency savings of approximately £21.7M in 2015/16 and £14.2M in 2016/17.
- Projected population growths of 7%, and projected increases in the number of older people of 33%
- Third highest levels of deprivation in Merseyside
- All age all-cause mortality rates are higher than the regional and national average
- Projected rise in people requiring community based services from 3,340 to 4,220

5.2 In light of the current financial and other pressures within the LA it is proposed that the majority of this allocation is utilised to support the whole system, which are of benefit to the wider health and care systems and provide good outcomes for service users.

5.3 Proposed funding main allocation for 2014/15:

- Maintain the Telecare Service- £140,000
- Additional support to the Community Care budget - £500,000
- Support of mainstream service delivery - £1,756,355

5.4 Proposed funding allocation Implementation & Preparation of Better Care Fund including early progress against national conditions and performance measures - £533,000

- Early progress against national conditions and performance measures an additional 14 Intermediate Care Beds-£300,000
- Preparation and Implementation, it should be noted that further work is required to develop detailed plans and contingencies- £233,000

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

None identified.

6.2 Employment, Learning & Skills in Halton

None identified.

6.3 A Healthy Halton

To maintain the capacity, quality and range of social care services ensuring that the services provided are relevant to the health, social care and cultural needs of the local population and support people to remain as independent as practicable through a rehabilitative and enabling approach to care delivery.

6.4 **A Safer Halton**

To maintain safe and effective discharge from hospital for residents of Halton. Promote the protection and dignity of vulnerable adults.

6.5 **Halton's Urban Renewal**

None identified.

7.0 **RISK ANALYSIS**

7.1 As outlined in paragraphs 5.1 – 5.2 of this report there are increasing financial pressures on the Local Authority's budget, in particular on the Community Care Budget.

7.2 If the proposals in relation to the revised funding allocations, as outlined in paragraph 5.3, are not approved, then this will have a detrimental effect on the ability of the whole system to be able to deliver existing services, for example Telecare Services, as there is no alternative funding available to deliver this particular service.

7.3 If the proposals to use the allocations in 5.4 are not approved, this will have a detrimental effect on the ability of the Council and CCG to be able to achieve the performance requirements as outlined in the Better Care Fund.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 No adverse impact and positively promotes social inclusion.

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

None.

REPORT TO: Health and Wellbeing Board

DATE: 17th September 2014

REPORTING OFFICER: Jim Wilson (Healthwatch)

PORTFOLIO: Health & Adults; Children, Young People & Families

SUBJECT: Healthwatch Annual Report 2013-2014

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 The Board will receive a presentation on the Healthwatch Annual Report 2013-14.

2.0 RECOMMENDATION: That the Board note the contents of the report.

healthwatch Halton

Healthwatch Halton
Annual Report 2013/14

"I am really pleased with the Healthwatch service. It's good to know that we have someone we can turn to if we have any problems with the health services we use."

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Annual Report 2013

Healthwatch Halton

Chair's Introduction

Welcome to our 1st Annual Report

This year has been a rewarding yet challenging year for Healthwatch Halton, starting with the establishment of a Community Interest Company and the election of a management committee that reflects the breadth and diversity of communities of interest within the voluntary sector and the wider community.

I would like to give special thanks to the members of the interim management committee, especially Paul Cooke, and Brian Miller, who put a lot of time, effort and commitment into establishing Healthwatch Halton as a Community Interest Company. I would also like to thank Mike Hodgkinson for accepting the post of Director and for the work he has done as lead on Enter & View and the CQC liaison.

I would also like to express my appreciation and thanks to all those members who have throughout this year, supported the activities carried out by Healthwatch Halton.

It has been this involvement and commitment of members that has led to the success of Healthwatch Halton as a recognised and respected voice in the community by users, carers, commissioners and service planners.

On behalf of the Directors, I would like to extend my thanks to the Healthwatch Support Team for all their hard work in helping the Directors and Management Committee members to plan and carry out events, consultations, surveys and task & finish groups. These activities have made sure that the voice of Healthwatch Halton continues to gain in strength and effectiveness.

Finally, I would like to pass on my appreciation to our statutory colleagues in the Health & Social Care Sector, who have proactively sought to use Healthwatch Halton to engage with the wider community and have listened to their views and concerns.

Thank you to all the individuals and organisations who have worked with us in the last year.

We look forward to continuing to work with you, to ensure that people's voices get heard..

Jim Wilson

About Halton

Halton is a local government district in the North West of England, with borough status and is administered by a unitary authority. It was created in 1974 as a district of Cheshire, and became a unitary authority area on 1 April 1998. It consists of the towns of Widnes and Runcorn and the civil parishes of Hale, Daresbury, Moore, Preston Brook, Halebank and Sandymoor.

Halton is divided by the River Mersey with historical cultural differences between Widnes, Runcorn Old Town and Runcorn New Town. Although Halton has been a unitary authority for over 16 years, crossing the River Mersey when the bridge is congested and cultural perceptions can still cause challenges when trying to engage with the community.

Healthwatch Halton took great care to ensure that the membership of the Management Committee would be inclusive and equitable to all residents of Halton.

Halton at a glance

- The health of people in Halton is generally worse than the England average. Deprivation is higher than average and about 6,800 children live in poverty. Life expectancy for both men and women is lower than the England average.
- Life expectancy is 11.1 years lower for men and 10.8 years lower for women in the most deprived areas of Halton than in the least deprived areas.
- Over the last 10 years, all cause mortality rates have fallen. The early death rate from heart disease and stroke has fallen and is worse than the England average.
- In year 6, 19.4% of children are classified as obese. Levels of teenage pregnancy, alcohol-specific hospital stays among those under 18, breastfeeding and smoking in pregnancy are worse than the England average.
- Estimated levels of adult healthy eating, smoking and physical activity are worse than the England average. Rates of hip fractures, smoking related deaths and hospital stays for alcohol related harm are worse than the England average. The rate of road injuries and deaths is better than the England average. The rates of statutory homelessness and excess winter deaths are better than average.
- Priorities in Halton include cancer, alcohol, falls, mental health and child development.

For more details see www.halton.gov.uk and www.haltonccg.nhs.uk

Governance

Healthwatch Halton has been set up as a Community Interest Company. It was registered with Companies House in February 2013, ready to take on the responsibilities of Healthwatch across Halton.

The Company has 3 Directors:

Jim Wilson, the former Chair of Halton & St Helens PCT, Paul Cooke and Mike Hodgkinson.

Jim was selected for his excellent knowledge and valued experience of health & social care.

Election of the Management Committee

Between April and June 2013 there was a Healthwatch Halton Board of Directors and an interim Management Committee, whose members worked hard to develop an accountable governance structure for Healthwatch Halton.

During June 2013, an election process took place to implement one of the governance arrangements agreed, to have a Healthwatch Halton Management Committee made up of 16 members to reflect the diverse range of voluntary & community groups concerned with health & social care in Halton, together with a fair distribution of individual members, who also care about services and who can bring key skills and experiences to Healthwatch.

The election count took place on 1st July 2014 and the count was independently scrutinised.

The 16 places on the management committee include the three Directors; 7 organisational places, split into 'functional' constituencies (see list below), and 6 individual places (3 from each side of the borough, (North and South of the Mersey)).

During the past year there have been 8 Management Committee meetings and 16 Directors' meetings.

Functional Constituencies

Carers:
Carl Harris, Halton Carers' Centre

Cultural & Environment (e.g. sport/arts/community):
Sue Ellison, Centre 8 Theatre

Mental Health & Wellbeing:
Hitesh Patel, Halton Citizens Advice Bureau

Minority Groups:
Sue Parkinson, Shap Ltd

Older People:
Dawn Kenwright, Age UK Mid Mersey

Specialist Needs:
Bill Rathbone, Alzheimers Society (Halton)

Younger People:
Currently vacant – Pauline Ruth acting Lead

Individuals

Bernadine Mitchell
Brian Miller
Doreen Shotton
Pauline Ruth
Roy Page
Tom Baker

"Healthwatch Halton seemed to be the only people that cared about my need for surgery. I feel my operation would not have been performed as soon as it was, had I not contacted them."

Community Membership

Any person who works or accesses health and social care services in the borough can become a Community Member of Healthwatch Halton.

Membership is open to individuals, groups and organisations across Halton.

Total membership at 31/03/2014 was **1372.**

Members receive copies of our newsletters and ebulletins either electronically or through the post,

They also receive regular updates on events we are organising or work we have planned.

We currently have 47 volunteer members or 'Healthwatch Champions'.

Outreach work carried out over the past 3 months with our local colleges is likely to lead to a large increase in the number of volunteers we have.

What we do

We actively seeks feedback from people who live and work in the borough, recording their comments, good and not so good, and feeding the information back to decision making bodies.

What we do

We also provide information about local health and care services, signposting members of the public to the services they need.

We are here to give people a stronger voice to influence the health and social care services that matter to them:

- We ask people about their experience of health and social care, going out and talking to people and communities.
- We listen to people's experiences and look for patterns that show where change needs to happen.
- We tell organisations in charge of health and social care what the public think works well and what needs to change.
- We check that these organisations are listening to people's views and using this information to improve services.

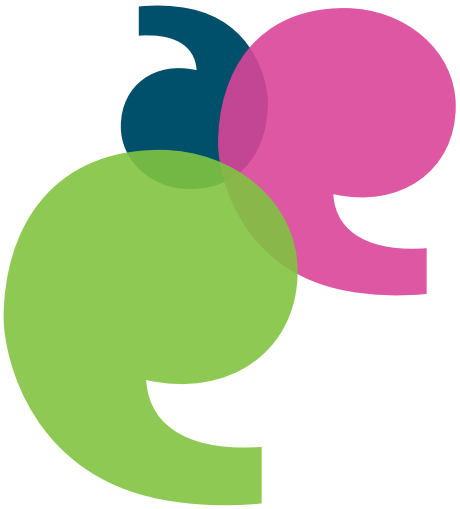
Signposting & Information

Our work is driven by what people tell us about health and social care services in Halton, both good and bad experiences.

We received **168** enquiries for information on local services. The majority of these have been from members of the public although we have also received enquiries from professionals looking to direct their patients to suitable services.

Examples of signposting include:

- Hospital outpatients struggling to access patient transport for their appointments
- Members of the public looking for dentists who carried out home visits
- Enquiries regarding local support groups for mental health users
- How to access specialist diagnostic equipment



Feedback

Gathering views from the public is an important part of how Healthwatch Halton will improve health and social care services.

We received **473** comments about local services. These help inform the focus of our work.

To make sure we gather these views from all parts of our community we use a number of different engagement methods:

- We have spoken at dozens of community groups and meetings, gathering people's views about the local health and care services they rely on.
- We hold regular 'Fact or Fiction' information events on local care services, allowing people to ask questions of those services, and also feedback their views on the services.
- People can share their views with us by phone, email or through our website.
- Our 'Share your Story' leaflet gives people information about us and allows them to share their experiences of local services by returning it to our freepost address.
- We work with a wide range of groups and organisations across Halton to ensure we gather views from all parts of our community.

North West Ambulance Service (NWAS)

From April 2013 onwards we began to receive comments and enquiries by patients trying to book the Patient Transport Service (PTS) provided by The North West Ambulance Service (NWAS).

The evidence received from the cases across the area suggested that people were being excluded from accessing the service due to a change in implementing the eligibility criteria.

Healthwatch Halton contributed to a joint report compiled by Cheshire & Merseyside Healthwatch organisations which resulted in a meeting between NWAS, Healthwatch representatives and the service commissioners. (These meetings are now on-going).

Remedial actions were agreed at the joint meeting, and we are continuing to monitor patient experience.

NWAS agreed to take part in one of our popular 'Fact or Fiction' events, held in March 2014. They gave a presentation on the PTS, explaining the eligibility criteria and how to access the service, and then took part in the Question and Answer session of the event.

Outreach to GP Practices

During 2013 we carried out outreach visits to a number of GP Practices to gain the experiences of patients and promote the role of Healthwatch.

The biggest single issue raised by patients across all the practices was the difficulty in actually accessing GP services.

This feedback was reinforced by the comments we were receiving when carrying out general outreach and engagement across the borough.

These concerns were taken to our Management Committee and it was decided to set up a Task & Finish group to look at 'Access to GP services' across Halton.

In March 2014 we launched a survey to gather the views of the public. Surveys were distributed to all our members, either electronically or through the post. The survey was made available on our website, and promoted through the local press.

At the time of writing this report the survey is still taking place. The survey ends in June 2014 and a report will be produced by the T&F group later in the year.

Who we've worked with

Complaints - Advocacy

Anna, our Healthwatch Advocate has been supporting clients in her role of Healthwatch Independent Complaints Advocate since June 2013

During the year our Healthwatch Advocacy Service has provided support for 34 new cases. These have ranged from providing self help information, i.e. leaflets, web sites information etc., through to more in depth support i.e. people with mental health problems or frail elderly people who are very distressed due to illness or bereavement.

Weekly Healthwatch advocacy drop-in sessions now take place at community venues across Halton.

Who we've worked with

In our first year we have heard from a wide range of people from right across Halton, and we've actively sought views from some groups whose voices aren't usually heard:

- older people
- children and young people
- minority ethnic communities
- people with physical and sensory disabilities
- carers
- people using mental health services

Our work with groups has ranged from giving them presentations and information packs on our services to carrying out more in-depth focus group work and providing access to advocacy support.

Over the next couple of pages we've covered some of the groups we've worked with:

Involve

INVOLVE is a participation group whose role is to act as a critical friend to Halton's Children's Trust on participation, and has strong links with Halton Safeguarding Children Board. The group can also act in an advisory capacity on participation, advising on how best to involve parents, children and young people in decision making processes.

The participation group is made up of lead engagement and participation professionals and Young person and parent/carer representatives from a range of organisations, including Healthwatch Halton.

Disadvantaged or vulnerable people

We worked with the BME Floating Support Officer from Plus Dane to help provide weekly drop in sessions at the traveller sites across Halton.

Lunch Bunch Support Group

We recognise the difficulties that some vulnerable adults (including individuals diagnosed with dementia) experience in giving their views

We worked with the Lunch Bunch, a local organisation that supports carers, cared for and former carers, who care for individuals diagnosed with dementia, to gather their comments on the refresh of the Dementia Strategy in Halton.

Deafness Resource Centre Halton

The Deafness Resource Centre contacted us to highlight the fact that there are times when family members were being asked to interpret on behalf of relatives, during appointments at hospital, which compromised patient confidentiality. We raised their concerns with the Equalities and Diversity, (E&D), Lead at Warrington Hospital and he agreed to look in to it.

A meeting was arranged between the E&D Lead and Deafness Resource Centre to discuss this issue.

Following on from this meeting it has been agreed that the Deafness Resource Centre will inform the Hospital of any impending appointments for the profoundly deaf community to ensure that appropriately qualified interpreters are booked.

Following our recommendations there are currently discussions taking place between the Hospital Trust and the Deafness Resource Centre to look at commissioning future interpretation services.

Who we've worked with

"I am really pleased with the Healthwatch service. It's good to know that we have someone we can turn to if we have any problems with the health services we use."

SPARC (Supporting People Achieving Real Choice)

SPARC is a project working with young people with low to moderate learning disabilities to help build their resilience, confidence and self-esteem. We met with the project team and explained how their group could get involved and feedback their group's comments to Healthwatch Halton.

Polish Family Support Group

Since January 2014, Irene Bramwell and Hubert Grabryszewski, a polish resident, a trained translator and Healthwatch Volunteer, have been engaging with the members of our Polish community. The family support group provide an opportunity for Polish families in Halton to socialise and engage in English lessons. With the support from Healthwatch Halton the group have been able to take part in our surveys and consultations and feedback their views on local health and care services.

Social Inclusion

It was agreed by our Management Committee that we would raise public awareness of the proposed changes to local Urgent Care services through our website and our outreach visits across the community.

We engaged with a wide range of people, including seldom heard individuals and groups, the local community were encouraged to send in their individual responses to the proposed changes to the CCG.

We realised that some vulnerable adults including adults diagnosed with learning disability may have difficulties in feeding back to the review.

Working with SHAP (St Helens Accommodation Project) we organised a focus group meeting to gather the views of the Learning Disabilities Group.

Riverside College

We have undertaken a number of outreach visits to the local colleges giving presentations to students regarding our role, as well as holding drop in sessions in the college foyer.

Students had the opportunity to take part in our *'Access to GP services'* survey, 68 students completed the survey. 6 students have volunteered to take part in our 'Enter & View' training, and a total of 43 students expressed an interest in becoming 'Healthwatch Champions'.

Young Womens Group - Catch 22

Halton Young Women's Group is organised by Catch-22 on behalf of Halton's Children's Trust and Halton Council as part of an on-going commitment to improve opportunities for all children and young people living in the borough.

We met with the group to find out the views of the group on the health and care services provided for young women in Halton and it was agreed that the group would feed back to Healthwatch Halton any issues they became aware of. Some members of the group have expressed interest in volunteering with Healthwatch Halton and taking part in training for the Enter & View Team.

Age UK Mid Mersey - Support Groups

Halton has many socially isolated and lonely older people in its borough. Age UK Mid Mersey aims to reduce the effect of social isolation by enabling older people to meet other people in the local community by facilitating OPEN (Older People's Empowerment Network)

We've given presentations to three of the Age UK Mid Mersey support groups since January 2014. These groups have given us valuable feedback on our local health and care services.

Children and Young People's Voluntary Sector Forum

The Halton Children and Young People's Voluntary Sector Forum (CYPVSF) is a partnership network consisting of representatives from voluntary, community and statutory sector organisations that provide services and opportunities for children and young people in Halton.

Currently, Irene, our Outreach Officer, attends the monthly meetings of the CYPVSF. A Management Committee member, Pauline Ruth, also attends meetings of the Children's Trust, CAMHS Steering Group and the Safeguarding board.

Who we've worked with

Parents' Voice

This group links into Halton Children's Trust, representing Halton Parents 'Voice' on a wide range of agendas and topics. Formally known as 'Halton Parents and Carers' it provides the opportunity for parents and carers to have a "Voice" in the planning, development and delivery of services for children and young people 0-19 years and families. Membership is open to all residents living in Halton who have a child 0 – 19 years of age.

Voluntary and Faith Sector Groups

In addition to the groups already mentioned in our report, we've worked with groups such as:

- Deafness Resource Centre Support Group
- Halton Carers Centre
- Parkinson's Support Group
- All Saints Church Runcorn, Coffee Morning
- Hope Corner
- St Vincent de Paul Society (SVP)

Face to face work

We can only carry out our work well if local people trust us, work with us and are willing to take part.

To build our relationship with local communities, we keep the public updated about our work and let them know how the experiences they have shared with us have helped to shape and improve services.

During the past 12 months we have been out and about across the borough at many events with our information stand.

- We attended 6 Local Area Themed Forums
- We took part in Disability Action Day 2013 at Walton Gardens
- Signed up over 40 new members at Party in the Park in Runcorn (as well as handing out over 350 Healthwatch Halton pens!)
- Held drop-in sessions at local GP Practices

We've been at lots of other events too:

- Our Healthy Halton Event
- Hope Reach Open Day
- Halton Open Day
- Vintage Group – 4 Estates
- Information stall at Green Oaks Shopping Centre
- Carers Mental Health Forum
- Disability Partnership Event
- Halton Health & Wellbeing Board - Shape the Future Event
- 5 Boroughs NHS Foundation Trust Event
- Safeguarding Children Trust Event

Statutory Powers

Healthwatch was established through legislation which gives us statutory powers and a strong position to influence decisions on health and social care.

Health and Wellbeing Board

We have taken our place on the Health and Wellbeing Board since it became fully operational in April 2013, with the seat taken by Jim Wilson, the independent Chair of the new Healthwatch Board. He is supported by the Healthwatch Manager and is briefed prior to each meeting.

Older People's Planning Board

Three committee members attend meetings of this board which is one of the health and social care boards which reviews reports prior to their submission to the Health and Wellbeing Board.

CQC

We have not made any formal requests for the CQC to undertake investigations. However we have established a good working relationship with the CQC and share information both ways.

Mike Hodgkinson, the lead director for CQC liaison, has attended CQC consultation events in Preston and London. A local CQC representative attends bimonthly meeting with Healthwatch Halton.

In 2013/14, we have fed in our knowledge of patient experience to CQC inspections at both Bridgewater Community NHS Trust and North West Ambulance Service.

Statutory Powers

Quality Accounts

A Quality Account is a report about the quality of services by an NHS healthcare provider. The reports are published annually by each provider, including the independent sector, and are available to the public.

Local Healthwatch use Quality Accounts to support discussions about NHS healthcare matters in the area.

Our Quality Account Sub Group meets to look and comment on a number of local NHS Trust Quality Account Reports and also one from our local hospice, Halton Haven.

Equality Delivery System

Healthwatch Halton has a scrutiny role to ensure that local Hospital Trusts are meeting their duty and complying with the Equality Act (2010) which it does through the 'Equality Delivery System'.

This means that each year local Hospital Trusts submit reports to Healthwatch Halton which demonstrates how they are trying to meet the needs of the parts of the Halton community covered by the Equality Act (2010) including the BME communities in Halton.

PLACE (Patient Led Assessments of the Care Environment)

PLACE, is the new system for assessing the quality of the patient environment, it replaces the old Patient Environment Action Team (PEAT) inspections. The assessments apply to hospitals, hospices and day treatment centres providing NHS funded care.

The assessments see local people go into hospitals as part of teams to assess how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance. It focuses entirely on the care environment and does not cover clinical care provision or how well staff are doing their job.

The assessments will take place every year, and results will be reported publicly to help drive improvements in the care environment. The results show how hospitals are performing nationally and locally.

We were approached by Warrington & Halton Hospitals NHS Foundation Trust and Knowsley & St Helens Hospitals NHS Trust to take part in the PLACE inspections. Nine volunteers took part in training for the PLACE visits at local hospitals. Our volunteers have now taken part in PLACE visits around four local hospitals.

Newsletters & E-bulletins

People who share their experiences with us or who want to know more about our work can also sign up to our mailing list. We send regular e-bulletins to those who have email, letting them know about our work, sending out copies of our reports, and inviting them to events.

We also produce a quarterly printed newsletter which is sent by post to another 600+ members while another 500+ copies are distributed through local organisations and groups.

Online

Our digitial media presence includes our website, e-bulletin and social media. In our first 12 months usage of our website has grown from 179 sessions (visits) in April 2013 to 605 in March 2014. We've had over 24,400 web pages viewed during the year.

We've also noticed that more people are using their mobile phones and tablets to keep in touch with our work, increasing from 9 sessions a month in April 2013 to 65 sessions per month by the end of March 2014.

Our twitter account @hwhaltonnow has 760+ followers.

Website Accessibility

In January 2014 we added 'BrowseAloud' capability to our website to improve accessibility for the 20% of the population who are unable to easily interact online.

BrowseAloud helps to ensure that those who are hardest to reach are not excluded from accessing information on our website, i.e. those with Mild Visual Impairments, Dyslexia, Low Literacy, the Ageing Population and those with English as a Second Language.

It gives people access to a wide range of accessibility tools such as translation of 75 languages, 33 with a supported voice, a PDF reader, Text Magnifier, Simplifier, Screen Masking and the ability to save text to voice as mp3 files.

Informing and keeping in touch

Local Media

We've been interviewed a number of times this year on the weekly voluntary sector show on Halton Community Radio.

News articles on Healthwatch have been published in:

Both our local papers – The Weekly News and The World

We've been mentioned in magazines from:

Bridgewater Community Healthcare NHS Trust

Halton Borough Council – Inside Halton

Liverpool Housing Trust magazine

5 Boroughs Partnership NHS Trust – Members Magazine

Warrington & Halton Hospital NHS FT – Members Magazine

Halton Carers' Centre – Newsletter

Halton & St Helens VCA – Health 'E' Times

Use of the Healthwatch trademark

When undertaking activities Healthwatch Halton use the Healthwatch trademark, which comprises of the logo and the Healthwatch brand. Materials we have used the trademark on include:

- Banners
- Board agenda & minutes
- E-bulletins
- Management meetings agenda & minutes
- Marketing materials, e.g. pens etc
- Promotional leaflets and posters
- Reports – Internal & External
- Stationary
- Social Media
- Website

Delivering our statutory activities

In the past 12 months:

- 7 new volunteers have been trained to undertake Enter and View activities
- 5 Enter & View visits to local Care Homes have taken place
- 5 volunteers have undertaken Effective Listening Training
- 6 volunteers have received training and taken part in PLACE visits around local Hospitals

Looking ahead - the coming year

Our plans for the next 12 months include:

Access to local GP Services

The results from the 'Access to GP Services' survey we are currently carrying out will be the starting point for more in depth work looking at the provision and access to GP services across Halton.

Enter & View visits

With the increase in the number of volunteers in our Enter & View Team we'll be looking to increase the number of visits undertaken. Our visits will also take in local hospitals this year.

Healthwatch Champions

We're aiming to increase the number of Healthwatch 'Champions' to support our network and expand the engagement we undertake in our community. We're also planning to build on the relationship we've built with local colleges to increase the number of young people involved with Healthwatch Halton.

To find out more about Healthwatch Halton visit www.healthwatchhalton.co.uk or call us on 0300 777 6543.

To find out more about the Healthwatch network visit www.healthwatch.co.uk

Finance figures

Healthwatch Halton - Income & Expenditure 2013-14		
Income	£	£
Unrestricted Grants		-
Restricted Grants		134,715
Bank Interest		-
Total Income		**134,715**
Expenditure		
Salaries & NI	95,474	
Staff Travel	1,250	
Staff Training	750	
Vol Expenses/Training	1,692	
Office Accommodation	6,432	
Line Management	7,788	
Printing, Stationery & IT	5,175	
Telephone & Postage	1,652	
Activities: VBS	320	
Activities: Networks	500	
Insurance	1,094	
Activites: RH	1,366	
Travel & Expenses	353	
IT & Communications	2,866	
Bank Charges	64	
Equipment	1,259	
Refreshments	7	
Sundry Expenses	114	
Stipend	5,000	
Total expenses	**133,156**	
Surplus/Deficit on activities		**1,559**
Fund balance b/fwd		-
Fund balance c/fwd		**1,559**

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enquiries@healthwatchhalton.co.uk
www.healthwatchhalton.co.uk

REPORT TO: Health & Wellbeing Board

DATE: 17th September 2014

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health & Wellbeing

SUBJECT: National Dementia Action Alliance 'Carers' Call to Action'

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To inform members of the Health & Wellbeing Board of the National Dementia Action Alliance 'Carers' Call to Action' and invite individual member organisations of the Health & Wellbeing Board to pledge their support.

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

3.0 **SUPPORTING INFORMATION**

3.1 A letter from the Secretary of State was sent to the Chairs of Health and Wellbeing Boards on 16th July 2014, relating to the Prime Minister's Challenge on Dementia.

3.2 The letter encourages Local Authorities to sign up to the National Dementia Action Alliance Carers' Call to Action. In addition to the Local Authority signing up, member organsiations of the Health & Wellbeing Board are invited to sign up individually to make pledges specific to their organisation, thus increasing the number of organsiations supporting the movement. Further information about the call to action can be found from the following link: http://www.dementiaaction.org.uk/carers

3.3 The call to action outlines 5 aims of a shared vision:

Carers of people with dementia:

1) Have recognition of their unique experience - 'given the character of the illness, people with dementia deserve and need special consideration... that meet their and their caregivers needs' (World Alzheimer Report 2013 Journey of Caring).
2) Are recognised as essential partners in care - valuing their

knowledge and the support they provide to enable the person with dementia to live well.

3) Have access to expertise in dementia care for personalised information, advice, support and co-ordination of care for the person with dementia.
4) Have assessments and support to identify the on-going and changing needs to maintain their own health and well-being
5) Have confidence that they are able to access good quality care, support and respite services that are flexible, culturally appropriate, timely and provided by skilled staff for both the carer and the person for whom they care.

3.4 Supported by the Chair of the Halton Dementia Partnership Board, Halton Borough Council signed up to the call to action on 23rd July 2014, pledging to deliver the actions contained in the local dementia strategy by 2018, formation of a Halton Dementia Action Alliance with membership from health, social care, private, public and 3rd sector organisations, and involving carers of people with a dementia diagnosis in the redesign of the Halton Carer's Centre delivery model. The Halton Dementia Strategy demonstrates how we are already meeting, and activities to further support, the 5 aims of the call to action.

4.0 POLICY IMPLICATIONS

4.1 The Policy Officer for Communities has been advised by the National Coordinator that there is no requirement to write an action plan or demonstrate outcomes.

4.2 It is envisaged by the National Coordinator that The Carers' Call to Action will develop into a support network for and with family carers to engage locally and nationally about the issues and examples of good practice.

4.3 By signing up to the Carers' Call to Action, with the evidence statement that the Halton Dementia Strategy meets the requirements of the five aims, Halton Borough Council will be permitted to use of the logo 'We support The DAA Carers' Call to Action'. Health & Wellbeing Board Member Organisations will be permitted to use the logo if they sign up their organisation.

4.4 Signing up to the call to action enables organisations to access on line peer support and other resources from the call to action network.

4.5 The Halton Dementia Partnership Board are coordinating the formation of a local Dementia Action Alliance, in which the Carers' Call to action will be promoted to member organisations as an action they can take towards becoming a dementia friendly organisation.

4.6 A report will be presented at the September Health & Wellbeing Board, inviting member originations to sign up to the Carers' Call to Action.

5.0 FINANCIAL IMPLICATIONS

5.1 None identified.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

None identified.

6.2 Employment, Learning & Skills in Halton

None identified.

6.3 A Healthy Halton

Supporting positive outcomes for carers may have a direct impact on their health.

6.4 A Safer Halton

None identified.

6.5 Halton's Urban Renewal

None identified.

7.0 RISK ANALYSIS

7.1 There is no risk associated with signing up to pledge support to the Carers' Call to Action, as the aims of the movement are reflective of the aims of the local dementia strategy which was ratified in early 2014.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None identified.

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

None.

REPORT TO:	Health & Wellbeing Board
DATE:	17th September 2014
REPORTING OFFICER:	Chief Officer, Halton CCG
PORTFOLIO:	Health & Wellbeing
SUBJECT:	Joint Public Services (Social Value) Act 2012 Policy, Procurement Framework and Charter
WARD(S)	Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To update Health and Wellbeing Board on the development of a Social Value approach for both Halton Borough Council and NHS Halton Clinical Commissioning Group. This is been carried out both in response to the needs of the Public Services (Social Value) Act, 2012 in conjunction with the Halton Health and Social Value Programme.

2.0 RECOMMENDATION: That members of the Board

1. **note the work carried out to date on the developing a Social Value Approach for Halton Borough Council and the NHS Halton Clinical Commissioning Group.**

2. **endorse both the attached Policy Statement and Procurement Framework and recommend it for approval by Executive Board.**

3. **consider opening the approach to the wider partnership for their use (as appropriate).**

3.0 SUPPORTING INFORMATION

3.1 The Public Services (Social Value), 2012 introduces a statutory requirement for public authorities to have regard to economic, social and environmental well-being in connection with 'public services contracts' within the meaning of the Public Contracts Regulations. The new duty, therefore, only applies to contracts for services where the value exceeds the OJEU threshold (currently £172,514) and those public services contracts where there is only an element of goods or works. It doesn't apply to public work contracts or public supply (goods) contracts. However, there is widespread interest in and support for public bodies considering social value in all forms of contracts where appropriate.

3.2 The Act requires us only to consider how what is being procured might improve the well-being of the relevant area and how the procurement process might act with a view to achieving that improvement. Whilst the Act positively encourages economic, social and environmental well-being to be taken into account, this still needs to be done within the context of existing constraints within EU public procurement rules and other legislation. This means that any specific benefits which may be sought from a procurement exercise must remain relevant to the contract and proportionate and not risk distorting the outcome of the competition by giving them undue emphasis.

3.3 The definition of social value contained within the Act is "the additional benefit to the community from a commissioning/procurement process over and above the direct purchasing of goods, services and outcomes". Social value makes it possible to weigh social benefit against the cost of investment, to think differently about the way resources are used and to show the additional value created by organisations. Social value can therefore be a way of thinking about how scarce resources are allocated and used, looking beyond the price of each individual contract and instead looking at what the collective benefit and additional gains to the community may be.

3.4 These gains could be in local employment, local sourcing of materials and goods, apprenticeship and training programmes for disadvantaged groups, volunteering programmes, the use of sustainable products and much more. Commissioning and procuring for social value can therefore help join up all the strategic aims of a public body. For example, every local authority has a best value duty to improve the economic, social and environmental well-being of an area. For Halton, this means our commitment to meet our needs to provide goods, services, works and utilities in way that produces social, economic and environmental benefits for the borough. Social Value can be used as another tool to help us consider how economic, social and environmental well-being may be improved, and how procurement may secure those improvements.

3.5 The Public Services (Social Value) Act, 2012 in line with the Best Value Duty, sets out three key themes to be addressed in seeking social value:

- Social
- Economic
- Environmental

4.0 POLICY OPTIONS

4.1 For Halton, Social Value sits within the overarching framework of the Halton Sustainable Community Strategy 2011-2026, the document that sets out our priorities and vision as a Borough and which is agreed by the Halton Strategic Partnership. The strategy was refreshed and endorsed by the Halton Strategic Partnership in June 2014.

4.2 Our vision under the Sustainable Community Strategy is that:

"Halton will be a thriving and vibrant Borough where people can learn and develop their skills; enjoy a good quality of life with good health; a high quality, modern urban environment; the opportunity for all to fulfil their potential; greater wealth and equality, sustained by a thriving business community; and safer, stronger and more attractive neighbourhoods."

And this is outlined through our key priorities of:

- A Healthy Halton
- Employment, Learning and Skills in Halton
- A Safer Halton
- Halton's Children and Young People
- Environment and Regeneration in Halton

4.3 In addition, this work on Social Value has been managed in order to take place in conjunction with a piece of partnership work being undertaken with funding through Social Enterprise UK as one of 4 national pilots looking at how we can create social value through health. As part of this activity, the 6 priorities of the Marmot review into Health Inequalities, Fair Society, Healthy Lives, have provided a context and focus of activity. These seek to:

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

4.4 An approach has therefore been taken to align, wherever possible, the environmental, social and economic focus of the Act with the duty of Best Value, Halton Sustainable Community Strategy and the Marmot priorities as there are clear correlations and intersections across all of these documents in relation to social value. Halton's bid was successful as being part of the first cohort alongside 4 other CCGs and LAs. It is widely recognised that Halton and Salford are the leaders in this approach across the UK.

4.5 A Social Value policy statement has been developed (attached), setting out a commitment, that through our commissioning and procurement activity and under the Public Services (Social Value) Act 2012 we will consider and, where appropriate, seek to secure wider social benefits for Halton as a whole. The policy statement will also support the Halton Social Value Charter which is being developed in partnership across the borough as part of the social value in Health programme.

4.6 To aid implementing the policy statement, a Social Value Procurement Framework has been produced and will be applied in the following way:

- For each procurement opportunity, above £1000, we will undertake a Social Value "Opportunity Assessment" which will identify output Indicators and outcomes that are appropriate for inclusion in the procurement process
- The output indicators and desired outcomes will be thematic and linked to the priorities of the Halton Sustainable Community Strategy and at least one of the six Marmot Priorities
- The outcomes identified will be both relevant, transparent and proportionate for each procurement opportunity
- Our processes will be fully compliant with EU procurement law and the council's own Procurement Standing Orders, thus minimising any risk
- Our approach to Social Value will be a bespoke approach, tailored for each and every Tender or Request for Quotation (RFQ) opportunity
- We aspire to include where appropriate in each procurement at least one Social Value outcome
- Where outcomes are applied they will form part of the award criteria and included in the evaluation matrix. How this happens will be clearly explained
- Outcomes where appropriate will be built into awarded contracts and monitored; winning bidders will be expected to report on them to evidence how they are achieving Social Value
- Where we undertake procurement support on behalf of other Public Sector bodies we will encourage to use this Framework wherever appropriate
- We will endeavour to integrate wherever possible our methodology for the purpose of best practice.

4.7 Within Halton we procure a wide range of goods and services, and it

is recognised that there can be no 'one size fits all' model. The policy and framework will therefore need to be applied in a proportionate manner and be tailored to reflect what is being procured and how it will be the role of service commissioners and procurement leads to consider, on a contract by contract basis, what Social Value opportunities and outcomes may be relevant to that contract.

4.8 Both the policy and framework have been consulted on with relevant stakeholders (internal and external) and the suggested approach has received universal support

5.0 POLICY IMPLICATIONS

5.1 The Public Services (Social Value) Act, 2012 sits alongside other procurement laws. Value for money is the over-riding factor that determines all public sector procurement decisions even with a growing understanding of how value for money is calculated, and how "the whole-life cycle requirements" can include social and economic requirements. The Act in essence builds upon, rather than being a replacement for, existing procurement legislation so the duty will need to operate within the existing boundaries of the legal framework. The Act acknowledges this by noting that the authority "must consider only matters that are relevant to what is proposed to be procured" and that authorities "must consider the extent to which it is proportionate…to take those matters into account".

5.2 The recent consolidation of EU procurement framework also makes it clear that social requirements can be embraced in procurement practice providing certain criteria are met. These criteria are:

- Social requirements should reflect policy adopted by the public body;
- Social requirements should be capable of being measured in terms of performance;
- Social requirements drafted in the specification become part of the contract;
- Social requirements should be defined in ways that do not discriminate against any bidders across the European Union.

5.3 The Equality Act 2010 introduced a general equality duty which applies to the procurement (including commissioning) function of public authorities. The duty extends to external contractors which carry out public functions. It repealed the Local Government Act 1988 provisions in relation to permitted race relations questions in public tenders; instead, local authorities are explicitly permitted to take non-commercial matters into account during the procurement process, when they consider it is 'necessary' or 'expedient' to do so

5.4 Local authorities, under their statutory duty to achieve best value

they must already consider social, economic and environmental value and this duty has not been repealed. The Act therefore sits alongside this commitment.

5.5 The Act is also important in the context of supporting other key pieces of legislation such as the Modernising Commissioning Green Paper, the Open Public Services White Paper and the Localism Act, particularly around the Community Right to Challenge. It also contributes to the civic society agenda and emerging policies around strengthening society through encouraging and creating social growth.

6.0 OTHER IMPLICATIONS

6.1 The Act is also viewed as being of significance to the Voluntary and Community sector as a whole as well as public services as it provides greater focus on outcomes and impacts rather than outputs and could improve the chances of the VCS successfully bidding to win contracts when it comes to procurement exercises. Voluntary and Community Sector organisations and public sector organisations will need to engage effectively in developing a joint understanding of needs and priorities and consider how they will measure and demonstrate social value. The work undertaken by the Health and Social Value programme in Halton will assist in support this, however it is proposed that this work on the policy and framework be formally shared with both the HSPB and Health and Wellbeing Board following Executive Board approval and made available to partners to use if appropriate.

6.2 Social Value is an emerging area for policy development and is gaining in prominence. There are a range of tools and systems available to measure social impact and social value such as Social Accounting and Auditing (SAN), Social Return on Investment (SROI), Local Multiplier Effect (LM3) as well as other systems being developed to give some legitimacy to measuring social value and social impact, as these can be subjective measures. It may be beneficial to consider the potential of a small number of relevant council officers undertaking formal training in some of these areas in order to lend additional rigour to the process of measuring social value and in supporting embedding social value within the community.

6.3 It is recognised that there can be no ‘one size fits all’ model. The policy and framework will therefore need to be applied in a proportionate manner and be tailored to reflect what is being procured and how. It will be the role of service commissioners and procurement leads to consider, on a contract by contract basis, what Social Value opportunities and outcomes may be relevant to that contract. If Social Value opportunities and outcomes are decided as being relevant, and form part of a contract award, these should be

capable of being measured and monitored by the service commissioner.

7.0 FINANCIAL IMPLICATIONS

7.1 Using the framework to undertake Social Value opportunity assessments will be an additional process stage in procurement and commissioning activity. However, the framework seeks to minimise this by setting out a simple set of steps and it is vital that we show that we have considered social value in pre-procurement in accordance with the Act. It should also be remembered that the additional benefits to Halton in seeking and embedding social value outcomes within our spend should far outweigh any initial time costs in considering it.

7.2 There will be a need to cascade this approach as widely as possible. It is anticipated that this can be done within existing planned programmes of work such as Procurement Training and Meet the Buyer events as well as through existing structures such as the HSPB and Health and Wellbeing Board, therefore the additional cost to officer time should not be excessive.

7.3 If it is agreed that accredited training in the use of techniques such as Social Return on Investment would be beneficial there would be a cost per officer trained. Estimates are that this is in the region of £550 per officer (although discounts may be available depending on numbers). This would need to be considered.

7.4 It is likely that there will be additional support available under the Social Enterprise UK Health and Wellbeing programme (and other sources) for Halton in rolling out the programme further and that this could be used to offset some of the costs involved (such as facilitation, print and venue costs etc.) in any further development of the Social Value approach in Halton.

8.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

8.1 Children & Young People in Halton

None other than those outlined in the body of this report.

8.2 Employment, Learning & Skills in Halton

None other than those outlined in the body of this report.

8.3 A Healthy Halton

None other than those outlined in the body of this report.

8.4 A Safer Halton

None other than those outlined in the body of this report.

8.5 **Halton's Urban Renewal**

None other than those outlined in the body of this report.

9.0 **RISK ANALYSIS**

9.1 Social outcomes, benefits and dis-benefits should always be critical to procurement decisions as much as price and direct service quality but should never be an excuse for a failure to secure value for money. Procurement should be based on the pursuit of value for money, public value, quality services and social value. There will always be a balance to be struck and transparency about how such balances are decided and the consequences of such decisions.

9.2 The Act should also not be misconstrued as permitting public bodies a broader scope than before in setting unrelated specifications or criteria to achieve social and environmental policy outcomes. Wherever possible, for all contracts over £1000, social value opportunities will be considered. However, it should be always be remembered that social value clauses may not be appropriate for every contract The key words contained within the Act around this are in relation to keeping social value 'relevant' and 'proportionate'.

9.3 If the procurement is carried out in emergency circumstances, not due to any delay on our part, making it impractical to comply with the Act, then we may need to disregard the requirements. This is set out in the Act as permissible.

9.4 The way in which evidence of Social Value benefits is measured is not set out either in the Act or this policy and framework. Dependent on the requirements of each procurement exercise, we may choose to specify requirements explicitly within a tender or ask suppliers to come up with their own innovative ideas and voluntary clauses. In all cases we will ensure we are clear as to how Social Value elements have been weighted in the evaluation and decision-making process. It is the job of commissioning and procurement managers and officers to specify what social values outcomes are sought and relevant to each procurement or commissioning exercise.

9.5 Whilst the Act only requires Social Value to be considered at pre-procurement stage, officers commissioning or procuring goods, where social value has formed part of the awarding criteria, are encouraged to monitor and measure this as part of their contract management.

10.0 **EQUALITY AND DIVERSITY ISSUES**

10.1 The Equality Act 2010 brings together into one Act all previous legislation around Equality and Diversity. Under the Duty a public

authority must, in carrying out its functions, take into account the need to: -

a) Eliminate discrimination, harassment, victimisation and any other conflict that is prohibited by the Equality Act 2010.

b) Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it.

c) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

10.2 The Act defines a number of characteristics which are protected: -

(a) Age
(b) Disability
(c) Gender reassignment
(d) Marriage and civil partnership
(e) Pregnancy and maternity
(f) Race
(g) Religion or belief
(h) Sex
(i) Sexual orientation

10.3 The Equality Act 2010 introduced a general equality duty which applies to the procurement (including commissioning) function of public authorities. The duty extends to external contractors which carry out public functions. It repealed the Local Government Act 1988 provisions in relation to permitted race relations questions in public tenders; instead, local authorities are explicitly permitted to take non-commercial matters into account during the procurement process, when they consider it is ‘necessary’ or ‘expedient’ to do so.

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

None.

Draft Social Value Policy Statement

This policy statement sets out a commitment, that through our commissioning and procurement activity and under the Public Services (Social Value) Act 2012 we will consider and, where appropriate, seek to secure wider social benefits for Halton as a whole. It is recognised that under this policy, individual organisations may have their own set of operating procedures that they need to adhere to in their commissioning and procurement activity.

The Public Services (Social Value Act) 2012

The Public Services (Social Value) Act 2012 (the Act) came into force during 2013. The Act introduces a statutory requirement for public authorities to have regard to economic, social and environmental well-being in connection with 'public services contracts' within the meaning of the Public Contracts Regulations. The new duty, therefore, only applies to contracts for services where the value exceeds the OJEU threshold. The Act requires local authorities to consider how what is being procured might improve the well-being of the relevant area and how, in the procurement process, it might act with a view to achieving that improvement.

Whilst the Act positively encourages economic, social and environmental well-being to be taken into account, this still needs to be done within the context of existing constraints within EU public procurement rules and other legislation. This means that any specific benefits which may be sought from a procurement exercise must remain relevant to the contract and proportionate and not risk distorting the outcome of the competition by giving them undue emphasis.

What do we mean by Social Value?

The term 'social value' refers to approaches that maximise the additional benefits created through the delivery, procurement or commissioning of goods and services, beyond those directly related to those goods and services. Social Enterprise UK in their Brief Guide to the Public Services (Social Value) Act 2012 define this as: "*If £1 is spent on the delivery of services, can that same £1 be used to also produce a wider benefit to the community*"?

For Halton, this means our commitment to meet our needs to provide goods, services, works and utilities in way that produces social, economic and environmental benefits for the borough. We will therefore wherever possible consider how economic, social and environmental well-being may be improved, and how procurement may secure those improvements.

Social value is about using the money we have more strategically, to produce a wider benefit. It also describes the values and principles which inform our behaviours and approaches.

The Act, in line with the statutory Best Value Duty, sets out three key themes to be addressed in seeking social value:

- Social
- Economic
- Environmental

For Halton, Social Value naturally sits within the overarching framework of the Halton Sustainable Community Strategy 2011-2026, the document that sets out our priorities and vision as a Borough and which is agreed by the Halton Strategic Partnership.

Our vision under the Sustainable Community Strategy is that:

"Halton will be a thriving and vibrant Borough where people can learn and develop their skills; enjoy a good quality of life with good health; a high quality, modern urban environment; the opportunity for all to fulfil their potential; greater wealth and equality, sustained by a thriving business community; and safer, stronger and more attractive neighbourhoods."

The Sustainable Community Strategy sets out how we will seek to achieve our visions through the key priorities of:

- A Healthy Halton
- Employment, Learning and Skills in Halton
- A Safer Halton
- Halton's Children and Young People
- Environment and Regeneration in Halton

In addition, this Social Value Policy Statements has been prepared alongside partnership work being undertaken UK as one of 4 national pilots looking at how we can create social value through commissioning for health. The 6 priorities of the Marmot review 2010 (Health Inequalities, Fair Society, Healthy Lives) have provided a context and focus of activity. The 6 priorities seek to:

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

We will therefore endeavour to align, wherever possible, the environmental, social and economic focus of the Act with the duty of Best Value, Halton Sustainable Community Strategy and the Marmot priorities as there are clear correlations and intersections across all of these documents in relation to social value

This policy statement acts as the overarching context for the Halton Social Value Procurement Framework and also supports the Halton Social Value Charter which has been developed in partnership across the borough.

Policy application

Within Halton we procure a wide range of goods and services, and it is recognised that there can be no 'one size fits all' model. This policy statement will therefore need to be applied in a proportionate manner and be tailored to reflect what is being procured and how. It is the role of service commissioners and procurement leads to

consider, on a contract by contract basis, what Social Value opportunities and outcomes may be relevant to that contract. However, our overall approach to implementing Social Value is set out below

The Act applies to services contract and contracts above the EU threshold which combine service with the purchase or hire of goods, but not work and supply contracts. However, we have for many years considered social, economic and environmental issues when procuring goods and services. We will therefore consider of social value outcomes in all contracts over a value of £1000 (i.e. both below and above the EU threshold set out in the Act), where it can be shown that it is **relevant and proportionate** and is compliant with EU regulation.

We will undertake, at pre-procurement stage, a social value opportunity assessment, alongside any consultation to help decide how what is procured or commissioned might improve the economic, social and environmental well-being of the area and how this may deliver outcomes relevant to the priorities of both the SCS and the Marmot Review.

If the procurement is carried out in emergency circumstances, not due to any delay on our part, making it impractical to comply with the Act, then we may need to disregard the requirements. This is as set out in the Act.

Under the duty of Best Value local authorities also need to consider overall value. Whilst this includes economic, environmental and social value, the duty also requires local authorities to secure continuous improvement in the way in which its functions are carried out and consider the combination of economy, efficiency and effectiveness. It should be noted that the Best Value duty has not been repealed by the Act. Therefore whilst looking at Social Value the Best Value duty remains throughout and is an important factor for local authorities in the weighting and evaluation of bids

How will we measure this?

It is the job of commissioning and procurement managers and officers to specify what social values outcomes are sought and relevant to each procurement or commissioning exercise.

At pre-procurement stage a Social Value Opportunity Assessment will be undertaken, linked to the Halton Social Value Procurement Framework, to decide what outcomes and benefits relevant to Halton's priorities may be possible from that opportunity.

The way in which evidence of Social Value benefits is measured is not set out either in the Act or this policy. Dependent on the requirements of each procurement exercise, commissioners and contract managers may wish to specify requirements explicitly within a tender or ask suppliers to come up with their own innovative ideas and voluntary clauses. In all cases it will be clear as to how Social Value elements have been weighted in the evaluation and decision-making process.

In addition to the Social Value Procurement Framework, organisations may have their own frameworks to identify and measure Social Value which may be used to facilitate this and which will be clearly referenced throughout each exercise.

Whilst the Act only requires Social Value to be considered at pre-procurement stage, officers commissioning or procuring goods (where social value has formed part of the awarding criteria) are encouraged to monitor and measure this as part of their contract management.

Supplementary documentation

Public Services (Social Value) Act 2012

Procurement Policy Note

Best Value Guidance

Social Value Procurement Framework (to be linked to when finalised)

Halton's Social Value Procurement Framework

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Social Value Procurement Framework

Introduction

This Framework sets out Halton Borough Council's approach to achieving Social Value through procurement and offers a way forward for both commissioners, buyers and procurement officers as a tool to inspire new thinking to deliver Social Value in all we do.

The council is committed to acting in a socially responsible way and would encourage the providers and suppliers it works with to do the same.

Our annual influencable spend is currently in excess of £70m; we trade with a range of 2462 organisations from National, Small Medium Enterprise (SME), to Micro and the Voluntary Community and Social Enterprise (VCSE) sector. As a council we have been nationally recognised for the innovative work we have done with SME's and the Voluntary Sector by removing unnecessary barriers for them; including simplifying our procurement processes, introducing risk based sourcing and removing a prequalifying procurement stage for opportunities below the current EU threshold (£172,514). Ultimately, organisations are able to trade with us more effectively and we are proud that 88% of our annual spend is with SME's.

By formally and consistently considering Social Value in the decisions we make in spending this money, we can make a major contribution to delivering a sustainable borough.

Social Value, why do it and when?

Because it's not difficult…… and because the outcomes are worth it! It's easy to dismiss Social Value through procurement as being too

difficult to achieve but it can make a great difference to people, service delivery and the council's ever diminishing resources. If we require providers and suppliers to deliver Social Value benefits whilst they deliver the main element of their contract means that Halton will benefit. We will get more, both directly and indirectly for our money.

Until the recent introduction of the Deregulation Bill (2014-2015), a key role for local authorities and their partners was to produce a Sustainable Community Strategy for their area; Halton will continue with its Sustainable Community Strategy (2011-2026), which has been endorsed by the Halton Strategic Partnership Board and sets out the overall vision, priorities and strategic context for Halton. The aim of the strategy is to enhance the quality of life of local communities through actions to improve the economic, social and environmental wellbeing of the area and its inhabitants. Our Social Value Procurement Framework naturally compliments this.

We have pushed our procurement boundaries further and in addition to Halton's five Sustainable Community Strategy priorities we have included in our approach the six Marmot priorities which have come from 2011 Marmot Review, an evidence based strategy which looks to address the social determinants of health, the conditions in which people are born, grow, live, work and age and which can lead to health inequalities. It draws further attention to the evidence that most people in England aren't living as long as the best off in society and spend longer in ill-health.

We believe that both sets of priorities should be considered when developing desired outcomes and output indicators for achieving Social Value.

Social Value Policy and Legislation

The law has changed and there is now an additional duty on the council to do this. The Public Services (Social Value) Act, 2012 came into force during 2013 and introduces a statutory requirement for public authorities to have regard to economic, social and environmental well-being in connection with 'public services

contracts' within the meaning of the Public Contracts Regulations, 2006.

The new duty, therefore, only applies to contracts for services where the value exceeds the EU threshold. The Act requires local authorities to **consider** how what is being procured might improve the well-being of the relevant area and how, in the procurement process, it might act with a view to achieving that improvement. The Council is committed to using this framework for opportunities below the EU threshold; however, these will be assessed in terms of both relevance and proportionality.

How we will use this Framework

- For each procurement opportunity, above £1000, we will undertake a Social Value "Opportunity Assessment" which will identify output Indicators and outcomes that are appropriate for inclusion in the procurement process
- The output indicators and desired outcomes will be thematic and linked to the priorities of the Halton Sustainable Community Strategy and at least one of the six Marmot Priorities
- The outcomes identified will be both relevant, transparent and proportionate for each procurement opportunity
- Our processes will be fully compliant with EU procurement law and the council's own Procurement Standing Orders, thus minimising any risk
- Our approach to Social Value will be a bespoke approach, tailored for each and every Tender or Request for Quotation (RFQ) opportunity
- We aspire to include where appropriate in each procurement at least one Social Value outcome
- Where outcomes are applied they will form part of the award criteria and included in the evaluation matrix. How this happens will be clearly explained
- Outcomes where appropriate will be built into awarded contracts and monitored; winning bidders will be expected to report on them to evidence how they are achieving Social Value

- Where we undertake procurement support on behalf of other Public Sector bodies we will encourage to use this Framework wherever appropriate
- We will endeavour to integrate wherever possible our methodology for the purpose of best practice

Our Procurement Principles

As we face increasing pressure on resources and an increased demand on public services, it is essential that we achieve the maximum value from each pound we spend. When we commission and procure services, we need to be outcomes focussed in addition to concentrating on outputs, by doing this we will ensure that the greatest impact **and** the best value for money for the residents of the borough are achieved.

This Social Value Procurement Framework will achieve this by ensuring that social, economic and environmental outcomes are embedded where appropriate into our procurement practices, not only to achieve greater impact from each procurement opportunity but to act as a support mechanism to enable true consideration by Commissioners, Buyers and Procurement Officers.

Halton Borough Council is committed to, and expects that our providers and suppliers be committed to:

- Supporting the local economy including SME's and voluntary community and social enterprise (VCSE) sector
- Delivering at doorstep level wherever appropriate including the local supply chain
- Including measurable voluntary clauses in contracts to demonstrate both Social Value and value for money
- Supporting the business and voluntary community and social enterprise (VCSE) sectors through transparent and proportionate procurement processes and contracts
- Ensuring robust contract management is in place to monitor and measure social value outcomes in partnership with our providers and suppliers
- Paying our suppliers promptly through the Council's Early Payment Scheme

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Taking full account of EU procurement law and our Procurement Standing Orders we **must** ensure that the Social Value "offer" that comes from a bidder must be either be:

- A voluntary offer where the bidder offers something that we can put in a voluntary clause but where this offer has not influenced the evaluation criteria that was published
- Where we build Social Value into evaluation criteria and it is weighted and the bidder can receive a percentage of marks on their Social Value submission

Finally, Social Value will not override the council and other public sector partners continuously seeking value for money but it will enhance the "offer" by providing tangible and measurable outcomes.

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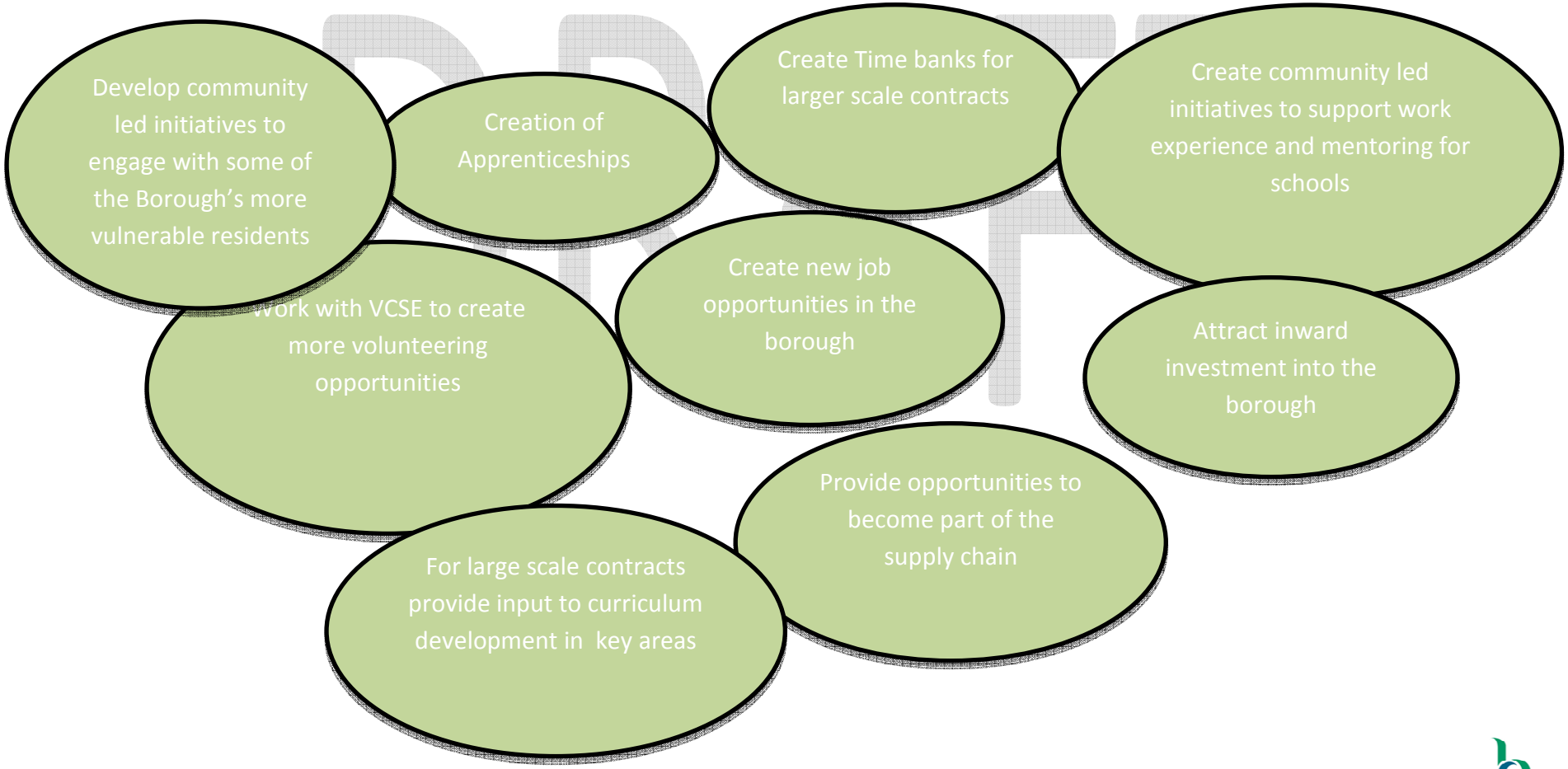
What Our Outputs Could Look like



Key Components of our Assessment Opportunity

Halton's Sustainable Community Strategy Priorities

- A Healthy Halton
- Halton's Children and Young People
- A Safer Halton
- Employment, Learning and Skills
- Environment and Regeneration

Social Value Themes

- Social
- Economic
- Environmental

Marmot Priorities

- Best Start in Life
- Ensure a Healthy Standard of Living
- Fair Employment and or Good Work
- Healthy and Sustainable Places and Communities
- All People can Maximise their Potential and or Capabilities
- Prevention of Ill Health

Our Social Value Procurement Opportunity Assessment

Social Value Theme	Link to Halton's Sustainable Community Strategy Priorities	Link to Marmot Priorities	Outcomes	Output Indicator What the Business and VSCE Community could Offer	Voluntary Offer and or Award Criteria
Social	A Healthy Halton Halton's Children and Young People A Safer Halton Employment, Learning and Skills in Halton	Fair employment and good work Best Start in Life Ensure a Healthy Standard of Living for all Prevention of Ill Health All People can Maximise their potential and or capabilities	More local people retained in Work Increased skills levels	Create new job opportunities in Halton Create apprenticeship opportunities for Halton residents Create and support work placements/work experience and vocational opportunities Offer work based learning opportunities Support people back to work by providing career mentoring, CV and career advice and guidance (including 50+) Supporting young people into work	

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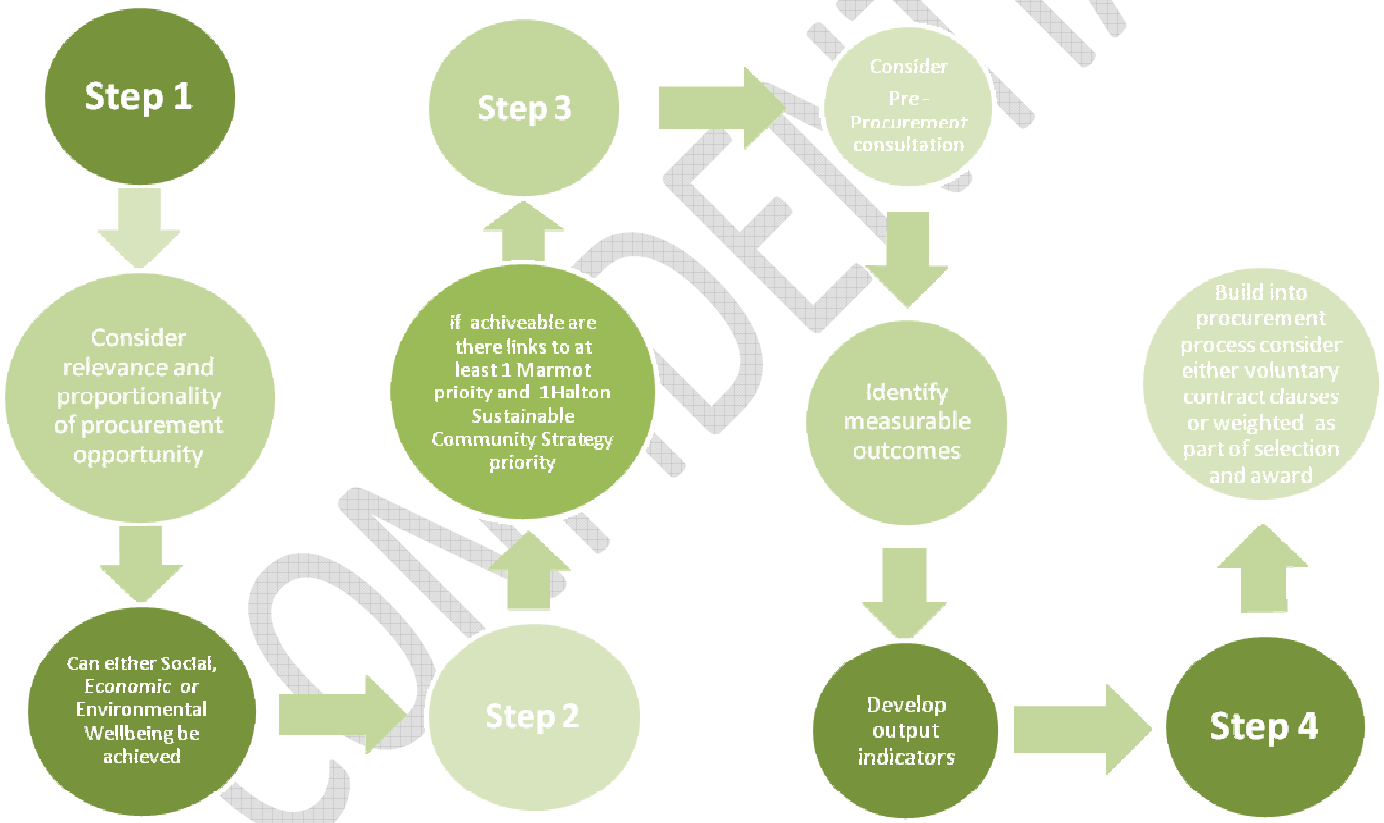
				through employability support (schools and colleges) Create opportunities for disadvantaged people including long term unemployed, ex offenders and people with disabilities Creation of healthy workplace schemes Offer accredited or recognised qualifications	
			Improve Health Inequalities and Other	Bespoke to the procurement opportunity	
Economic	Employment, Learning and Skills in Halton Environment and Regeneration in Halton A Healthy Halton	Ensure a Healthy standard of living Fair Employment and Good work Prevention of Ill Health	Responsible Businesses effectively contributing to the borough	Secure a positive profile for Halton through positive stories in the media Develop Community Sourcing approaches to regenerate local communities Attract inward investment into the borough Time banking Create Employer volunteering schemes	

				Business to business skill support Delivery of Meet the Buyer/supplier Events Provide opportunities to become part of the supply chain	
			An effective and resilient VCSE Sector	Work with VCSE sector to create increased volunteering opportunities in the borough VCSE organisations achieving the Star Standard foundation stage award VCSE organisations progressing to achieve the full Star Standard award	
			Health related outcomes and Other	Bespoke to the procurement opportunity	
Environmental	Environment and Regeneration in Halton A Healthy Halton	Healthy and Sustainable places and communities Prevention of Ill Health	Protecting Halton's physical environment	Demonstrate Commitment to Environmental projects Development of community led initiatives	

	A Safer Halton		Health related outcomes and Other	Commitment to improving environmental practices with demonstrable targets Reduce the amount of waste generated Reduce energy consumption Support sustainable travel Bespoke to the Procurement Opportunity	

Some of these outcomes/outputs are intended as a guide and may form part of the wider procurement process, award and evaluation criteria

Opportunity Assessment Stepped Approach



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Halton Borough Council Case Study

The use of Voluntary Clauses to achieve Social Value through the Highways Term Maintenance Procurement Process Jointly Procured with Warrington Borough Council

- ***The contract delivers measurable social benefits – targeted employment and training are included, delivering measurable employment apprenticeships and training opportunities both through the contract and via support for the local supply chain.***

Question section Extract from ITT Document and winning Bidders responses

Quality (Stage 1)

Quality of Service 40%		
Method of assessment	Assessed by consideration of the Tenderers plans for:	
Approach to Combining the Operations of both Councils		**6%**
Proposals to drive Cost and Performance Improvement though Collaborative Contracts		**5%**
Proposals to drive Continuous Improvement over the term of the contract		**4%**
Proposed Management Structure and Key Personnel		**3%**

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Proposals for Supply Chain Management and Engaging SME's		**4%**
Compliance with Employers Objectives in relation to Environmental Impact Planning		**2%**
Proposals for Winter Maintenance Service		**4%**
Added Social Value and Community Benefits		**4%**
Project Planning		**4%**
Mobilisation and Demobilisation Proposals		**2%**
Management and Mitigation of Disruption Risks and Business Continuity Planning		**2%**
Marking Guidance	*Submission for this section should be dealt with by responding to the questions detailed in the tender questions table later in this document, in the format described in the question table. **Each question will be marked in accordance with the statements in the marking matrix above. Max 40% of overall mark available, scored on scale of 0-5 in accordance with the matrix (table A) with 0-5 score factored to represent the % available for the individual questions in accordance with table B above. Scores will be rounded to 1 decimal place.**	

Q8	***1.1.8***	**Added Social Value and Community Benefits**
Question		Halton and Warrington Borough Councils would like to realise the potential for a contract of this type to add social value and community benefit and would like to establish a voluntary agreement and measure any benefit through the application of key performance indicators. What are your company's proposals for this contract in respect of the above?
Required Standard		Tenderers proposals identify measures which indicate their approach to: • partnering with organisations such as **The Halton Employment Partnership** and **Warrington Employment, Learning and Skills Partnership** to address issues of worklesness, and the development of construction skills in the workforce. • Interaction with schools colleges and training providers to provide work experience, work placements and training opportunities • The promotion of trade apprenticeships and training opportunities for adults, school leavers, and young people and their

	retention in employment following training. • The development of trade skills and on-going training within your existing workforce. • Measuring and reporting on the above issues.

Winning Tenderers ITT Response

Tenderer's Proposals Q8. 1.1.8

Added Social Value and Community Benefits Halton and Warrington Highways Improvement and Maintenance Term Services Contract 2013 - 2019 Page 1 of 4 **Strategy**

As a major employer operating across the UK, we recognise that X has an important role to play within the communities in which we operate. We look to support the aspirations of our clients who aim to make the communities they serve better places to live and do business and we seek to be sensitive to local community and their social and economic needs.

To ensure this contract has a positive community impact, particularly in relation to employment and skills, we will:

Develop an Employment and Skills Plan

We will work with the Council, the Employment Partnerships and other stakeholders to develop an Employment and Skills Plan. This Plan will outline the initiatives that will be put in place and exactly how these will benefit the community. This will be a targeted plan that will develop as part of our mobilisation approach that will identify specific activities and initiatives, clearly defined owners, agreed KPIs and targets to ensure we focus on those areas that will maximise benefit for the local community.

This will constitute much more than a voluntary arrangement it will be part of our commitment to deliver value and benefits to the local community. We will commit to the initiatives and suggest that a suite of KPIs on 'Localism' is developed from this Plan.

Work with schools and educational facilities

Working with young people to develop an understanding of our industry and work placement opportunities will enable them to make educated decisions about their futures. Additionally, through our community benefits initiatives, we can work with schools to give children important life skills, such as road safety and environmental awareness.

Focus on developing the skill base of our existing workforce

Providing our workforce with the skills required to undertake their roles efficiently and effectively is a fundamental requirement. We will undertake annual performance reviews with every employee, which will look at future aspirations and how we can provide them with the skills to enable them to progress in their careers in X. This will be particularly important in respect of TUPE transferees, see below for more detail. This approach will be extended to include engagement and management of SMEs to support their growth and development.

Partnership working with organisations

Working in partnership with both the Halton Employment Partnership (HEP) and the Warrington Employment Learning and Skills Partnership (WELSP) is a key priority for X, as it will be through these groups that we can obtain understanding of the needs and objectives of the community and regional stakeholders and be aware of local initiatives. During mobilisation, our General Manager will set up meetings with the partnerships and other stakeholders such as both region's Local Strategic Partnerships to align our needs with the regional objectives and develop a clear and focused Employment and Skills Plan.

Once the Employment and Skills Plan has been agreed, we would propose to hold six monthly review meetings with all the parties involved in its compilation to monitor progress against the Plan and to continually evolve the objectives and targets in line with regional need. Our General Manager will attend all of these meetings on behalf of X, along with any necessary experts such as our HR and Training Managers. Our Education and Skills Plan will ensure we fully understand the needs of the community and enable us to develop and implement plans to address these needs.

Initiatives to address worklessness

When the need to recruit arises on this contract, or within our wider regional business, we will engage with the HEP and the WELSP. Although we will always recruit candidates based solely on merit, using the employment partnerships will enable us to ensure that we are advertising the vacancies in the most appropriate media to make the opportunity visible to all people, including the long term unemployed.

Throughout the year we will work with the employment partnerships to offer work placements or work experience positions wherever we can. We will also make the members of our Strategic Board and Operational Board on this contract available to help mentor and coach the unemployed in Halton and Warrington, through activities such as open days, speaking at events, CV assistance and mock interviews. Our collaborative approach will support local agencies with addressing the challenge of worklessness, especially the long-term unemployed, and ensure that transferable skills are developed as part of the programme to facilitate improved longer-term prospects.

Initiatives to address development of construction skills

Due to the nature of the work that we undertake on the public highway, we require our employees to be competent and qualified to ensure the works are executed safely and to the required standard. We have in place clear and defined processes to ensure all personnel have the necessary skills to complete their roles. In order to ensure that the level of construction skills is increasing across the region we will:

Utilise work placements as an opportunity to take on capable, but not necessarily qualified, people and train them to the required standard;

Offer 'Role swaps' with our supply chain and the Council, so our respective employees gain insight and understanding into other elements of the service and increase their skill base;

Share best practice, including our systems and procedures with other parties such as SMEs to help develop the overall standard throughout the industry (See Q5 for further detail).

Our approach will support the development of a sustainable workforce that will be flexible and responsive to the changing needs of the Council throughout the term of the contract. Through developing the skill set of our employees, we are in turn providing the community with a population who possess a recognised skill set, making individuals more employable thereby positively contributing to the local economy.

Interaction with schools, colleges and training providers

Recruiting school leavers or young people is difficult for X, due to the health and safety restrictions involved with our activities. All employees must be aged 18 to work on our sites and all plant operators must be 21.

However, we acknowledge that providing opportunities for young people is vital for both the community and for the development of a young and dynamic workforce, therefore we will take on at least two work placement students every year and two work experience students per Lot per year.

We anticipate that work experience students will be 16 years of age and are usually embarking on a college course, which will result in a career in the construction industry. We will approach schools and colleges throughout the year to offer this opportunity to a variety of students, including St Chad's High and Great Sankey High, both of which have an Engineering focus. During the placement, we will ensure that the students spend time in various departments, including our technical laboratories. This will provide less academically focused students with guidance on a more a vocational career and hopefully garner interest amongst students as a potential path to employment.

On our term surfacing contract for Blackpool Borough Council we identified a need to recruit two Traffic Management personnel. We advertised the job roles in a variety of medias, including through the Blackpool "Build Up Programme". The "Blackpool Build Up" programme is a 4 year £1.8 million project run by Blackpool Borough Council and Blackpool and Fylde College, aimed at training adults in construction skills. All learners on the Blackpool Build Up Programme are aged 21 and over, unemployed or in receipt of benefits and living in a Blackpool postcode. All learners seeking work placements and employment have a personal plan which clearly identifies attendance, punctuality, attitude towards work and ability as well as a reference from their tutor. The programme also provides training. The two successful candidates were selected from the programme and have been given a training plan as Traffic Management Trainees for X.

We will also commit to working with schools and colleges through Science, Technology, Engineering and Maths (STEM) ambassadors. STEM ambassadors work with young people to promote careers in STEM industries. As a diverse national business we have a number of employees in various roles that will offer their services as STEM ambassadors in Halton and Warrington, including our Operations Manager, surfacing and civil engineering personnel, geologists, sustainability personnel and quarrying personnel. The number of events in the region our STEM ambassadors will attend will be agreed with the Council and will feature in the Employment and Skills Plan.

In 2010 we entered into an agreement with Wolverhampton University to provide internships for unemployed graduates to give them much needed work experience within some of the functions in our Ettingshall office. We were able to offer a number of roles and one converted into a permanent role. The permanent role went to a graduate who lives in Walsall, he was seconded to the operational team at our term contract in Walsall. Having graduated in Civil Engineering, he had been unemployed for 18 months until the secondment.
We will work with local universities including the University of Chester, Liverpool and John Moore's University to arrange similar programmes for this contract.

In addition to our interaction with schools and colleges from a recruitment perspective, we will work with them to provide wider community benefits, such as a greater understanding of road safety through attendance at assemblies or an appreciation of their local environment, through visits to our restored quarries. (See below for more details.)

Promotion of trade apprenticeships and training opportunities and retention following training
We commit to having two apprentices per Lot on this contract (in addition to the two apprentices on the TUPE list) throughout the duration of the contract. Additionally should we be awarded both Lots 1 and 2, the continuity of work we would be able to provide to our supply chain partner Lambros Ltd, would allow them to recruit one apprentice of their own. These apprentices would be recruited and selected through the Employment Partnerships, contributing to their own targets of recruiting 100 apprentices in 2012.

Every year, new apprentices join the four-year apprenticeship scheme for our Buxton Lime and Cement business. Practical, on-the-job training is complemented by vocational training for NVQ level 3 and the BTEC National Certificate in Engineering. Trainees have the opportunity to gain an in-depth knowledge of the industry and benefit from the experience of senior team members, which motivates them to develop their careers at X. Since 2009 we have recruited 28 mechanical and electrical trade apprentices through this scheme.

Wherever possible we will retain personnel in the role that they were recruited for. However, this is not always possible, particularly where people have been recruited for seasonal work. In the instances where we cannot retain people in the same roles, we will use our strong regional presence to redeploy people on to other contracts and activities, providing them with the necessary skills to undertake different roles. This approach will contribute to the local employment figures, reducing the local NEET statistics and adding value to each employee as they will gain recognisable qualifications.

Development of trade skills with the existing workforce

An individual's training must serve a number of purposes, although the two main criteria are that:
a) courses must satisfy the needs of the business and its ability to deliver the Service, and
b) that it must add value to the individual's development.
The employee and their line manager, with input from the Regional Training Manager if necessary, identify training needs through the annual review process, 'My X Plan.'
Each of our regional offices maintains a training and skills matrix. This contains a list of all employees along with what training they have completed, and when. This is used to ensure that all training is up-to-date. To prevent any shortage of skills, at least two people (more if necessary) from each office must hold any specialist certification or training such as EPIC licences to operate plant and machinery. Tenderer's Proposals

Based on the information in the training and skills matrix, each office compiles an annual training plan. Where there is a shortage of a particular trade or skill identified, an individual who has expressed interest in that field during their performance review will be put forward to undertake the training. This ensures the business can operate as normal in the event of retirement or resignation, as well as providing opportunities for development of our existing workforce. Additionally, this will ensure that a legacy is left for the next iteration of this contract, as the personnel who deliver it are trained to execute their roles, safely and expediently.

Due to the long term nature of the surfacing works that we were awarded for Birmingham PFI, we needed an additional Surfacing Supervisor. Through the performance review process, we identified one of our Plant Operators, Carl Cooper, had shown an interest in becoming a Supervisor. Carl was offered a Trainee Supervisor position for 6 months, where he would work closely with Paul Conlan, our Contracts Manager for the PFI. At the end of the 6 months we reviewed Carl's performance and due to his progress were able to offer him a full time Supervisor's role. Carl completed all the mandatory training to be a Supervisor such as IOSH and since taking on the role full time has been enrolled on NVQ Level 3 for Roadbuilding.

Wider community benefits

Communication with communities is vital to ensuring our service has a positive impact. We will liaise with our partners and stakeholders to understand how we can all support local community projects and initiatives. We will provide wider community benefits on this contract through:

Implementing our 'X in the Community' initiative

'X in the Community' is a business-wide initiative that works to build awareness of our industry and what we do. We do this through engaging with key groups in the community, such as schools, colleges and local interest groups. Our links with local schools have been particularly effective; site visits to active and restored quarries educate children about the environment, school visits by our staff build road safety awareness and our dedicated education website for Key Stages 2 and 3 called Quarryville, helps children understand what we do operationally.

Supporting local charities and community projects through X's Regional Fund

The regional fund provides funding in support of community-based projects organised by local organisations, charities, voluntary groups, community groups, educational institutions and environmental bodies. We will work with the Service Manager to identify projects looking for support, ensuring that they:

o Are within a 10 mile radius of a fixed X site/depot;

o Benefit the local community, environment, biodiversity or education;

o Show evidence of being well managed with efforts attributed to fundraising locally

We can also offer this support through the service based fund described in Question 2.

Mitigating disruption to our neighbours by integrating them into our operations

We have community based 'Engagement Plans' at all of our production operations. This process takes account of local issues to provide clear guidance to site managers on how to develop specific community plans and targets over a five-year period, enabling us to develop closer links to our neighbours and learn from best practice across different sites. Due to the long term nature of this contract, we will produce an 'Engagement Plan' for our proposed combined depot location, ensuring that we engage with the community in which it is located.

Measurement and Reporting

We propose that our Employment and Skills Plan and our progress against the targets it contains are developed to be a suite of KPIs on this contract. We have enclosed a draft Employment and Skills Plan in Appendix L. The targets in the Plan will be agreed by the Strategic Board during mobilisation and

progress against the targets will be monitored monthly by the Efficiency Adviser. Progress against the Employment and Skills Plan will be presented back to the board on a quarterly basis, where they will be given the opportunity to review the targets and add in any new objectives.

Tenderer's Proposals

Appendix L: Draft Employment & Skills Plan

No.	Category	Proposal/Activity	Annual Target	Notes/A
1	Partnership Working	Hold 6 monthly meetings with the LSP and employment partnerships	Attendance of all Tarmac representatives or suitable replacements at every meeting	
2	Work Experience Placements	Take on at least 2 work experience students (Aged 16 to 18) from local schools and colleges, per Lot, per year	4 work experience placements completed per year	
3	Work Placements	Take on at least 1 work placement candidate, through the Local Employment Partnership per Lot per year	2 unpaid work placements provided by the contractor per year	
4	Employment	Recruit required personnel from the local area	At least 80% of personnel recruited each year must reside in a WA or LL postcode. Recruit 4 operatives by end of 2013.	
5	Site Visits	Host site visits from schools, interest groups and stakeholders.	Hold 6 site visits per year with local stakeholders or interest groups on either contract sites or in local Tarmac fixed sites.	
6	Events	Each STEM Ambassador to attend at least 2 events/hold competitions per year	At least 6 events/competitions attended by STEM ambassadors	
7	Qualified Workforce	All operatives will be accredited to NHSS 12D	Training plan for all operatives in place, with accreditation for 25% of operatives completed	
8	Apprenticeships	Recruit 2 apprentice per Lot per year	Maintain at least 3 apprentices at all times throughout the contract	

HALTON BOROUGH COUNCIL

Links to Key Documents

Social Value (Public Services) Act, 2012
www.legislation.gov.uk/ukpga/2012/3/enacted

Halton's Sustainable Community Strategy 2011-2016
http://moderngov.halton.gov.uk/documents/s28017/HSPB%20SCS%20Q2%202012%20-%2014%2022%2011%2012%20Final.pdf

Marmot Review
www.ucl.ac.uk/gheg/marmotreview

Halton's Joint Strategic Needs Analysis (JSNA)
http://www.haltonchildrenstrust.co.uk/index.php/jsna/

HALTON BOROUGH COUNCIL

HALTON BOROUGH COUNCIL

REPORT TO:	Health & Wellbeing Board
DATE:	17 September 2014
REPORTING OFFICER:	Strategic Director, Children and Families
PORTFOLIO:	Children, Young People & Families
SUBJECT:	Supporting Pupils at School with Medical Conditions
WARD(S)	Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 This report provides an overview of the new statutory duties under the Children and Families Act 2014, to ensure schools make arrangements to support pupils with medical conditions.

2.0 RECOMMENDATION

That the Board notes the contents of the report.

3.0 SUPPORTING INFORMATION

3.1 Mismanagement of a child's health conditions whilst at school can have serious consequences. In 2010, the inquest into the death of asthmatic 11-year-old Samuel Linton, a pupil at Offerton high school in Stockport, Cheshire, heard how a teacher told him to sit in a corridor when he had a serious asthma attack one afternoon in December 2007. A teacher whom pupils alerted to Sam's situation told them she was in a meeting and he would have to wait. By the time his mother got to the school, he was grey and his lips were blue. He died soon afterwards. The inquest jury returned a verdict of neglect which, they said, had involved 12 separate failings by the school, 10 of which "caused or significantly contributed to" his death.

3.2 There are estimated to be over 1 million children in the UK with an underlying health problem such as asthma, epilepsy, Type 1 Diabetes, anaphylaxis and ME whose condition means they either need extra support while at school, or could end up needing emergency assistance, or both.

3.3 This statutory duty under the Children and Families Act 2014 addresses the need for children and young people to get the help, support and understanding which they need from schools and their staff to manage their medical conditions whilst at school.

4.0 OVERVIEW

4.1 From **1st September 2014**, governing bodies will have a new statutory duty - under the Children and Families Act 2014 - to ensure schools make arrangements to support pupils with medical conditions.

4.2 A medical conditions policy will be required, ensuring pupils with medical conditions have full access to education, including physical education and school trips.

4.3 The Department for Education's revised guidance, states:

- a medical conditions policy must be in place, so that pupils with medical conditions have full access to education, including school trips and physical education
- governing bodies should ensure this policy is reviewed regularly and is readily accessible to parents and staff
- appropriate training for school staff must be arranged
- governing bodies should ensure that school leaders consult health and social care professionals, pupils and parents to ensure children's needs are effectively supported.

4.4 The guidelines say: "Parents of children with medical conditions are often concerned that their child's health will deteriorate when they attend school.

4.5 "It is therefore important that parents feel confident that schools will provide effective support for their child's medical condition and that pupils' feel safe."

4.6 The new Statutory Guidance issued in April 2014, 'Supporting pupils at schools with medical conditions' replaces the previous Guidance 'Managing Medicines in Schools and early Years Settings' which was issued in 2005. So this role isn't totally new to schools, however there are some key changes that schools must respond to quickly.

4.7 This Guidance applies to **schools, academies and Pupil Referral Units**. For further information please click on the link provided.

5.0 WAY FORWARD

5.1 In order to support schools to fulfil their statutory duties, a range of resources will be made from 1st September 2014. These resources have been developed in conjunction with:

- Consultant, Public Health
- Health Co-ordinator for Children of School Age
- Clinical Manager School Health, Bridgewater
- Lead Pharmacist - Halton Locality Medicines Management Team
- Commissioning Manager Health, Public Health
- Acting Divisional Manager, Inclusion 0-25
- Principal Health and Safety Advisor

- Operational Director, children's Organisation and Provision

These resources include:

- A revised 'Supporting pupils at school with medical conditions' policy, including a blank policy template which schools can adopt if they wish to do so;
- A list of the available training for school staff, including governors and teachers;
- Information bulletins will be circulated to schools advising them of the changes through the schools e-bulletin, Chairs of Governors Briefings etc.
- Information will be made available through Halton's Local offer and the Children's Trust websites.

6.0 POLICY IMPLICATIONS

6.1 The policy implications stemming from the Statutory Guidance issued under the Children And Families act 2014, firmly puts responsibility for supporting pupils at school with medical conditions onto schools. Although schools must take the lead, they will need support from local authorities and health providers if they are to be able to undertake this role.

7.0 OTHER/FINANCIAL IMPLICATIONS

7.1 There may be financial implications for schools in responding to the changes, for example should they wish to employ a dedicated person to have overall responsibility for this policy implementation or should they wish to buy in additional training for staff.

The local authority and health providers must consider the support offered to schools including training, to ensure that this meets the needs of pupils and schools where appropriate.

8.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

8.1 Children & Young People in Halton

The legislative changes, which will be implemented in line with the statutory guidance, will ensure that pupils with medical conditions receive the support they require to have full access to education, including school trips and physical education. This can only benefit children, young people and their families, improving their health and well -being and enabling them to participate more fully in school life.

8.2 Employment, Learning & Skills in Halton

If pupils are able to fully participate in school life and are given the support they need to manage their medical condition whilst at school, this should contribute to improving attendance and academic

achievement, which in turn will improve their chances of employment and accessing higher education.

8.3 **A Healthy Halton**

Pupils health is at the centre of these changes, as mismanagement of a pupil's medical condition whilst at school can have serious consequences. It is important that both the child/young person and their families can feel confident that they will receive the appropriate level of support required so that their medical condition will be appropriately and well managed whilst at school.

8.4 **A Safer Halton**

None

8.5 **Halton's Urban Renewal**

None

9.0 RISK ANALYSIS

9.1 It is vital that schools, health providers and the local authority are clear about their statutory duties and responsibilities under the Act with regard to supporting pupils at school with medical conditions. In discharging these responsibilities, there will be a need for risk assessments to be undertaken, to ensure the safety of all pupils and staff. The risk to pupils of schools not providing appropriate support to help manage their medical condition whilst at school can be serious and far reaching.

10.0 EQUALITY AND DIVERSITY ISSUES

10.1 Supporting pupils at school with medical conditions will enable them to fully access education including school trips and physical education. No child with a medical condition should be denied admission to a school or prevented from taking up a place in school because arrangements for their medical condition have not been made. This should improve equality for these pupils within the school setting.

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

Document	Place of Inspection	Contact Officer
Children and Families Act 2014	2nd Floor, Rutland House, Runcorn	Debbie Houghton
Supporting Pupils at School with Medical Conditions Policy	6th Floor Municipal Building	Tony Dean
Supporting pupils at school with medical conditions Statutory guidance for governing bodies of maintained schools and	2nd Floor, Rutland House, Runcorn	Debbie Houghton

proprietors of academies in England		