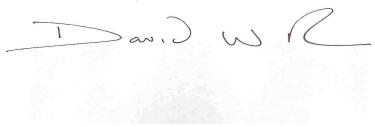
Public Document Pack

# Health Policy and Performance Board

**Tuesday, 13 January 2015 at 6.30 p.m.**
**Council Chamber, Runcorn Town Hall**



**Chief Executive**

**BOARD MEMBERSHIP**

| | |
|---|---|
| Councillor Ellen Cargill (Chairman) | Labour |
| Councillor Joan Lowe (Vice-Chairman) | Labour |
| Councillor Sandra Baker | Labour |
| Councillor Marjorie Bradshaw | Conservative |
| Councillor Mark Dennett | Labour |
| Councillor Margaret Horabin | Labour |
| Councillor Martha Lloyd Jones | Labour |
| Councillor Chris Loftus | Labour |
| Councillor Carol Plumpton Walsh | Labour |
| Councillor Pauline Sinnott | Labour |
| Councillor Pamela Wallace | Labour |
| Mr T BaKer | Healthwatch Co-optee |

*Please contact Lynn Derbyshire on 0151 511 7975 or e-mail lynn.derbyshire@halton.gov.uk for further information.*

*The next meeting of the Board is on Tuesday, 10 March 2015*

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

**Part I**

***In accordance with the Health and Safety at Work Act the Council is required to notify those attending meetings of the fire evacuation procedures. A copy has previously been circulated to Members and instructions are located in all rooms within the Civic block.***

Agenda Item 3

**REPORT TO:** Health Policy & Performance Board

**DATE:** 13 January 2015

**REPORTING OFFICER:** Strategic Director, Policy & Resources

**SUBJECT:** Public Question Time

**WARD(s):** Borough-wide

## 1.0 PURPOSE OF REPORT

1.1 To consider any questions submitted by the Public in accordance with Standing Order 34(9).

1.2 Details of any questions received will be circulated at the meeting.

## 2.0 RECOMMENDED: That any questions received be dealt with.

## 3.0 SUPPORTING INFORMATION

3.1 Standing Order 34(9) states that Public Questions shall be dealt with as follows:-

(i) A total of 30 minutes will be allocated for dealing with questions from members of the public who are residents of the Borough, to ask questions at meetings of the Policy and Performance Boards.

(ii) Members of the public can ask questions on any matter relating to the agenda.

(iii) Members of the public can ask questions. Written notice of questions must be given by 4.00 pm on the working day prior to the date of the meeting to the Committee Services Manager. At any one meeting no person/organisation may submit more than one question.

(iv) One supplementary question (relating to the original question) may be asked by the questioner, which may or may not be answered at the meeting.

(v) The Chair or proper officer may reject a question if it:-

- Is not about a matter for which the local authority has a responsibility or which affects the Borough;
- Is defamatory, frivolous, offensive, abusive or racist;
- Is substantially the same as a question which has been put at a meeting of the Council in the past six months; or
- Requires the disclosure of confidential or exempt information.

(vi) In the interests of natural justice, public questions cannot relate to a planning or licensing application or to any matter which is not dealt with in the public part of a meeting.

(vii) The Chairperson will ask for people to indicate that they wish to ask a question.

(viii) **PLEASE NOTE** that the maximum amount of time each questioner will be allowed is 3 minutes.

(ix) If you do not receive a response at the meeting, a Council Officer will ask for your name and address and make sure that you receive a written response.

Please bear in mind that public question time lasts for a maximum of 30 minutes. To help in making the most of this opportunity to speak:-

- Please keep your questions as concise as possible.
- Please do not repeat or make statements on earlier questions as this reduces the time available for other issues to be raised.
- Please note public question time is not intended for debate – issues raised will be responded to either at the meeting or in writing at a later date.

**4.0 POLICY IMPLICATIONS**

None.

**5.0 OTHER IMPLICATIONS**

None.

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

6.1 **Children and Young People in Halton** - none.

6.2 **Employment, Learning and Skills in Halton** - none.

6.3 **A Healthy Halton** – none.

6.4 **A Safer Halton** – none.

6.5 **Halton's Urban Renewal** – none.

**7.0 EQUALITY AND DIVERSITY ISSUES**

7.1 None.

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

8.1 There are no background papers under the meaning of the Act.

**REPORT TO:** Health Policy and Performance Board

**DATE:** 13 January 2015

**REPORTING OFFICER:** Chief Executive

**SUBJECT:** Health and Wellbeing minutes

**WARD(s):** Boroughwide

## 1.0 PURPOSE OF REPORT

1.1 The Minutes relating to the Health and Wellbeing Portfolio which have been considered by the Health & Wellbeing Board Minutes are attached at Appendix 1 for information.

## 2.0 RECOMMENDATION: That

**(1) the Minutes be received for information; and**

**(2) consideration be given to future minutes being reported via the Health Information Briefing.**

## 3.0 POLICY IMPLICATIONS

3.1 None.

## 4.0 OTHER IMPLICATIONS

4.1 None.

## 5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 **Children and Young People in Halton**

None

5.2 **Employment, Learning and Skills in Halton**

None

5.3 **A Healthy Halton**

None

5.4 **A Safer Halton**

None

5.5 **Halton's Urban Renewal**

None

## 6.0 RISK ANALYSIS

6.1 None.

## 7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

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

8.1 There are no background papers under the meaning of the Act.

# HEALTH AND WELLBEING BOARD

*At a meeting of the Health and Wellbeing Board on Wednesday, 12 November 2014 at Karalius Suite, Halton Stadium, Widnes*

Present: Councillors Philbin, Polhill, Woolfall and Wright and E. Anwar, K. Appleton, S. Banks, S. Boycott, G. Ferguson, A. Marr, A. McIntyre, E. O'Meara, D. Parr, N. Rowe, M. Trehare, J. Wilson, S. Yeoman.

Apologies for Absence: K. Fallon, D. Lyon and N. Sharpe.

Absence declared on Council business: None

Also in attendance: Dr Mandel and two representatives of North West Ambulance.

**ITEM DEALT WITH**
**UNDER DUTIES**
**EXERCISABLE BY THE BOARD**

*Action*

HWB22 MINUTES OF LAST MEETING

The Minutes of the meeting held on 17 September 2014 having been circulated were signed as a correct record.

HWB23 INTEGRATED SEXUAL HEALTH SERVICE

The Board was advised that as part of their new Public Health responsibility, local authorities were mandated to commission the following sexual health services:

- Contraception outside the GP contract;
- HIV Testing;
- Chlamydia testing as part of the National Chlamydia Screening Programme and treatment;
- Testing and treatment of other sexually transmitted infections;
- Sexual health aspects of psycho sexual counselling; and
- Any sexual health specialist services e.g. sexual health promotion, young persons' services, HIV prevention, outreach work, teenage pregnancy.

It was noted that prior to 1st November 2014 these services were delivered under four separate contracts, each with a different area of focus or responsibility but with strong interdependencies between the services.

Halton had participated in a review of sexual health services provided across Cheshire and Merseyside in late 2013. This resulted in the development of a common specification for integrated sexual health services combining the elements listed above which local authorities were able to adapt to meet local circumstances.

Members were advised that the Halton specification was adapted to fit local need and took account of feedback from two public and stakeholder surveys and several focus groups held with young people and young mums in the Borough. The tender opportunity to deliver the integrated sexual health services was advertised on the Due North Chest e-procurement system at the end of March 2014 and interviews of shortlisted candidates were held on the 13th June 2014. It was noted that the bid by Warrington and Halton NHS Hospitals Trust (WHNHST) was the most economically advantageous and was, therefore, successful. The report outlined key features of the successful bid and advised that the new contract commenced on the 1st November 2014.

Dr Mandel, consultant and Lead Clinician from WHNHST, attended the meeting and delivered a presentation which outlined the benefits of the provision of the new integrated service.

RESOLVED: That the contents of the report be noted along with the accompanying presentation.

HWB24 CHILD SEXUAL EXPLOITATION

The Board considered a report which provided a summary of the approach in Halton to addressing Child Sexual Exploitation (CSE) within the Borough.

Halton, along with Cheshire East, Cheshire West and Warrington had begun to focus on CSE prior to the Rotherham report following concerns in other areas such as Rochdale and Oxfordshire. Learning from these cases, a range of actions had been undertaken details of which were outlined in the report. It was highlighted that a website www.knowandsee.co.uk had been launched by Warrington, Halton, Cheshire East and West Councils which provide help and support to young people.

The Board was advised that following the publication of the Rotherham Report, a further review of Halton's approach to CSE had been undertaken. The Review would be led and co-ordinated by Halton LSCB and an interim report would be produced at the end of October 2014 which would identify the immediate issues to be addressed to ensure that children and young people were safe. The final report would then be completed by December 2014 and presented to a private session of full Council. The LSCB would then publicise the findings and response and if any urgent action was identified the appropriate action would be taken immediately.

In parallel to this work, Halton was establishing a co-located multi-agency CSE Team which would include colleagues from Cheshire Police and the NHS locally. In addition, the Cheshire LSCBs were working collaboratively with Cheshire Police and the PCC to share best practice and review the "high risk" factors identified in the Rotherham Report, on a wider Cheshire footprint.

Arising from the discussion it was agreed that the possibility of inviting Voluntary Sector organisations to the PAN Cheshire Communication Group be explored.

Also in attendance were representatives from the North West Ambulance Service. They advised the Board that this had been a challenging year for the Service with a 8-9% increase in activity in Halton. In response to recent incidents in the Borough the funding of an extra vehicle had been obtained from the CCG and an acute visiting team had been introduced.

RESOLVED: That the Board note the response by Halton Council and its partners in the Local Safeguarding Children Board to Professor Jay's report into Child Sexual Exploitation in Rotherham.

Strategic Director Children and Enterprise

HWB25 PUBLIC HEALTH ANNUAL REPORT 2013-14: DRINKING LESS AND LIVING LONGER

The Board considered a report from the Director of Public Health, which provided Members with information on the 2013-14 Annual Report: Drinking Less and Living Longer. The draft Annual Report was attached as Appendix 1 to the report.

The Board was advised that this year's Public Health Annual Report focussed on the topic of alcohol related harm

and set out how work was taking place in partnership to reduce the alcohol harm for individuals, families and communities. It was reported that alcohol-related harm affected all age groups within Halton. The report was therefore written from a life course perspective and set out key actions that would be taken for each group. A communities chapter was also included which covered issues that affected people of all ages, e.g. crime and community safety, alcohol availability and price.

The Board was further advised that reducing alcohol-related harm was chosen as a topic as it demonstrated the importance of working in partnership and what could be achieved when organisations worked together across organisational boundaries. It was also timely as the Public Health Team were currently working in partnership to develop a local alcohol harm reduction strategy. In addition, Halton was only one of twenty areas in the country to be awarded the status of being a Local Alcohol Action Area.

It was reported that chapters included in the report were as follows:-

- Promoting an alcohol free pregnancy and protecting Halton babies and toddlers from alcohol related harm;
- Reducing under-age drinking in Halton;
- Promoting safe and sensible drinking among adults;
- Promoting safe and sensible drinking among older people; and
- Keeping our local community safe from alcohol related harm.

Each chapter outlined the current levels of alcohol-related harm, described current local activity to reduce alcohol related harm, outlined gaps in current activities and made recommendations for future actions.

RESOLVED: That the Board note the contents of the report and support the recommendations.

HWB26 HALTON ALCOHOL STRATEGY: REDUCING ALCOHOL-RELATED HARM ACROSS THE LIFE COURSE, 2014-2019

The Board considered a report of the Director of Public Health, which presented the final draft of the Halton Alcohol Strategy: Reducing Alcohol-related harm across the life course. The report set out the vision, outcomes and objectives of the Alcohol Strategy.

The Board was advised that the Halton Alcohol Strategy outlined actions aimed at rebalancing the relationship Halton had with alcohol. The strategy took a life course approach to reducing alcohol-related harm at all stages of life from birth to old age and also included a "Communities" chapter.

Members were advised that the strategy built upon the effective work that had been undertaken by partners locally and had been written in collaboration with all partners who had agreed the vision, outcomes, objectives and actions. The strategy was also supported by a detailed action plan outlining actions, the responsible leads, timescales and outcomes to be achieved. The plan would be monitored by the Alcohol Strategy Implementation Group and outcomes reported to the Safer Halton Partnership, Health and Wellbeing Board and all other relevant bodies.

It was also reported that a formal public consultation would be undertaken to enable local people to provide feedback and insight to the final version of the strategy and action plan. In addition, it was reported that the strategy would also be presented to the following Boards for input and discussion:-

- Safer PPB;
- Safer Halton Partnership Board;
- Children's Trust Board;
- Halton Clinical Commissioning Group Executive Board; and
- Executive Board.

In addition, it was noted that Halton was one of only 20 areas in the country to be awarded the status of being a Local Alcohol Action Area. The award provided support from the Home Office and Public Health England and related to addressing the harm from alcohol across three areas – health, crime and anti-social behaviour, and diversifying the night time economy. Key partners had been involved from local authority, health and community safety and an action plan had been developed. This work was integrally linked to the development of the alcohol strategy and action plan.

Members were also advised that this report and the Public Health Annual Report would be submitted to a future meeting of the Council's Regulatory Committee.

RESOLVED: That the Board

1. note the contents of the report; and

2. support the strategy outcomes, objectives and actions.

HWB27 EARLY INTERVENTION

The Board received a report of the Strategic Director, Children and Enterprise, which provided a summary of the revised Early Help Model and sought approval of the governance arrangements. Early Help and Support was an approach established in Halton in 2010 with an overarching Early Help Strategy launched in April 2013. There had since been an agreement to develop the next stage of Early Help.

Following work by a sub group of the Early Help and Support Group, in September 2014, Halton launched its locality model based on the realignment of the current Integrated Working Support Teams, and the Intensive Family Work. This new approach was known as Early Intervention. The new Early Intervention Model had set up three locality Early Intervention Teams, one in Widnes and two in Runcorn, reflecting the current volumes of referrals. Each team consisted of staff from the Integrated Working Support Teams, family support teams and intensive family work teams. In November the staff member from the police previously seconded to the Troubled Families would move to be part of the CART.

Members were advised that the next phase of the development of the programme was to work with key partners in the police, health and adult services to establish the correct links with the locality services. In addition, it was suggested that the Health and Wellbeing Board would act as the governing body for Halton's approach to Early Intervention, setting the strategic direction and acting as the driver for planning, co-operation and working. It would also ensure effective information sharing and performance management systems were established across partners. The Board would receive regular reports from the Partnership Board. It was proposed that:-

- the current Troubled Families Strategic Group would be revised and renamed as the Partnership Strategic Board;
- the Partnership Board would be accountable to the Health and Wellbeing Board; and
- the current Early Help and Support Group of the Children's Trust Executive would be responsible for operational delivery and ensuring services were delivered in line with the agreed business plan,

priorities and local needs.

RESOLVED: That

1. the governance arrangements for Early Intervention be agreed;

2. all partners commit to working with the locality based Early Intervention Teams; and

3. all partners commit to ensuring the appropriate information sharing arrangements are in place and that CART can access the relevant data bases.

HWB28 HALTON CANCER STRATEGY

The Board considered a report of the Director of Public Health, which provided a final version of the joint Halton Cancer Strategy 2014-2019, along with the supporting action plan. The prevention and early detection of cancer was identified as one of the five health and wellbeing priorities for Halton via the Joint Strategic Needs Assessment. The Halton Cancer Strategy, in line with the Joint Health and Wellbeing Strategy, took a life course approach from prevention and early detection through to treatment and survivorship. The vision was to deliver on reducing the under-75 mortality rates from cancer, by preventative methods, increased early detection rates and tangible improvements in cancer services.

The strategy had been developed and endorsed by the Halton Action on Cancer Board which included representation from the Strategic Clinical Network, secondary care cancer teams, the GP Clinical Lead for Cancer, the Director of Public Health, the CCG Commissioning Lead, Voluntary Sector representation and had been further supported by numerous public and patient engagements as detailed within the strategy.

It was noted that cancer outcomes were monitored in both the CCG Outcome Indicator Set and the Public Health Outcomes Framework. The indicators included:

- Improved uptake of cancer screening;
- Increased numbers of cancer diagnosed at an early stage;
- Reduced mortality from under 75 cancer;
- Improved one and five year survival rates from cancer, in particular, breast, lung and colorectal.

RESOLVED: That

1. the Board approve and support the contents of the strategy; and

2. the Board support the implementation of the attached action plan for all partners.

HWB29 DUE NORTH: THE REPORT OF THE INQUIRY ON HEALTH EQUITY FOR THE NORTH

The Board considered a report which provided an overview of Due North: the report of the Inquiry on Health Equity for the North, which was the outcome of an independent inquiry commissioned by Public Health England to examine health inequalities affecting the North of England.

The inquiry brought together expertise from people working across the North of England from universities, local government, the NHS and the voluntary and community sector. Due North highlighted that the North of England had persistently had poorer health than the rest of England and that this gap had continued to widen over four decades. Also, there was a gradient in health across different social groups within the North: on average poor health increased with increasing socio-economic disadvantage, resulting in the large inequalities in health between social groups that were observed today.

In addition, the report highlighted that austerity measures introduced by Central Government since the 2008 recession had been making the situation worse, with the burden of local authority cuts and welfare reforms falling more heavily on disadvantaged Northern local authorities such as Halton. In addition, the report recognised that Northern regions currently had limited collective influence over how resources and assets were used in the North of England and that hindered action on health inequalities. Greater devolution of powers and resources to cities and local government was required to drive economic growth and reduce regional inequalities in England.

Due North set out the following 4 high level recommendations to tackle the root causes of health inequalities both between the North and between the North and the rest of England:-

1) tackle poverty and economic inequality within the North and between the North and the rest of England;

2) promote healthy development in early childhood;

3) share power over resources and increase the influence that the public had on how resources were used to improve the determinants of health;

4) strengthen the role of the health sector in promoting health equity.

The report also outlined local activity within Halton to improve health equity in line with suggested actions and recommendations. Key activities to reduce health inequalities in Halton related to the Due North recommendations were detailed in the report. A copy of a discussion document on Due North would be circulated to Members for comment following this meeting.

RESOLVED: That

Halton take forward the Due North report recommendations, especially those related to:- | Director of Public Health

a) Lobbying Central Government for greater devolution of powers and resources to cities and local government;

b) Tackling poverty and economic inequality;

c) Developing a social value approach to procurement;

d) Promoting healthy development in early childhood;

e) Developing the capacity of local communities to engage with and influence local decision-making; and

f) Addressing premature mortality through primary care, with a focus on improving treatment and outcomes among older people living with long-term conditions.

HWB30 DISABLED CHILDREN'S CHARTER

The Board considered a report of the Strategic Director, Children and Enterprise, which sought approval from Every Disabled Child Matters and the Children's Trust, Tadworth for the Board to support the Disabled Children's Charter. The report outlined details of the seven commitments which, by signing the Charter, the Board would be agreeing to meet within 12 months. It was also noted that work was already being undertaken in the

Borough to meet the requirements of the Children and Families Act April 2014, it was therefore suggested that these two areas of work continue to be combined.

RESOLVED: That

1. the Board accepts the Charter; and
2. the Charter is reviewed annually.

Strategic Director Children and Enterprise

HWB31 HEALTH & WELLBEING GRANTS

The Board considered a report which provided an update on the progress of the Health and Wellbeing Grants which were launched at the Vintage Rally in September 2014. Four categories of application were available: Recognition Award, Community Group Award, Healthy Workplace Award and Health School Award. Three rounds of applications would be invited with deadlines of 17th October 2014, 19th December 2014 and 27th March 2015.

It was noted that the first round of grants received 17 applications for funding and the Panel had agreed eleven grants, one was deferred for further information, one was rejected as it would have been retrospective funding and four were referred to other avenues for support. The total amount awarded in the October round was £5,085. Three of the applications were for recognition awards for contributions to supporting Health and Wellbeing. Full details of all applications received and the grants awarded were outlined in the report.

RESOLVED: That the report be noted.

*Meeting ended at 3.55 p.m.*

| | |
|---|---|
| **REPORT TO:** | Health Policy & Performance Board |
| **DATE:** | 13th January 2015 |
| **REPORTING OFFICER:** | Strategic Director, Communities |
| **PORTFOLIO:** | Health and Wellbeing |
| **SUBJECT:** | Creating Tomorrow's Healthcare Today – Warrington and Halton Hospitals NHS Foundation Trust five year strategy |
| **WARD(S):** | Borough-wide |

1.0 **PURPOSE OF THE REPORT**

1.1 For the Board to receive, from Mel Pickup, Chief Executive of Warrington and Halton Hospitals NHS Foundation Trust, details of the Trusts' five year Strategy 'Creating Tomorrow's Healthcare Today'.

2.0 **RECOMMENDATION: That PPB :**

**i) Notes the contents of the report; and**
**ii) Comment on the Trust's five year strategy (See Appendix 1 & 2)**

3.0 **SUPPORTING INFORMATION**

3.1 <u>What is creating tomorrow's healthcare today all about?</u>

Over the last five years we have made massive changes to our services at Warrington and Halton Hospitals - modernising our hospitals, investing in our staff and, most importantly, delivering quality and safety improvements for our local population.

Creating tomorrow's healthcare today is our way of setting out our strategy for the next five years. It sets out our overall vision for the hospitals. It allows you to see the plans that we have to continue to deliver these and other improvements in line with the local and national picture and changes taking place in the wider NHS.

It is the result of work with our governors, members and public over the last few months as well as being informed by commissioning intentions and national mapping work across the health and social care sector.

We've called our strategy creating tomorrow's healthcare today because that is what we are doing at Warrington and Halton Hospitals - creating a sustainable organisation for the future that will deliver what our local population needs from their NHS hospital services.

Our aim is to reinvent what the district general hospital does and how it works over the next five years for the benefit of patients, staff and stakeholders.

4.0 **POLICY IMPLICATIONS**

4.1 None associated with this report.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 None associated with this report.

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

6.1 **Children & Young People in Halton**
None associated with this report.

6.2 **Employment, Learning & Skills in Halton**
None associated with this report.

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

6.4 **A Safer Halton**
None associated with this report.

6.5 **Halton's Urban Renewal**
None associated with this report.

7.0 **RISK ANALYSIS**

7.1 None associated with this report.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None associated with this report.

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

9.1 None under the Meaning of the Act

**Appendix 1: Creating Tomorrow's Healthcare Today – Warrington and Halton Hospitals NHS Foundation Trust five year strategy**

**Attached to the report**

**Appendix 2 - Creating Tomorrow's Healthcare Today – Plan on a Page**

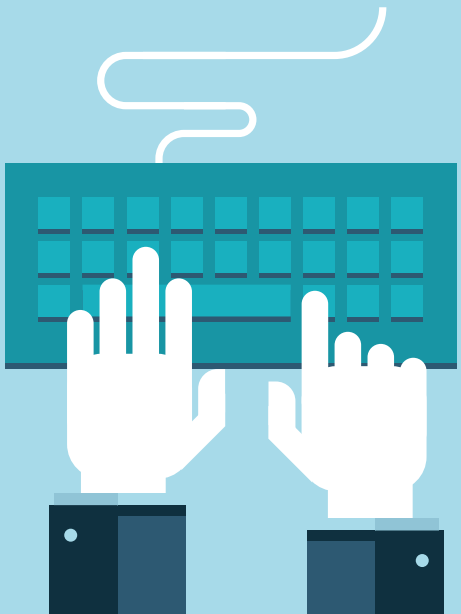
**Attached to the report**

High Quality, Safe Healthcare
Quality People Sustainability

Warrington and Halton Hospitals NHS
NHS Foundation Trust

# *Creating tomorrow's healthcare today*

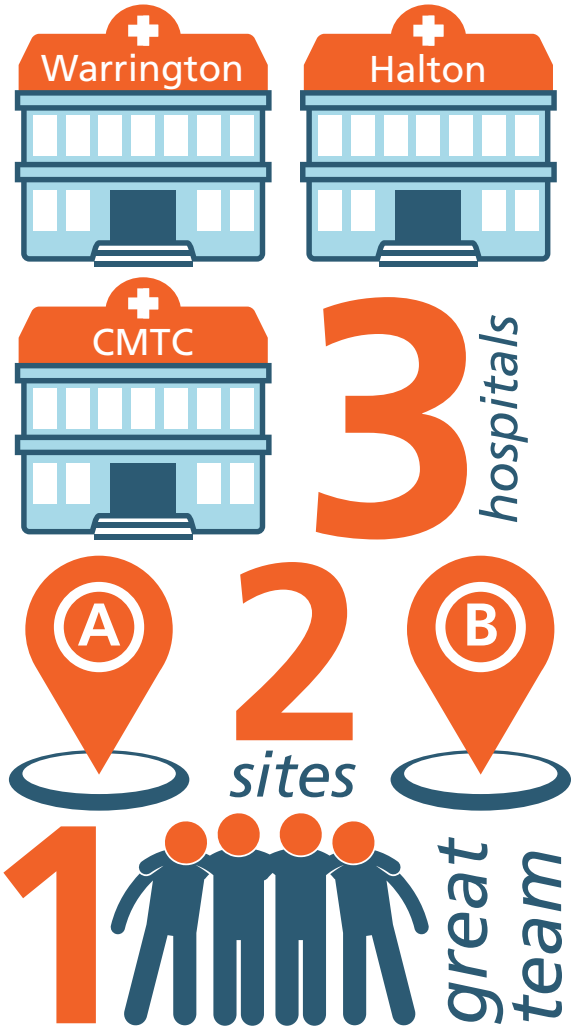
## How we plan to develop your hospitals over the next five years



# Contents

# Creating tomorrow's healthcare today

Warrington and Halton Hospitals NHS Foundation Trust provides first class services at Warrington Hospital, Halton General Hospital and the Cheshire and Merseyside Treatment Centre located in the North West of England.




The majority of our emergency care and complex surgical care is based at Warrington Hospital whilst Halton General Hospital in Runcorn is a centre of excellence for routine surgery. The Cheshire and Merseyside Treatment Centre is home to our orthopaedic surgery and treatment services located on the Halton campus.

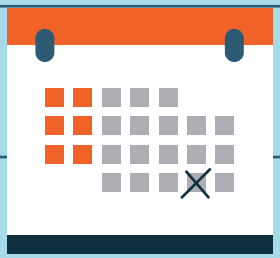
Although each of our centres specialises in particular aspects of care, we provide outpatient clinics for all our specialties and diagnostic (scanning) services at both Warrington and Halton so patients can access their initial appointments close to home wherever possible. We also provide some outpatient and other services in the local community.

We've invested heavily in our hospitals over recent years - nearly every ward has been refurbished and we've seen development of new facilities and departments that make our hospitals an even better place to receive your care.

Over the last five years we have made massive changes to our services - modernising our hospitals, investing in our staff and, most importantly, delivering quality and safety improvements for our local population.

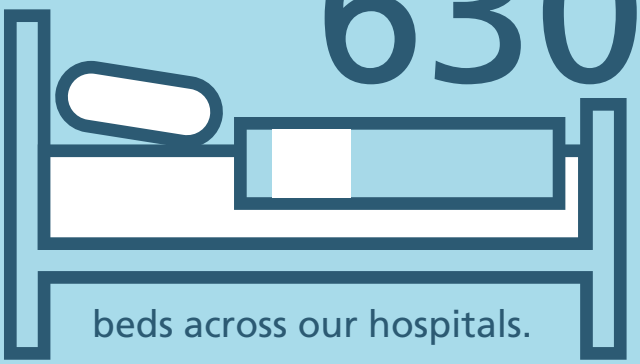
Staff work across our wards and departments.

4,100



We provide almost 500,000 individual appointments, procedures and stays in hospital each year.

There are over 630



beds across our hospitals.

90%

We have cut hospital infection rates by over 90% in five years.

Patients rate Halton General Hospital and the Cheshire and Merseyside Treatment Centre as five stars on the NHS Choices website. Warrington also scores well at four stars.

The trust has an annual turnover of over £210 million.

## *About this document*

This document sets out our vision for the next five years for our hospitals. It allows you to see the plans that we have to continue to deliver these and other improvements in line with the local and national picture and changes taking place in the wider NHS.

We've called our future strategy ***creating tomorrow's healthcare today*** because that is what we are doing at Warrington and Halton Hospitals - creating a sustainable organisation for the future that will deliver what our local population needs from their NHS hospital services.

**Our aim is to reinvent what the district general hospital does and how it works over the next five years.**

# What we do and how we do it

Over the last 12 months, working with our governors and external stakeholders, we have defined the long term vision for the trust in a simple statement supported by a set of strategic objectives.

Our vision is to be ***the most clinically and financially successful integrated healthcare provider in the mid-Mersey region.***

In order to achieve our vision we believe we need to focus on the ***quality*** of our services, on the ***people*** who deliver them and on ensuring our organisation's ***sustainability***. We call this our QPS framework - it is the framework for everything that we do.

# Nine things we are doing as part of QPS

## Quality

Delivering excellence for our patients.

1. We will reduce harm and focus on having no avoidable deaths by managing and reducing clinical and operational risks.
2. We will improve outcomes, based on evidence and deliver care in the right place, first time, every time.
3. We will focus on the patient and their experience, adopting 'no decision about me without me' as a way of life and we will get the basics right so our patients will be warm, safe, clean, well fed and well cared for.

## People

Committed to and caring for our staff.

4. We will ensure that our teams are skilled, available in the right numbers to deliver our services and fit and well in work so that we improve their working lives.
5. We will communicate openly with our teams and expect the same from them in return. We expect staff to take accountability for their actions and will support them to do so. We want to be an employer of choice and we encourage loyalty from our staff and recognise their discretionary efforts.
6. We will reward talent, supporting the development of leaders as role models within the organisation and invest in the education, training and development of our teams.

## Sustainability

Being here for our communities, now and going forward.

7. We will ensure we have effective leadership and provide robust assurance to our board of directors, ensuring compliance across all areas of regulation and develop and encourage our governors and members.
8. We will ensure we have robust contracts for services provided and develop service line management so that we understand how effectively we use our resources, invest in IM&T and look for opportunities to collaborate on services for reciprocal benefit.
9. We will be recognised as a good corporate citizen, market our services effectively and develop and diversify our business whilst also pursuing the collection of charitable funds.

# What's in our strategy?

All of the commitments in our five year strategy are based on improving the patient experience and delivering high quality safe healthcare by developing sustainable, appropriate, and high performing services.

We intend to meet the challenges we face through the development and delivery of this strategy which encompasses several ongoing work streams within the organisation. This includes a five year clinical services strategy, the implementation of a comprehensive programme of service redesign and through developing a variety of partnerships and networks both within the local health economy and also regionally and beyond.

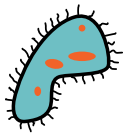
## A lot can happen in five years...

**2008**

We became an NHS Foundation Trust in 2008 and there's been a lot of changes in the last five years.

**We've grown activity:**
+1.5% Patient visits and procedures
+5.76% A&E attendances

**We've grown our workforce:**
+6.55% In overall staff numbers
+7.77% Whole time equivalent



**We've cut infection:**
-72.3% C-diff infection cases
-75% MRSA infection cases

We've consistently met our quality and performance targets over the last five years - and improved patient and staff engagement and satisfaction.

- **Patient visits and procedures:**
  2008/09 = 468,450
  2013/14 = 475,484

  **A&E attendances:**
  2008/09 = 96,666
  2013/14 = 102,234

- **Staff in post 2009** = 3940
  (3168 whole time equivalent)

  **Staff in post March 2014** = 4198
  (3414 whole time equivalent)

- **C-diff infection cases:**
  2008/09 = 112 2013/14 = 31

  **MRSA infection cases:**
  2008/09 = 12 2013/14 = 3

We now need to look to the next five years...

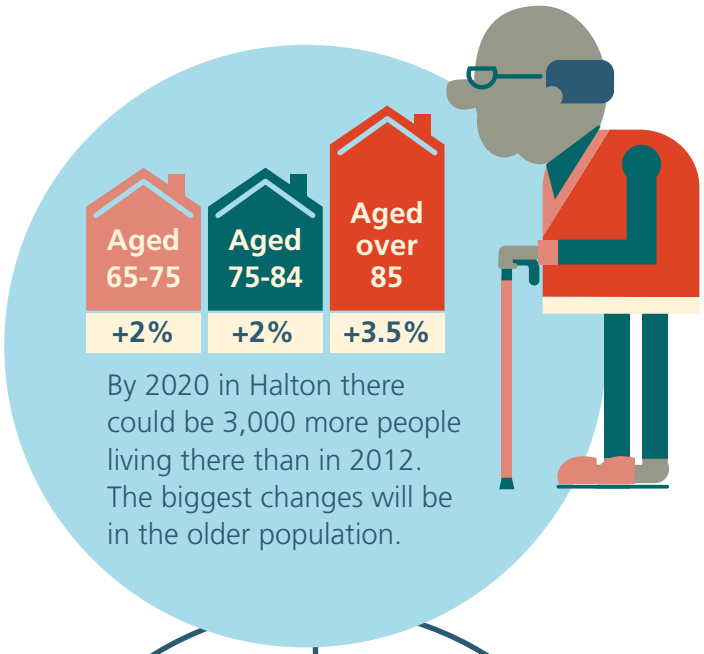
# Context - The changing health landscape

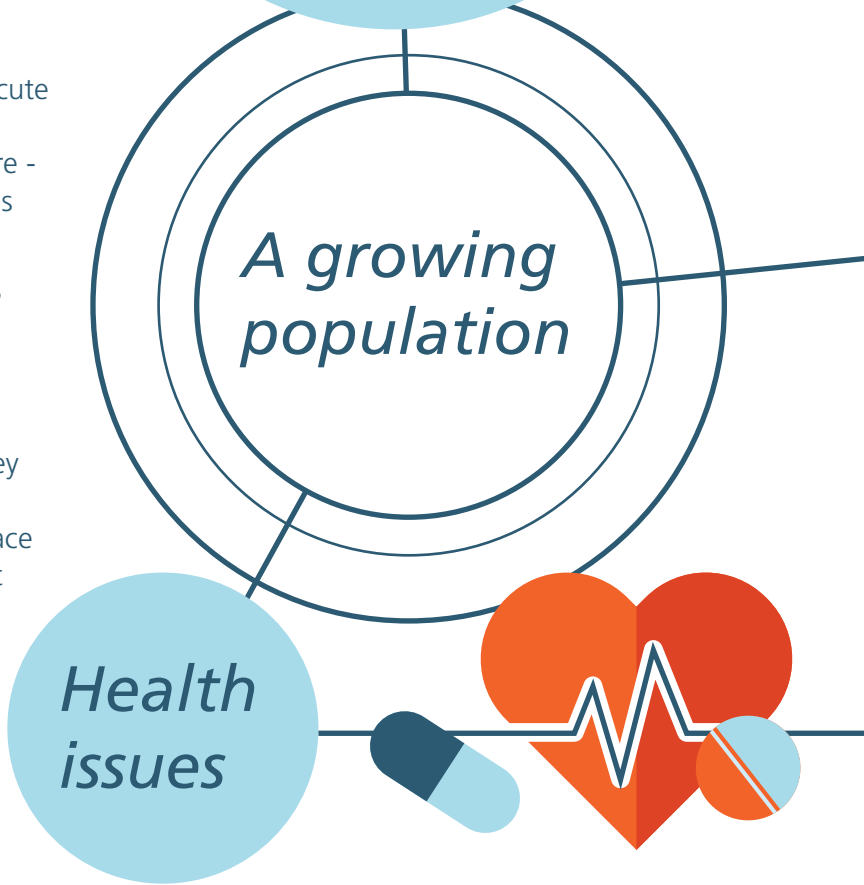
At all levels within the NHS today significant challenges are being faced. The provision of services in the UK is coming under unprecedented pressure and despite improvements the current system delivery needs to change to meet the needs of the 21st century.

The main drivers for change are:

- demand for healthcare, in particular acute services, is increasing;
- there are wide and unacceptable variations in care across hospitals in England;
- there is a growing body of opinion that services should be centralised where necessary;
- as a consequence of the increase in demand for acute services and the variation in patient outcomes the workforce is coming under unprecedented pressure - hospitals alone cannot deliver the healthcare needs of the modern population;
- the scale of the financial challenge facing the NHS means that individual hospitals simply increasing their productivity is not the whole solution.

Overall, these challenges mean that local hospitals will have to think differently about what services they provide in what locations and how. The situation in Warrington and Halton is no different, but it does face some unique challenges and could therefore benefit from a variety of opportunities.

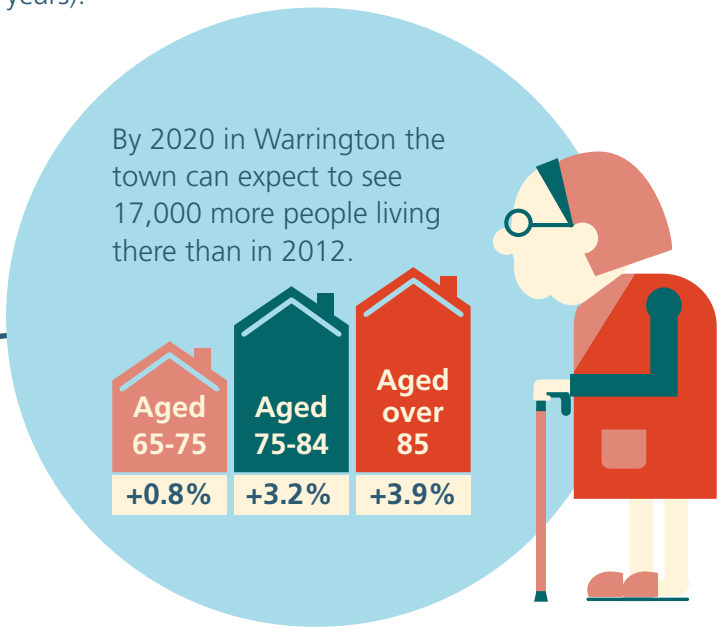


> *We must radically review the organisation of hospital care if the health service is to meet the needs of patients... this will require service reconfiguration. Decisions about service redesign must be clinically led.*
>
> Royal College of Physicians

## The scale of our financial challenge

Over the past year we have been assessing the financial challenge in the coming years and identifying potential options for further productivity gain and service transformation in order to reduce the cost base at the same time as delivering on quality and safety - a key feature of the Francis Report. This analysis has indicated that the scale of the challenge is equivalent to annual savings of around £11m (around c£56m over the next five years).




## National drivers to improve quality of care

The Francis Report is the final report into the quality of care provided by Mid Staffordshire NHS Foundation Trust. The report's chair, Robert Francis QC, concluded that patients were routinely neglected by a trust too focused on financial targets, so much so that it lost sight of its responsibility to provide safe care. The report contains 290 recommendations which have implications for all levels of the health service and all who work in the NHS.

Many of the recommendations following the Francis, Berwick, & Keogh reports that define quality care as providing patient safety, patient experience, and effectiveness of care, are already in the process of being implemented by us locally.

We have been keen to use these reports as a springboard to providing better quality care and a number of themes have stimulated planned action in the key areas of:

- A focus on a culture of caring
- Improving leadership
- Communication with patients.

Our area has a higher prevalence of Coronary Heart Disease, Dementia, Depression, Chronic Kidney Disease, Hospital readmissions within 30 days (65yrs+) and Admissions to residential care from hospital (65yrs+).

It also has poor health outcomes including mortality from cancer and cardiovascular disease, emergency admissions of alcohol related liver disease, a high proportion of people feeling supported to manage their condition and unplanned hospitalisation.

# Our key challenges and opportunities

## Collaboration opportunities

### Working with partner organisations

- Serving a population of 313,000 we operate on the lower end of the ideal scale for a full range of District General Hospital services which nationally is seen as a 450,000 - 500,000 population base. The trust is also surrounded by trusts serving population sizes of similar size so there are opportunities to collaborate to provide services.
- Increasing subspecialisation and reductions in junior doctor staffing rotas will be challenging for us as well as for the other trusts. The scale of activity for some of our specialties and neighbouring trusts is in the lower quartile when compared to trusts across the country.
- The clinical viability of providing all of the services that we currently provide is questionable due to the smaller population size that we serve so collaboration is essential to keep providing them.

## Productivity opportunities

### Maximising our current potential

- We've already identified a number of ways that we can be more efficient. A focused programme to drive performance in these areas will be executed and form the basis of early years CIP delivery.
- A review of income identified significant variation in a vast range of specialties. A programme of medical productivity will need to be designed and executed, changing our ways of working.
- The scale of possible internal productivity gains is between £5.9m and £20m but no more.

## Growth opportunities

### Developing our services

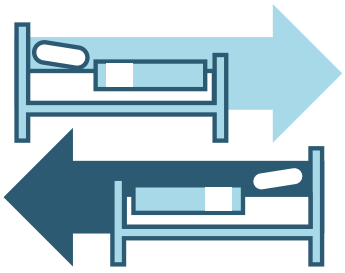
- There are a number of core business opportunities open to the trust (that will support the reduction in the cost base and deliver income generation and which we can implement ourselves) including:

**1 Site reconfiguration**

Using our two hospital sites in the best possible way to be more efficient.

**2 A new model of ambulatory care**

Reducing the need to admit patients from A&E to hospital.



**3 A new model for complex discharges**

Ensuring that our beds are not blocked by patients who have completed their hospital care but cannot go home as they are waiting for community care packages.

**4 Service expansion**

Growing our services in key areas - service wise and geographically.

# *In context - How we're responding*

With the national context in mind, our five year strategy is based around meeting nine clear challenges that have been identified through our analysis and engagement work.

**1 *PROVIDING SUSTAINABLE, HIGH QUALITY INTEGRATED SERVICES***
We will develop sustainable clinical services which deliver improved care in terms of clinical effectiveness, patient safety and patient experience.

**2 *SUPPORTING DEVELOPMENT OF INTEGRATED CARE***
We will play a key role in supporting the design, development & integration of primary (GP led), acute (hospital based), community and social services led care to provide a seamless service for our patients.

**3 *BRINGING CARE CLOSER TO HOME FOR PATIENTS***
We will support the local health community in providing care closer to home for the patients of Warrington, Halton and neighbouring areas.

**4 *PROVIDING GOOD ACCESS TO CARE THAT IS NEEDED***
We will deliver the level of access to our services, and level of clinical activity, that meets the expectations of our patients and as required by our commissioners.

**5 *DELIVERING FINANCIAL SUSTAINABILITY***
We will deliver the range of services within agreed financial boundaries, whilst supporting the development of the Better Care Fund.

**6 *TRANSFORMING USE OF OUR ESTATES AND TECHNOLOGY***
We will deliver major site infrastructure changes and utilise information technology led transformational change and support increased use of telemedicine to reduce admissions to hospital.

**7 *JOINT WORKING ACROSS SERVICES***
We will work with partners to develop a truly integrated service with single points of contact to signpost patients to the most appropriate service/location.

**8 *CHANGING CULTURE***
We will embed a culture of true staff engagement and involvement in clinical decision making.

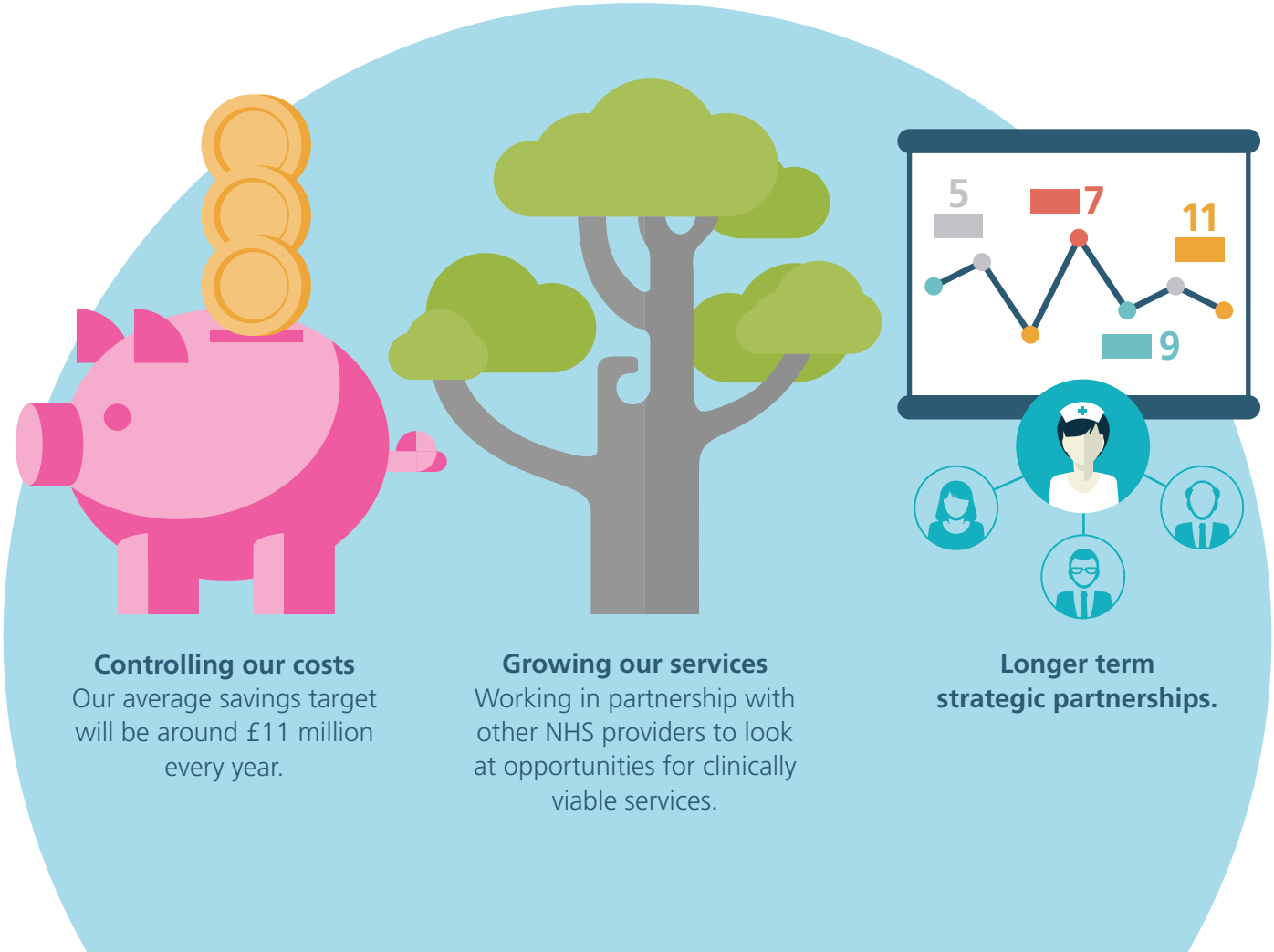
**9 *MAKING SEVEN DAY SERVICES A REALITY***
We will embed seven-day services into the culture of the organisation and in the service models being developed as part of our Clinical Services Strategy.

# What you will see - Services in focus

We need to deliver three core things: transformed and modern urgent and emergency healthcare; modern and excellent elective healthcare; and increasing amounts of community based care.

We will need to take three steps to deliver these outcomes over the next five years and our strategy is structured to reflect these three steps:

1. **A sustainability and transformation programme** focused on ensuring a return to profitability and improved efficiency over years 1 and 2 by improving our productivity, controlling costs more effectively, improving our estate, modernising our information technology and bringing back activity to the trust from other hospitals wherever possible. This will happen over the full five years life of this strategic plan with the early years work enabling further development and modernisation.
2. **A modernisation programme** which encompasses modest service level growth, growing levels of collaboration and - where appropriate - integration with other healthcare providers on particular services.
3. **A strategic change programme** to deliver stability beyond year 5, which includes the development of a range of strategic partnerships.




**Controlling our costs**
Our average savings target will be around £11 million every year.

**Growing our services**
Working in partnership with other NHS providers to look at opportunities for clinically viable services.

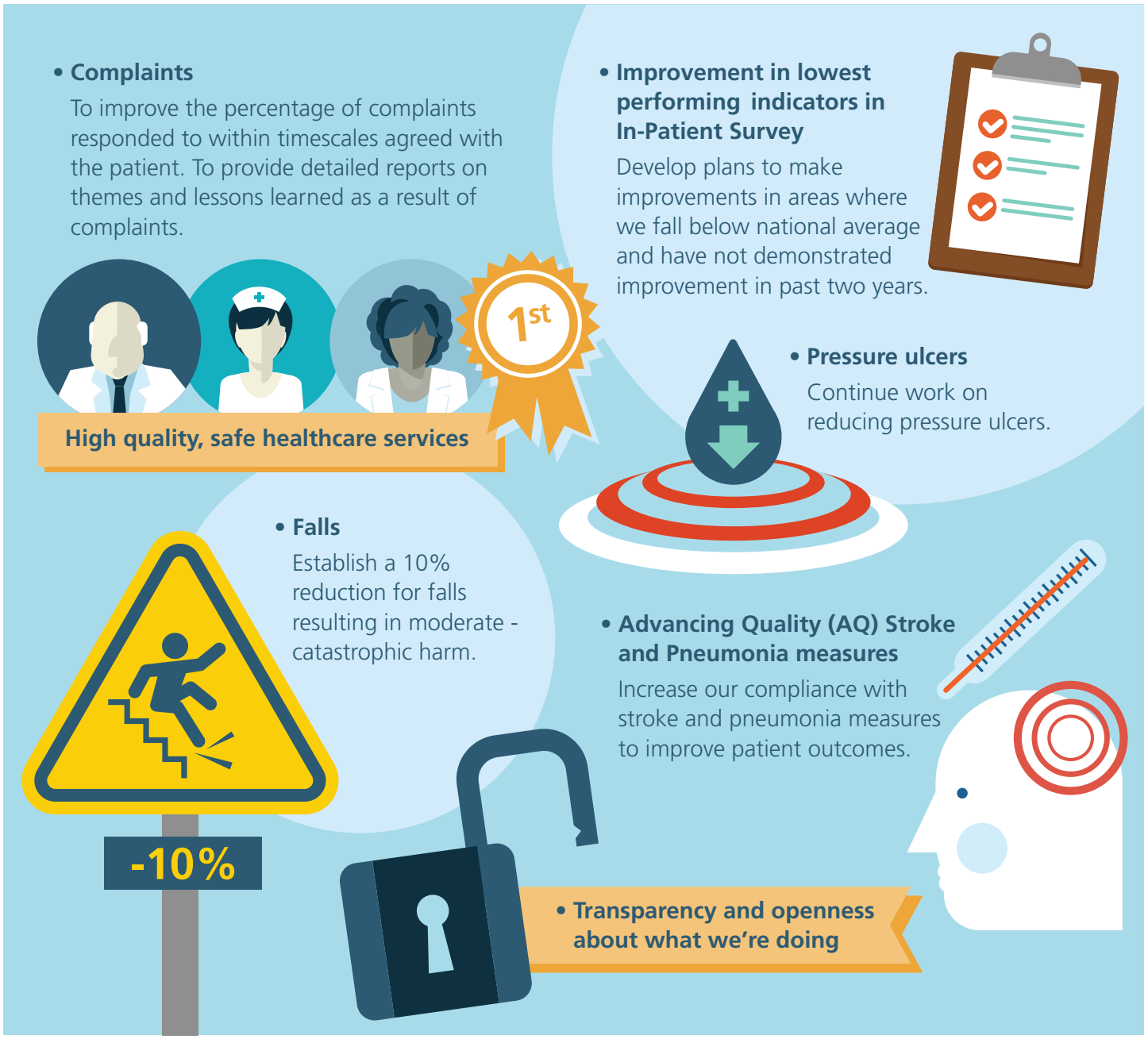
**Longer term strategic partnerships.**

# Quality in focus

Our quality strategy focuses on three core components: delivering a safe organisation; a clinically effective organisation; and an excellent quality of experience for our patients.

Each year we identify a series of quality improvement priorities that are developed in partnership with our governors and other stakeholders. These are published, and reported on, in our annual quality account.

Our quality improvement priorities are reviewed every year. For the current year they are:



# What you will see - Facilities in focus

Over the next five years we will begin the process of further modernising our estate. The aim is to ensure that our healthcare services are provided in modern, fit for purpose accommodation.

The critical building works between 2015 and 2017 involve the demolition and re-provision of facilities between the Warrington and Halton sites to generate efficiencies and savings and improve conditions and environment to enable more strategic future site use.

This will see Warrington emerge as the emergency (hot) site and Halton becoming a day case and surgical centre (cold site).

## The next two years

Years 1 and 2 of our programme will involve:

- The demolition and removal of facilities at Warrington including Cheshire House, Daresbury, Kendrick and residential accommodation.
- In order to do this there will be a focus on the provision and construction of new facilities at Warrington for administrative services (so we can clear the older inefficient hospital buildings), to provide new accommodation for our stores and catering facilities and facilities management and complete a flagship development of a new centre of excellence for Ophthalmology on both the Warrington and Halton sites.
- This will be complemented at Halton by minor works to make land available for future long term development of new facilities on that site.


## Looking further ahead

Our longer term plans will focus on the development of the Halton site which will modernise and improve facilities and services whilst also rationalising site usage and enable a reduction in running costs.

This will in turn lead to the creation of an elective and day case flagship centre for the region.

# Technology in focus

Our Information Management and Technology strategy is a key part of our strategic plan over the next five years. Effective use of IT can support all elements of our plan - from new ways of working and efficiency through to improving quality.

It is aimed at providing services that are focussed on improving staff access to patient information and supporting speedier and more effective decision making. We have three key priorities:

- **Connecting people:** with information as we move from PCs to Tablets.
- **Consolidating and optimising current systems:** with new ways of working and investing benefits to reduce our costs.
- **Move to paperless**: by implementing an electronic patient record to replace paper with electronic notes to support high quality care.

## What are hot and cold sites?

Many hospital trusts based over two sites try and focus emergency work (hot) on one site and planned, routine surgical work (cold) on the other.

The main benefits of this are being able to group your expert staff together in one place (e.g. emergency doctors working together as a team at the hot site) and reducing the number of operation cancellations as routine surgery at the cold site is not impacted by emergency work which can sometimes take priority.

## The next two years

Our major developments over the next two years will include the following:

- New integrated Patient Administration System (Lorenzo) and an integrated electronic patient care record.
- Introduction of iBleep - electronic bleep systems to summon medical staff.
- Introduction of wireless mobile devices and electronic document management systems.
- Development of care co-ordination systems.
- Introduction of e-rostering system for all areas.
- Introduction and development of patient web access technology and systems.
- Introduction of e-Prescription connectivity.
- Delivery of electronic medicines management systems.
- Reducing paperwork and moving to a paperless hospital.

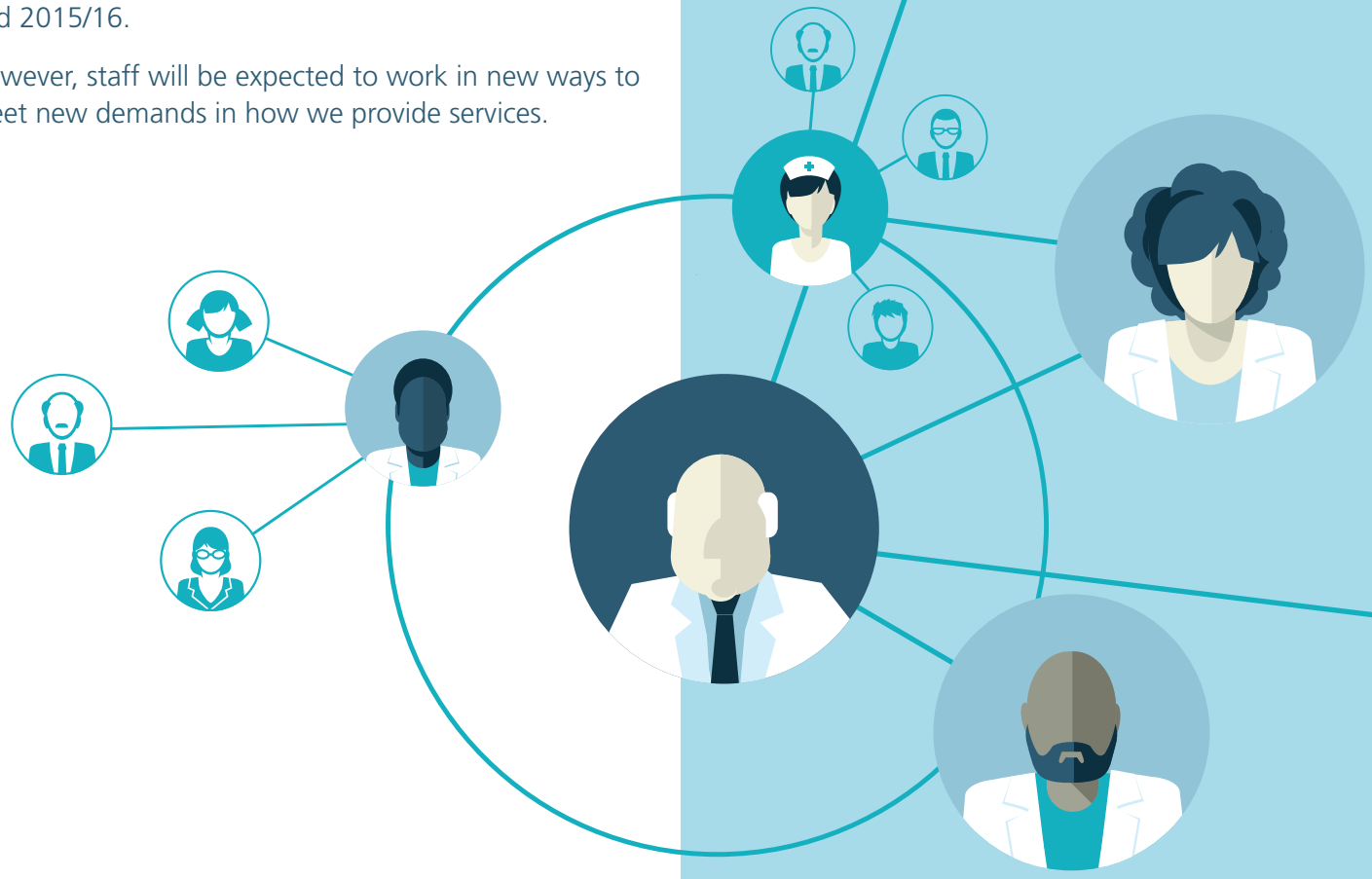
# What you will see - Workforce in focus

Our strategic people plan is designed to support the achievement of the nine objectives for the hospital. It specifically underpins the achievement of delivering sustainable, appropriate and high performing services for our patients and communities, supporting and developing our workforce, and is underpinned by the vision of having a truly engaged workforce.

We anticipate that the number of staff in the trust will remain relatively stable over the five year period although small changes will happen as a result of efficiency initiatives across the trust as we introduce new ways of working and new technology in 2014/15 and 2015/16.

However, staff will be expected to work in new ways to meet new demands in how we provide services.

## Over the next five years:

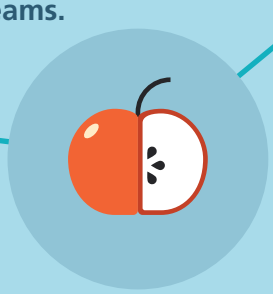


## Developing our leaders for the future

- We will be developing our leaders through a variety of routes, right through from the tools and training that we give to managers in their first appointment leading a team, through to more formal development for middle and senior managers which will enable them to motivate and engage their teams.
- Our workforce planning will become more sophisticated over the next five years to take account of significant changes across the health and social care system.
- Taking account of changes such as the provision of more seven day services, person centred care and a more integrated approach to patient pathways will present challenges in relation to supply of people with the right skills. This coupled with funding, education and commissioning challenges will mean we have to look at new workforce models for the delivery of care, often in partnership with other organisations.
- We have an on-going need to provide a level of education and learning support to all colleagues to enable them to do their jobs effectively.
- We will increasingly make demands on all staff in relation to new ways of working, technology and changes to care pathways and we will need to ensure that our education and learning plans take account of all of this.
- We have developed a health and wellbeing strategy and will be developing a plan for each year to include specific initiatives that will encourage people to take responsibility for their own health and wellbeing as well as support that we can provide as a Trust.

**Sophisticated workforce planning for the future.**

**Health and wellbeing for staff - looking after our teams.**



**New models of delivering care 7 days a week and in the community - possible joint roles with the community.**

# Summary

**Creating tomorrow's healthcare today is about taking Warrington and Halton Hospitals NHS Foundation Trust forward over the next five years.**

We believe we have a strong future and are in a position to meet the challenges faced by the health service and the wider public sector during this time.

This won't be easy but this plan has set out what you will see from our hospitals in this time. There is a focus on continually improving quality of our care, embracing new ways of working to grow our services and an investment in the key things that will make this happen - new buildings, state-of-the-art information technology and developing our workforce.

***We have a unique opportunity to redesign the district general hospital of the future at Warrington and Halton Hospitals.*** It's going to be an exciting and challenging period.

We want our patients, members, public, staff and wider stakeholders to understand our plans moving forward. We want these groups to work with us on developing them further. In 2015 will be asking more formally for people's ideas on what they want from their local hospitals so we can do that.

We hope you are excited and encouraged by our plan and that together we can work to create tomorrow's healthcare today at Warrington and Halton Hospitals.

# Glossary

***Acute services***
Where the patient requires treatment for an episode of illness or in an emergency that usually requires a hospital stay.

***Advancing Quality***
AQ is a programme that defines best practice care in key conditions and measures if a patient has been given that care.

***Ambulatory care***
A patient focused service where some acute conditions can be treated without admission to hospital.

***Better Care Fund***
A joint budget for health and social care.

***CIP***
Cost Improvement Programme, a hospitals overall plan to save money through efficiencies and new ways of working each year.

***Cold site***
A hospital site focusing on routine, non-emergency care, often surgical.

***Commissioners/Clinical Commissioning Groups***
The bodies run by local general practitioners (GPs) and healthcare professionals who run primary care services. They hold the budget for the majority of health care locally and then commission health services from hospitals.

***District General Hospital***
The NHS term used to describe non-specialist general hospitals like ours.

***Hot site***
A hospital site providing emergency and urgent care.

***IM&T***
Information Management and Technology, the use of technology and information in the hospitals to support care and administration.

***NHS Choices***
The national NHS website with information about all NHS services

***Patient Administration System***
The PAS is the central computer system for managing patient records and information in the hospital.

***Staff in Post***
The total number of individual people employed by the hospital.

***Whole Time Equivalents***
The number of staff if part time roles are merged (e.g. two part time staff in post may be counted as one whole time equivalent).

# Further reading and useful links

Our website **www.whh.nhs.uk/letscreate** has a range of further information on our strategy and updates on our progress. You can also find out a lot more about the trust and the people who work for us on the website.

# Contacting us

We really want to hear your comments and ideas about our future plans and what we want to do. Drop us a line at:

- Email - **letscreate@whh.nhs.uk**
- Phone - **01925 664222**

Warrington and Halton Hospitals NHS Foundation Trust
Warrington Hospital
Lovely Lane
Warrington WA5 1QG

letscreate@whh.nhs.uk

*Creating tomorrow's healthcare today*

# Creating Tomorrow's Healthcare Today

Warrington and Halton Hospitals NHS
NHS Foundation Trust

*Our vision is to be the most clinically and financially successful integrated healthcare provider in the mid-Mersey region*



## Aims

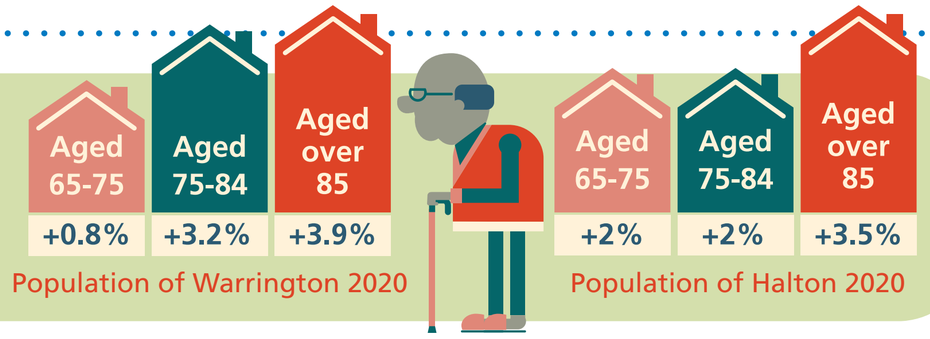
### Quality
- Reduce risk
- Improve outcomes
- Patient focus

### People
- The right team
- An exemplary employer
- Reward talent

### Sustainability
- Responsible leadership
- Effective use of resources
- A good corporate citizen

## Why change?

### Increased demand
- More older people
- Growth in emergency admissions of up to 23% predicted by 2023




### Financial pressure
- Need to save £53m over 5 years…while improving the quality of care


## How we do it

### Transformation
- Increase productivity
- Control costs (*£11m per year*)
- Improve estate

### Modernisation
- Develop IT
- Service Level growth
- More collaboration

### Strategic change
- Develop partnerships
- Delivering services in new ways (*Warrington Healthcare +*)

## Tools

### Workforce
- Developing our leaders
- Delivering new ways of working
- Looking after our staff

### Estates
- Demolish older buildings
- Create new Healthcare Environments
- Develop flagship elective surgery centre

### Technology
- Tablet technology for improved communication
- Optimising current systems to reduce costs
- Paperless records to improve patient care

## Quality Outcomes

**Clinical effectiveness**

**A safe organisation**

**Excellent patient experience**

High Quality, Safe Healthcare
Quality People Sustainability

High Quality, Safe Healthcare
Quality People Sustainability

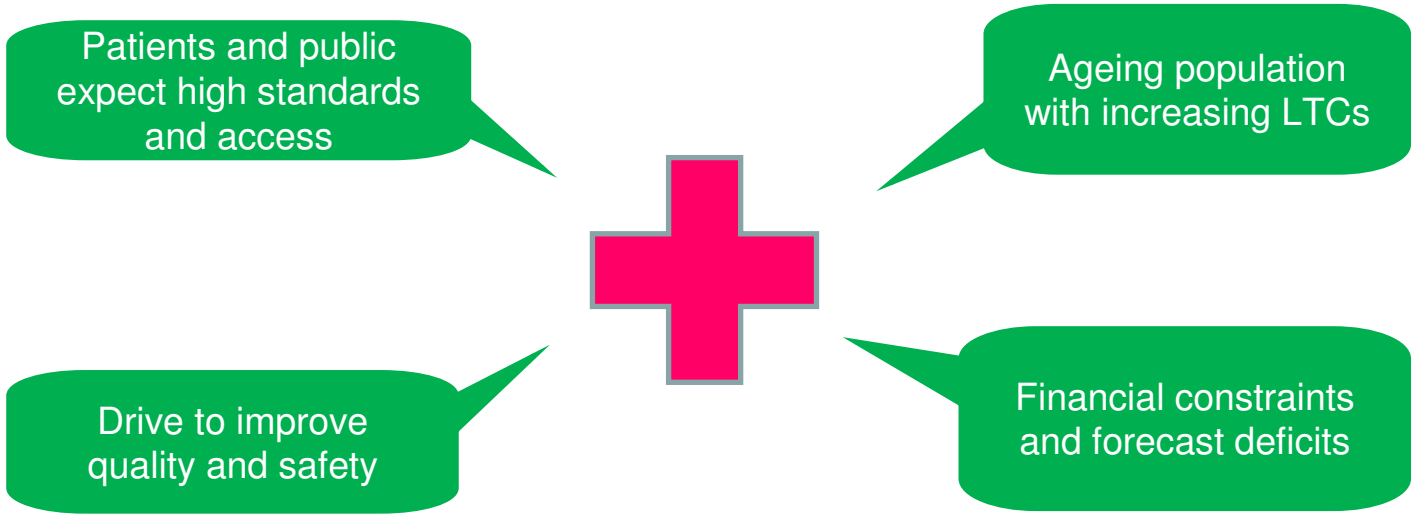
Warrington and Halton Hospitals NHS
NHS Foundation Trust

# Creating tomorrow's healthcare today

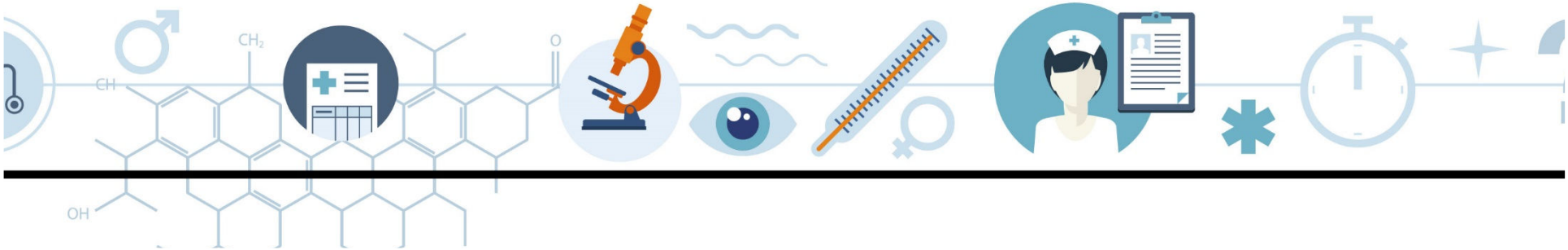
## Mel Pickup, Chief Executive

**13th January 2015**

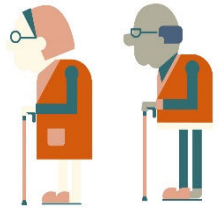
# National forces affecting healthcare



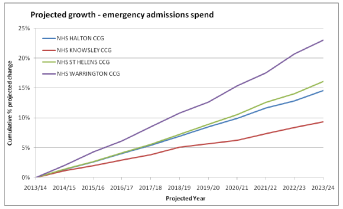

- Recognised that NHS providers need **flexibility** to work in new and innovative ways to improve **quality** and become more **efficient**
- Commitment that there will not be a single national solution – there needs to be a **range** of solutions to apply to different situations
- Solutions must come from organisations themselves but can be **enabled** by the centre



# Local forces affecting healthcare



Population is changing locally. Fastest growing town in England

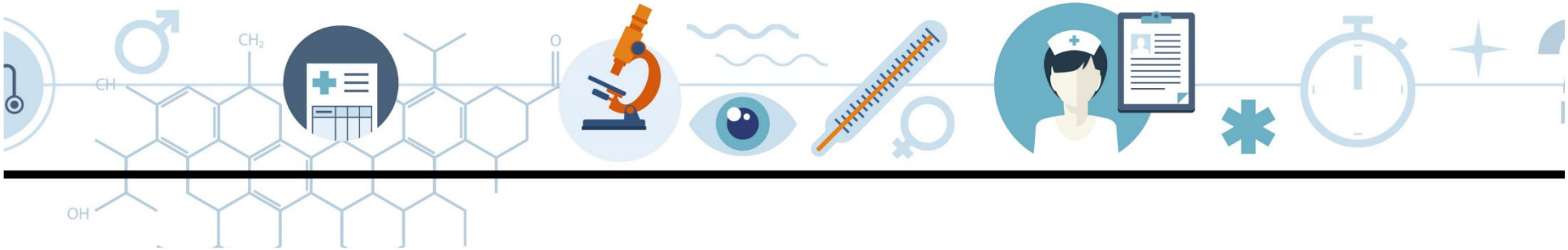



Do nothing will create 23% rise in emergency admissions by 2023

Commissioners seeking to shift activity between sectors – primary care home model; Better Care Fund


No let up on delivery of safety and quality obligations

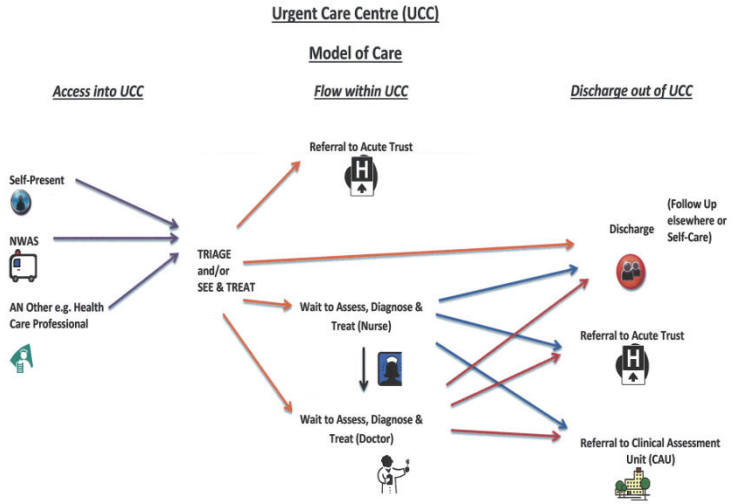
Significant but achievable CIP for us



# The commissioner response

*Integrated, joined-up care with better outcomes and more out of hospital*

- Urgent Care Centres in Halton
- Care co-ordination around the individual with delivery through integrated teams wrapped around the person
- Individually tailored response whether from health, social care or third sector services
- Redesigning primary care access to enable 7 day GP access same day appointments
- Reduce inappropriate A&E attendances by 15% and admissions also (Better Care Fund)
- Emergency activity closer to home, with increasing diagnostic activity in urgent care centres



# Our vision

*Organised through our Quality, People, Sustainability strategic framework*

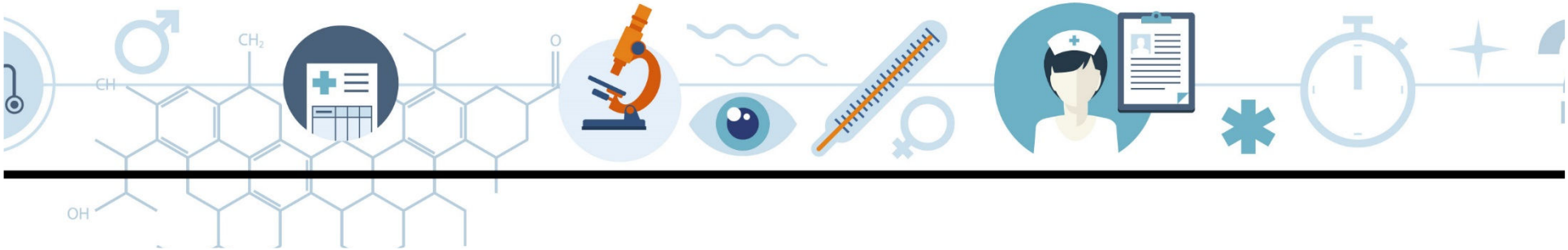
We will become the most clinically and financially successful integrated healthcare provider in the mid-Mersey region

This '**QPS**' framework describes the underpinning framework for everything that we do

# Route to Sustainability – 5 years

| WHHFT | 14/15 Forecast | 15/16 Plan | 16/17 Plan | 17/18 Plan | 18/19 Plan |
|---|---|---|---|---|---|
| | £m | £m | £m | £m | £m |
| 5 year plan (Deficit)/Surplus | (5.9) | (1.0) | 0 | 1 | 2 |
| CIP (required to deliver) | 8.1 | 11.5 | 9.5 | 10 | 9.5 |

- 14/15 is Trust latest forecast, years 2 to 5 are from our Monitor strategy plan
- CIP's required to deliver surplus represent over 5% of Annual Revenue
- Plan assumes significant savings from cost control, Estates rationalisation and IM&T programmes, innovation and sharing services across wider Provider footprint



# Transformational programme

*Ensuring profitability and efficiency today to enable major development tomorrow*

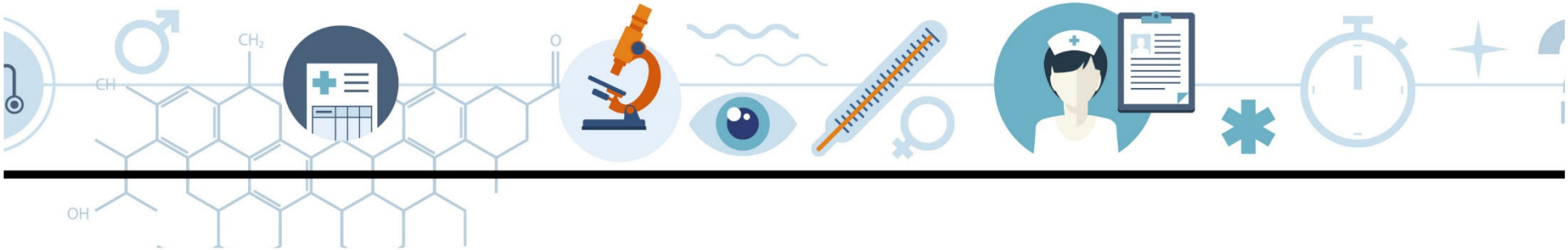
Controlling costs more effectively

Improving our estate and physical infrastructure

Improving our productivity


Modernising our IM&T platforms

Repatriating activity wherever possible



# Modernisation programme

*Future proofing and improving services today to enable strategic change tomorrow*

Service level improvements which will extend our pathway management out into community setting whilst also generate income or efficiencies

Growth into new territories, or through new service development of through new partnerships of mutual benefit with other providers

Collaboration and integration opportunities which will open up new avenues for revenue stability or clinical stability

High Quality, Safe Healthcare
Quality People Sustainability

Warrington and Halton Hospitals NHS
NHS Foundation Trust

# Our enabling strategies

# Quality

*Improving quality today to ensure we are here tomorrow*

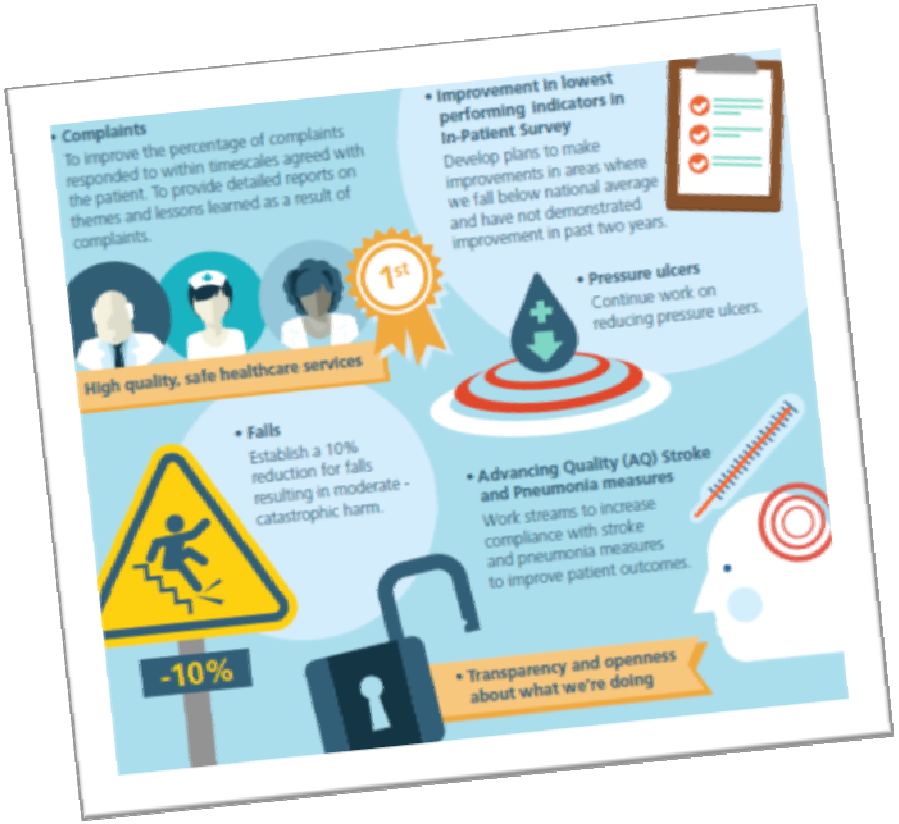
- Our quality strategy focuses on three core components:

    1. Delivering safe services
    2. Delivering clinically effective services; and
    3. Ensuring an excellent experience for our patients

- We have again identified a series of quality improvement priorities

- They have been developed in partnership with our governors and other stakeholders

- We intend to continue embedding into our annual planning cycles

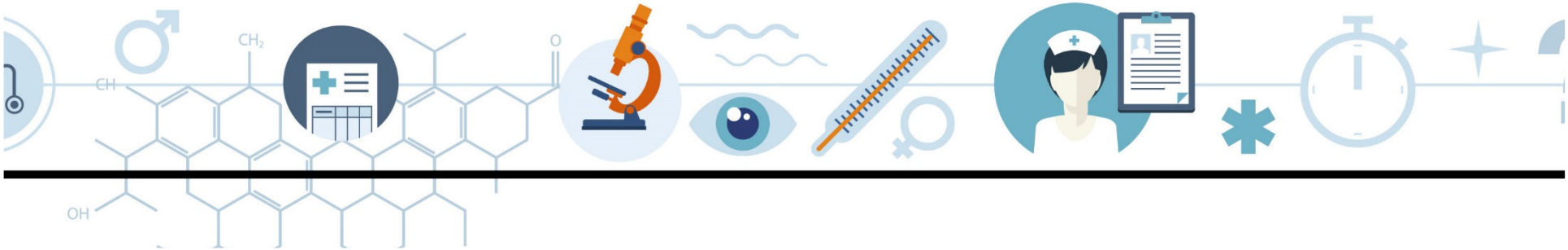


# Estate and facilities

*Creating new environments for tomorrow's healthcare needs*

- Two year (immediate) focus
  - Warrington - demolition and removal of various buildings including Kendrick, Cheshire and Daresbury houses
  - Halton – minor site works to enable future development

- Looking further ahead
  - Potential major development at Halton to enable further modernisation of services
  - Halton as a flagship day case surgical centre and a major healthcare hub



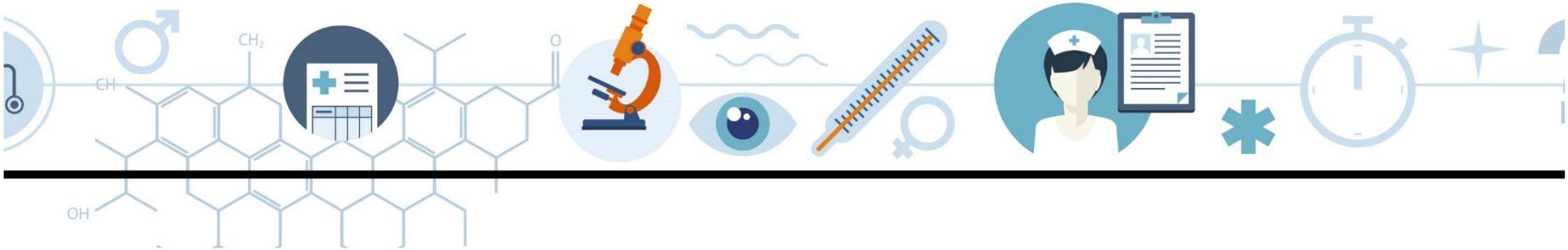
# Technology

*Developing new technologies today to support tomorrow's healthcare*

- We have 3 core priorities:
  - **Connecting people**: with information as we move from PCs to Tablets
  - **Consolidating and optimising current systems**: with new ways of working and investing benefits to reduce our costs
  - **Move to paperless environemtrn**: by implementing an electronic patient record to replace paper with electronic notes to support high quality care.

Over the next 2 years we will deliver 9 programme:

1. New integrated Patient Administration System (Lorenzo) and an integrated electronic patient care record
2. Introduction of iBleep - electronic bleep systems to summon medical staff
3. Introduction of wireless mobile devices and electronic document management systems
4. Development of care co-ordination systems
5. Introduction of e-rostering system for all areas
6. Introduction and development of patient web access technology and systems
7. Introduction of e-Prescription connectivity
8. Delivery of electronic medicines management systems
9. Reducing paperwork and moving to a paperless hospital

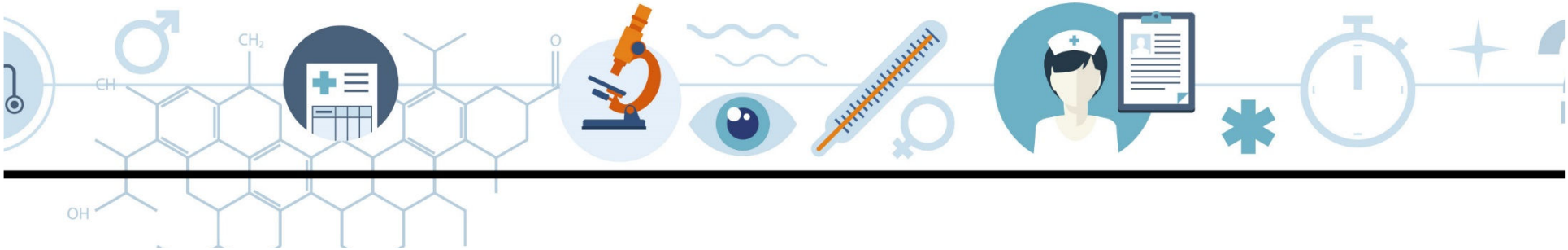


# Workforce

*Investing in our staff and skills today so that tomorrow's workforce is ready*

**Our 5 Priorities**

- To develop effective leadership capability throughout the Trust
- To have the right people with the right skills in the right place at the right time and cost
- To equip all staff with the skills, knowledge and behaviours required for their current role, and future career, to support the delivery of safe, effective, high quality care and services
- To provide an environment that helps all our people work effectively
- To support the health & wellbeing of colleagues



# Summary

*Creating tomorrow's healthcare today*

Quality → **Excellence for patients**

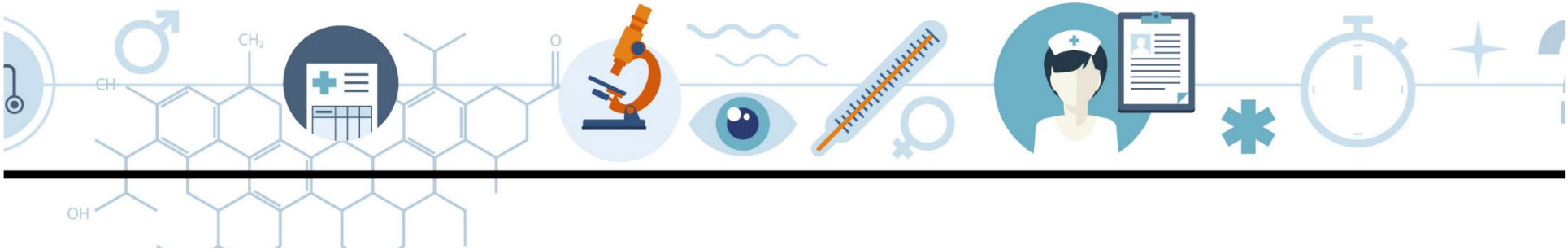
Through safety, effectiveness and providing a good experience

People → **Caring for our staff**

Through leading, engaging and developing staff.

Sustainability → **Here for our community**

Through good governance, financial viability and developing services.



# Creating Tomorrow's Healthcare Today

Warrington and Halton Hospitals NHS
NHS Foundation Trust

*Our vision is to be the most clinically and financially successful integrated healthcare provider in the mid-Mersey region*

## Aims

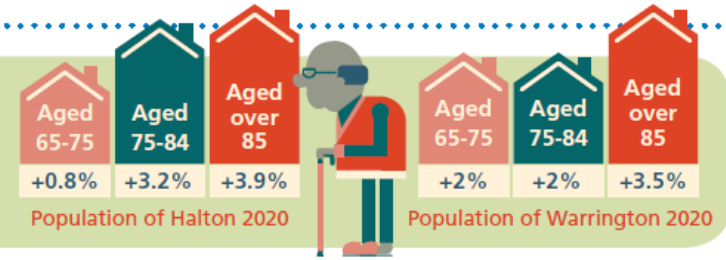
### Quality
- Reduce risk
- Improve outcomes
- Patient focus

### People
- The right team
- An exemplary employer
- Reward talent

### Sustainability
- Responsible leadership
- Effective use of resources
- A good corporate citizen

## Why change?

### Increased demand
- More older people
- Growth in emergency admissions of up to 23% predicted by 2023




### Financial pressure
- Need to save £53m over 5 years…while improving the quality of care


## How we do it

### Transformation
- Increase productivity
- Control costs (*£11m per year*)
- Improve estate

### Modernisation
- Develop IT
- Service Level growth
- More collaboration

### Strategic change
- Develop partnerships
- Delivering services in new ways (*Warrington Healthcare +*)

## Tools

### Workforce
- Developing our leaders
- Delivering new ways of working
- Looking after our staff

### Estates
- Demolish older buildings
- Create new Healthcare Environments
- Develop flagship elective surgery centre

### Technology
- Tablet technology for improved communication
- Optimising current systems to reduce costs
- Paperless records to improve patient care

## Quality Outcomes

- Clinical effectiveness
- A safe organisation
- Excellent patient experience

High Quality, Safe Healthcare
Quality People Sustainability

High Quality, Safe Healthcare
Quality People Sustainability

Warrington and Halton Hospitals NHS
NHS Foundation Trust

# Questions?

**REPORT TO:** Health Policy & Performance Board

**DATE:** 13th January 2015

**REPORTING OFFICER:** Strategic Director, Communities

**PORTFOLIO:** Health & Wellbeing

**SUBJECT:** GP Access & Out of Hours Provision

**WARD(S)** Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To present to the Health Policy & Performance Board the Healthwatch report on 'GP Access & Out of Hours Provision'

2.0 **RECOMMENDATION: That the Board Note the contents of the report and associated Appendix.**

3.0 **SUPPORTING INFORMATION**

3.1 Healthwatch Halton is the consumer champion for health and social care in Halton. Its purpose is to understand the needs, experiences and concerns of people who use health and social care services and to ensure their voices are heard and responded to.

From the launch of Healthwatch in April 2013 one of the main issues raised by local people was around the difficulties accessing local GP services. Having made note of the findings from the local feedback and the from national surveys it was decided that a Healthwatch Task and Finish group should be set up to look at 'Access to GP Services and Out of Hours GP Provision' across Halton.

A public survey was launched by Healthwatch Halton at the end of March 2014 and ran until the end June 2014. In total 491 surveys were completed with received responses covering all GP practices in Halton.

A number of recommendations have been put forward in the report produced by the Healthwatch Halton Task & Finish group. This report has now been sent to Halton CCG for a formal response to the recommendations, which is due in January 2015.

4.0 **POLICY IMPLICATIONS**

4.1 Not applicable.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 Not applicable.

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

6.1 **Children & Young People in Halton**
In terms of access to health services, please note the recommendations and the positive outcomes if implemented by commissioners.

6.2 **Employment, Learning & Skills in Halton**
None as a result of this report.

6.3 **A Healthy Halton**
If recommendations implemented by commissioners, it will improve access to health services in Halton.

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**

7.1 A lack of consideration of the recommendations could have a negative effect on Halton people accessing health services.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None associated with this report

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

9.1 None under the meaning of the Act

healthwatch Halton

# Healthwatch Halton

## 'GP Access and Out of Hours Provision' Survey 2014

# Contents

healthwatch Halton

## Who are we?

Healthwatch Halton was established under the Health & Social Care Act 2012 and came into existence on 1st April 2013.

Healthwatch Halton is the independent local consumer champion for health and social care services across Halton. We provide an opportunity for local people to have a stronger voice to influence and challenge how health and social are provided locally.

We bring together people's views and experiences of local health and social care services and use this feedback to build a picture of where services are doing well and where they can be improved.

We also provide people with information about the choices they have and what they can do if things go wrong

Nationally the Healthwatch Network is made up of 148 local Healthwatch with Healthwatch England in place to offer leadership, guidance and support to the network.

healthwatch Halton

# National Context

Nationally over 90% of patient contacts within the NHS are carried out in general practice[1] yet easy access to a GP continues to be a concern for a lot of patients.

The number of visits people make to their GP is continuing to rise year on year. Between 1995 and 2008, the number of patient consultations rose by 75%, from 171 million to more than 300 million[2]. From 1995 to 2011 there was only a 33% increase in the number of registered GP's.

When patients cannot get to see a GP because there are no more appointments available that day or the wait will be several weeks, they often resort to attending A&E or a Walk-in-Centre: According to the July 2014 Ipsos MORI GP Patient Satisfaction (GPPS) survey 14% of those who could not get an appointment with their GP in Halton attended A&E or the Walk-in-Centre or instead. Not only is this more costly for the NHS than a visit to the GP, it is also an inappropriate use of these services and puts greater strain on already pressurised services.

According to the Royal College of General Practitioners (RCGP), the number of occasions during which patients have to wait more than a week to see their GP or practice nurse are set to go through the 50m barrier for the first time ever in 2015 following successive rises in previous years: up from 41.9m occasions in 2013 and 46m occasions for this year.

The Royal College of General Practitioners (RCGP) stated: "No GP wants to turn away a single patient – but surgeries are being faced with no choice because they don't have the resources to cope with the increasing number of older people who need complex care, whilst also meeting the needs of families and people of working age.

"The profession has been brought to its knees both by a chronic slump in investment and the fact that there are now simply not enough family doctors to go around."[3]

The RCGP recognise that with the increasing use of technology amongst young people "the traditional face-to-face consultation will no longer be accepted as the 'default' way to access care."

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[1] Royal College of General Practitioners press release, October 2013 http://www.rcgp.org.uk/news/2013/october/patients-bear-brunt-as-gps-reveal-shocking-400m- black-hole.aspx

[2] Royal College of General Practitioners http://www.rcgp.org.uk/policy/rcgp-policy- areas/~/media/Files/Policy/A-Z-policy/The-2022-GP-Compendium-of-Evidence.aspx p21

[3] Royal College of General Practitioners press release, July 2014 http://www.rcgp.org.uk/news/2014/july/crisis-hit-gp-surgeries-forced-to-turn-away-millions-of-patients.aspx

In their 2013 policy paper '2022 GP A vision for General Practice in the NHS the RCGP' said "Simply increasing the quantity of face-to-face GP consultations alone will not be a cost-effective or sustainable strategy for achieving increased capacity and meeting growing demand, especially given the need to provide longer consultations to patients with more complex needs. The GP of the future will need to be skilled in using a suite of new and flexible tools for communicating with patients, including telephone, email and various online forms of consultation. This will include online group discussions, where appropriate, for example, patients with long-term conditions where peer-to-peer support and shared experience can be particularly valuable."

# Executive Summary

*'Involve patients in the design of services. It is not rocket science to look at the best customer service in the outside world and apply those lessons across the NHS'*[4]

# Introduction

From the start of Healthwatch Halton in April 2013 one of the main issues we were receiving comments on was access to local GP services.

Having made note of the findings from national surveys and the local feedback we were receiving, it was agreed by our management committee that we set up a task and finish group with the aim of gathering the views of Halton residents on Access to GP Services and the Out of Hours GP Provision.

In undertaking this piece of work and talking with members of the public, as well as community and voluntary sector representatives in the borough, we've identified what has been clear to many for some time - that GP access is currently not meeting the needs of many individuals in our borough. This is a pattern witnessed not just locally, but regionally and nationally.

# Methodology

The survey was launched towards the end of March 2014 and ran until the end of June 2014. It was distributed to over 1200 Healthwatch Halton members either by post, with the newsletter, or electronically via email and the regular Healthwatch Halton E-Bulletin. The survey was also promoted on the Healthwatch Halton website and widely through social media. All GP Patient Participation Groups were sent details of the survey and asked to promote it within their respective practices.

Visits were carried out to a variety of groups and organisations to inform them of the service and give them the opportunity to take part in the service, including the Umbrella Group, SHAP Social inclusion Group, Halton People Health Forum Steering Group and Riverside College students.

A news article promoting the survey was published in the Runcorn & Widnes Weekly News.

491 surveys were completed. 105 surveys were completed online and 386 paper copies returned.

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[4] NHS England – Improving General Practice – A call to action Phase 1 report March 2014 - http://www.england.nhs.uk/wp-content/uploads/2014/03/emerging-findings-rep.pdf

healthwatch Halton

# Summary of Observations and Recommendations

The principle observations and recommendations are stated below. Please refer to the full report for results, observations and recommendations on all questions.

## Observation 1 – Poor Communication

Results show that for certain areas there is a lack of knowledge about the services provided and how they are delivered at the GP Practices.

For example, over a third of people (35%) didn't know if they could speak to a GP or practice Nurse on the telephone if required (Q8). In addition 45% of respondents didn't know if they could request prescriptions online (Q30). While the majority of people knew the opening hours of their practice 23% of respondents were unsure of the opening hours (Q20).

We are aware that many practices already use a variety of different methods to try to inform patients of the services they provide. We believe it would be useful to have a standard model layout for the notice boards in waiting areas showing the details such as opening hours, website address, out of hours procedures, how appointment systems and options for making appointments work etc. This information should be repeated on the practice website and any electronic notice boards in waiting rooms. Information about current wait times and the reasons for any delays could also be added to these displays and notice boards.

## Recommendation 1

That the CCG co-ordinate a short project with the GP Practices to produce some model systems for Notice Systems

Practices to work with their Patient Participation Group to develop the best ways of prominently displaying information within the practice. We would recommend that the Halton CCG look at a small project with the PPG+ Group to develop a 'best practice guide for patient information'. If possible we'd also like to see this information included as a pull out in a future issue of Halton Borough Council's 'Inside Halton' magazine, which is distributed free to all homes in Halton.

## Observation 2 - Triage Systems (Q9 & 9a)

The reasons why practices use triage systems seems not to be widely understood by all patients. Just over half of respondents did not know if their practice used a nurse to triage "Book on the day" appointments. We understand that various triage systems are currently being trialled at the GP practices.

It appears from anecdotal evidence that there may be patient resistance to telephone consultations with GPs and Nurses

## Recommendation 2 (Q9 & 9a)

We recommend that Halton CCG work with the local practices and their Patient Participation Groups to produce a guide / information for patients explaining what triage is, why it is used and how it could benefit both patient and practice. We would like to see the results of the trials of triage systems shared or publicised to show the benefits to the patients/practices.

The necessity for triage by clinical staff, as opposed to reception staff, should also be considered.

We also recommend that GP surgeries and the PPG's should review guidelines for emergency and non-emergency appointment booking. Guidelines should be standardised across the borough so patients understand the system, including how and when to access emergency care appropriately.

## Observation 3 - Single Call Centre (Q13 & Q14)

From the responses received it seems that options for a single call centre in Halton for access to GP services is not a popular one.

Overall 62% of respondents didn't like the idea of a single call centre. Breaking down the response by age group it failed to show majority support for the idea in all but one age group, with the 18-24 age group having a majority in favour (45% Yes to 30% No) of the idea.

It is possible that those surveyed see this option as a means of diverting appointments away from their GP practice. However when faced with an option to visit another practice if their registered practice had no appointment availability the percentage not liking this reduced to 48% (Q14). An influencing factor could be that older people, possibly some with multiple health issues, prefer to see their own doctor or visit the practice they are familiar with. Whereas younger patients may not mind which practice or doctor they visit and access to treatment is their main priority.

## Recommendation 3 (Q13)

Whilst Healthwatch understands the predicted shortage of GPs over the longer term, the general public of Halton may not be aware of this.

If the single call centre option is to proceed, more in depth information showing the key reasons should form part of publicity material. Including consultation with interested parties so that all concerned fully understand the reasoning behind the initiative.

## Observation 4 - General Practice Opening Hours (Q20 & Q21)

62% of Halton patients thought GP practices should be open for longer hours. Of the 62% who chose longer hours, weekend and evening opening were the most popular option. To a lesser degree early mornings and lunch times were preferred.

Additional opening hours, particularly across the larger practices may have a knock on benefit in reductions of attendance at emergency centres, A&E, minor injuries etc.

## Recommendation 4 (Q20 & Q21)

Consideration to be given to longer GP practice opening times. With changing work patterns etc. for many people it isn't always easy to arrange appointments at times to suit. We would like to see research carried out into the options for increased opening hours.

Review GP practice opening hours to ensure that additional opening hours are widely available in the borough, if not uniformly across the borough.

Practices should consult with their patients, possibly through their PPG, to identify popular methods of booking appointments and adopt a variety of the most popular methods so that patients have choice in how they can book an appointment: including in person, by phone, by text and online booking. The particular needs of those, for example with visual impairment or deafness, should be adequately accommodated within these options.

It would also be of a benefit to see a list of opening hours of GP practices, as well as those of the walk-in centre and minor injuries unit, published on a regular basis within the local press.

## Observation 5 - Patient Records (Q26 & Q27)

Patients can be treated outside the boundary of their GP practice, by Out of Hours GP services, and Urgent Care Centres, with the possibility of other GP practices as an option in the review of GP Services. Our survey results show that a large majority, 73% of patients, would like their medical records available anywhere they will be treated in Halton.

## Recommendation 5 (Q26 & Q27)

We recommend that Patient Records are made available across local primary care services.

There may be technical difficulties to overcome to achieve this, however if the treatment routes are to be flexible, access to patient records shows to be very important in the minds of patients.

## Observation 6 - Urgent Care Centres (Q23)

The success of the new Urgent Care Centres in both Widnes and Runcorn can be seen as crucial to providing valuable relief to the A&E departments of local hospitals. Our survey revealed that 61% of participants were not aware of the plans for the new Urgent Care Centres in Halton

## Recommendation 6 (Q23)

Ensure that information on the new centres is made widely available across the borough and in both of our local hospital A&E units, Whiston & Warrington, in time for their opening. Further and/or alternative ways of advertising should be considered to increase public awareness of these improvements in Halton.

A survey of patients attending our local A&E units at Whiston & Warrington Hospitals could be carried out to find out how they ended up at A&E, why they are using it and also to inform them of the new urgent care centres. This could be repeated after 12 months to review the awareness and use of the new centres. (appropriate use etc.,)

## Observation 7 – Complaints (Q33 to Q35)

While our figures show that 66% of people were comfortable in making a complaint if needed that still left 34% who weren't. Research conducted by Healthwatch England[5] has shown that people find the complaints process 'utterly bewildering'. Our results seem to reinforce this.

Almost a third of the people who had made a complaint were not happy with how it was dealt with. Only 20% of people knew what to do next if their initial complaint was not taken seriously.

As Anna Bradley, Chair of Healthwatch England stated[6], "It's no wonder the public are left confused and frustrated. With so many organisations involved it's difficult to know where to start, let alone having the strength and persistence to navigate the system on your own."

## Recommendation 7 (Q33 to Q35)

Almost a third of the people surveyed were not happy with how their complaint - concerning GP services - was dealt with. This level of dissatisfaction would not be tolerated in other organisations/businesses.

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[5] Health & Care complaints system is 'utterly bewildering for people -20th March 2014 - http://www.healthwatch.co.uk/news/health-and-care-complaints-system-utterly-bewildering-people

[6] Health & Care complaints system is 'utterly bewildering for people -20th March 2014 - http://www.healthwatch.co.uk/news/health-and-care-complaints-system-utterly-bewildering-people

Ideally, it should be a straight forward process to raise a complaint with a local service, currently it is anything but.

The complaints process should be simplified. There should be clear information readily available to patients explaining the complaints process, who to contact and how to progress a complaint.

In addition we would like to suggest that training is offered to all relevant staff in complaints handling and customer service to ensure they can offer appropriate help and support to members of the public who wish to raise a complaint.

## Summary

The overall results from our survey show both good and poor aspects of our local services. It is not therefore possible for us to draw conclusions about the individual surgeries, but rather gain a general insight into GP practices across the borough.

When we started the survey, our aim was to gather the views of patients accessing local GP services, find out what worked well for them and see if there was room for improvement.

From the results we can see that people are generally happy with the services provided. However there are some specific areas that could be improved on.

- Better access to appointment bookings, both online and by telephone
- Being able to get through to the surgery on the telephone
- Seeing a GP of choice at a date and time to suit the patient
- The complaints process
- Staff training
- Communication & Information

We believe there are many positives to be taken from this report though we realise it does raise more questions.

Our hope is that Halton residents, Patient Participation Groups and the Halton Health Community, including local GP practices, take on board all the views expressed in our survey and report and work together towards excellent health care.

# Survey Results

491 surveys were completed and of these 472 related to GP surgeries in Halton.

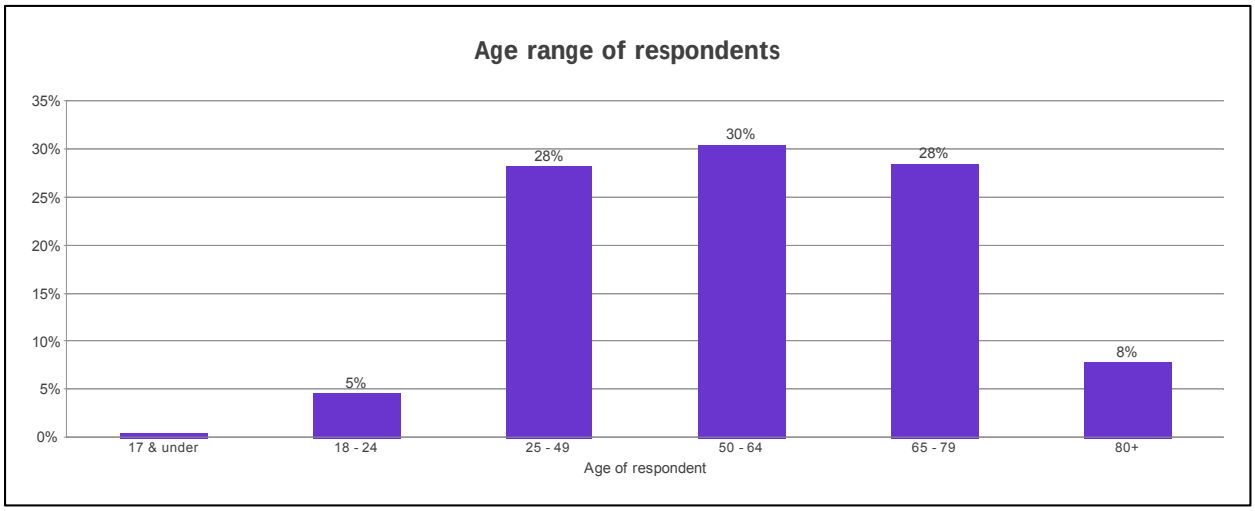
Of the 19 responses where people selected 'other' for their GP Practice, 17 people stated the practice name. 5 people named 'shared' medical centres were there are more than one practice based, i.e. 'St. Paul's' where both Grove House and Tower House practice are based.

The other 12 'other' responses covered GP practices in Liverpool, Frodsham, Northwich, Warrington & Holyhead.

The analysis count varies throughout the report, as not everyone answered every question.

The percentage figures are based on the total number of respondents to each question

**Please Note : Not all graphs and charts will add up to 100% due to rounding up of the statistics**

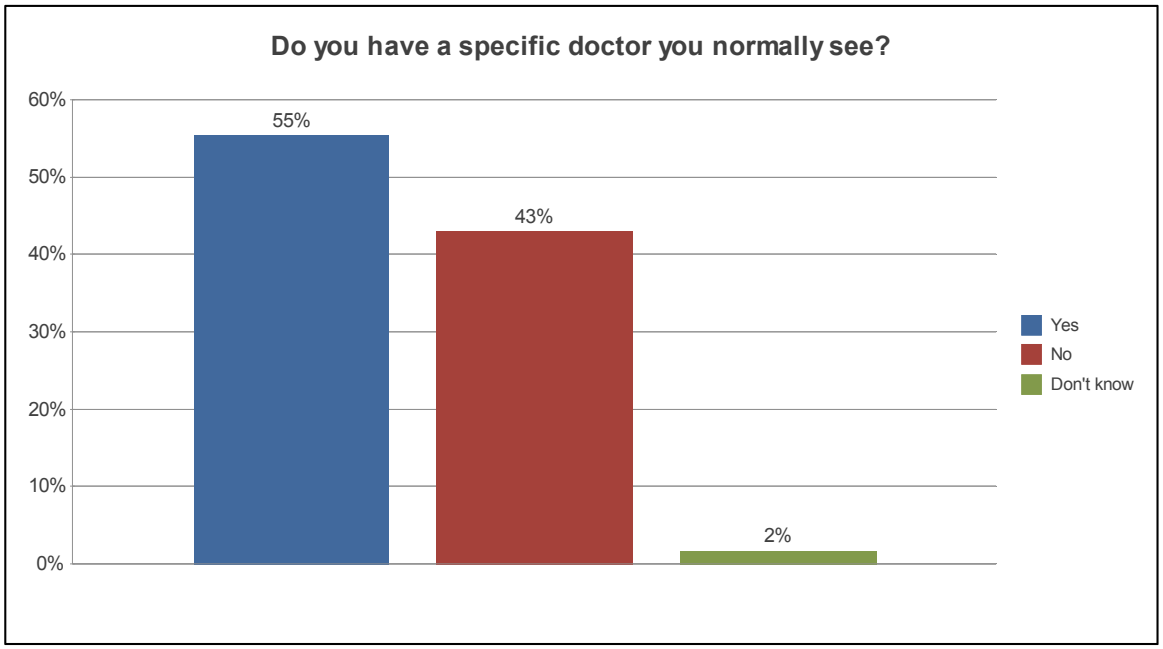


## Q1) Firstly, please tell us the name of your usual GP Practice

Responses were received from patients of all GP Practices in Halton, 213 from Widnes based practices and 259 from Runcorn based practices. The number of responses received from patients registered at each practice varied considerably, ranging from 4 to 51 responses for individual surgeries.

It is not therefore possible to draw conclusions about the individual surgeries, but rather gain a general insight into GP practices across the borough.

## Q2) Do you have a specific doctor you normally see?




## Survey Comments

*"I find it hard to get to see my own GP every visit. I would be happier if this was possible but unfortunately she has a busy schedule and is very popular. Otherwise I have no complaints and other GPs are good but I prefer this particular doctor"*

*"My GP is familiar with my medical history. I would not change or go to any other practice."*

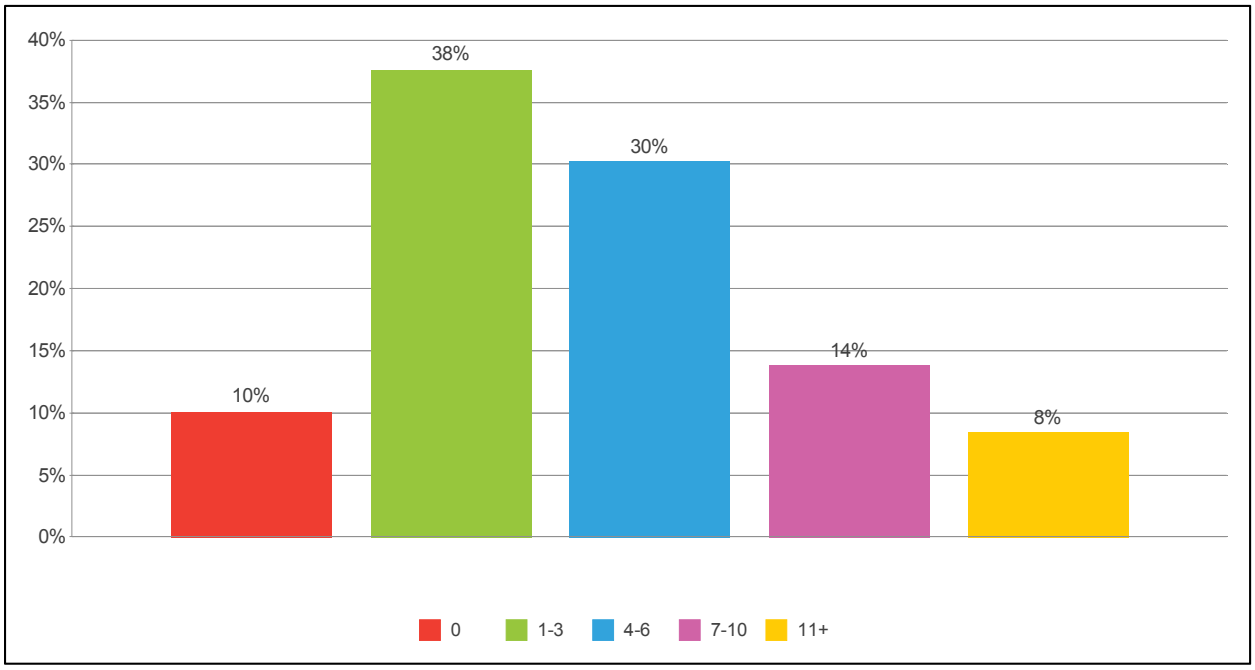
## Healthwatch Comment

While 55% of the respondents reported being able to see a specific doctor it is apparent that patients cannot always see a specific doctor due to the heavy demand on appointments.

Triage systems are being trialled at some practices which allow this. The idea of the

"Family Doctor" who knows you and your medical history is important for some patients, and is supported by the recent Government moves to have "over 70s" given specific GPs.

## Q3) In the past 12 months, how many times have you seen a doctor from your practice?

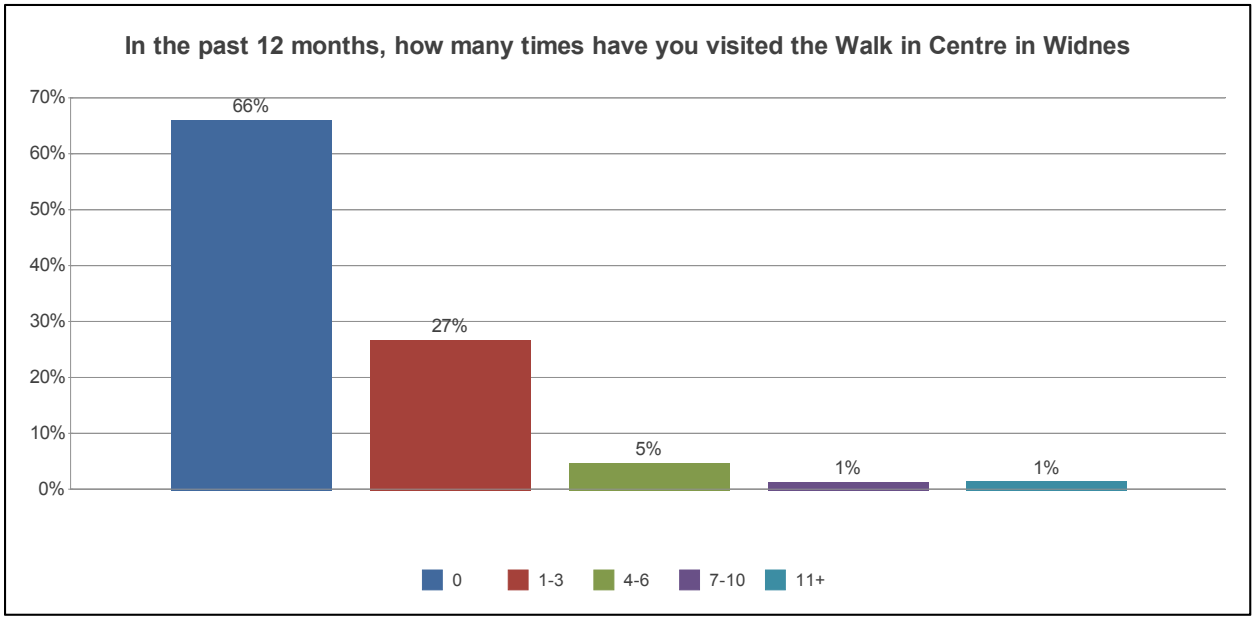



48% of respondents had visited the GP less than 4 times in the previous 12 months or conversely 52% had visited at least 4 times, with 22% averaging a minimum of a visit every 2 months and 8% visiting on average at least once a month.

## Healthwatch Comment

These figures indicate the heavy workload placed on the GP Practices and high demand for appointments.

## Q4) In the past 12 months how often have you visited the walk-in centre in Widnes?




Only 34% of respondents to the survey had used the Walk-in centre in the previous 12 months.

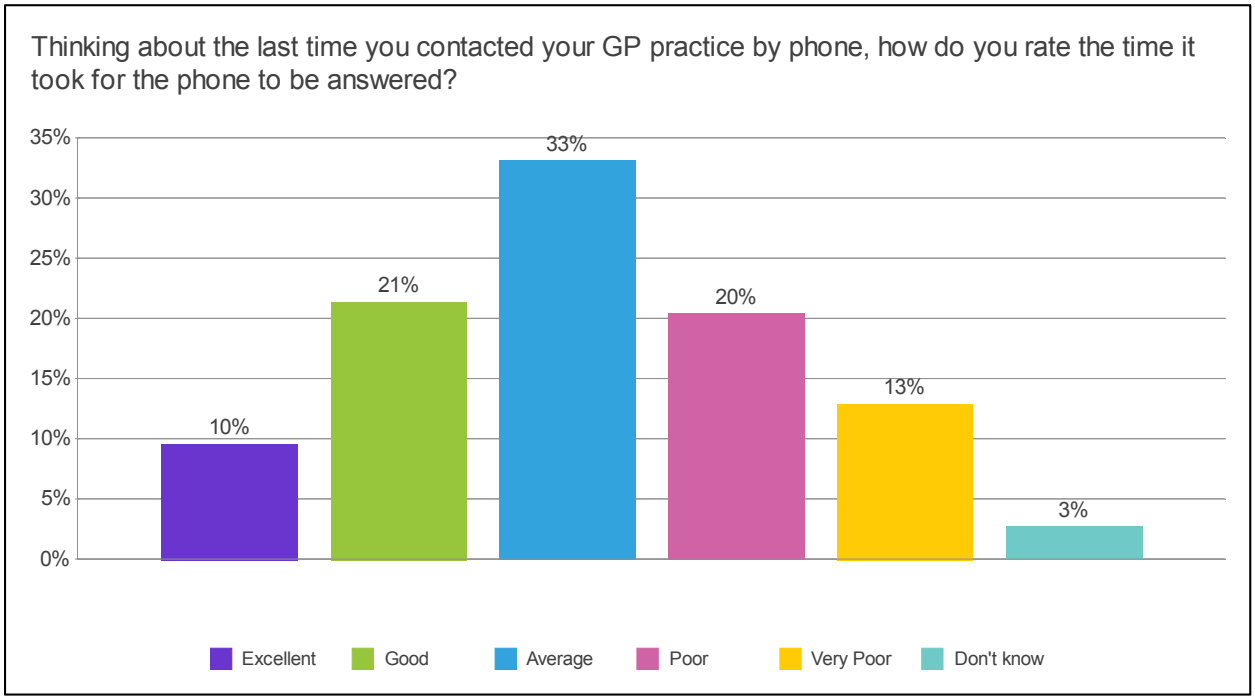
Of those who had visited the Walk-in Centre, the majority, 66%, were patients from Widnes based GP practices. 39% of users were aged 25-49. About 9% of people used the centre more than 4 times a year.

## Healthwatch Comment

From the figures it can be seen that the walk-in-centre in Widnes is not necessarily thought of as a suitable alternative for patients from Runcorn who are unable to access their GP.

Hopefully, the plans for a new urgent care centre in Runcorn should provide a welcome boost to Runcorn patients.

## Q5) Thinking about the last time you contacted your GP practice by phone, how do you rate the time it took for the phone to be answered?

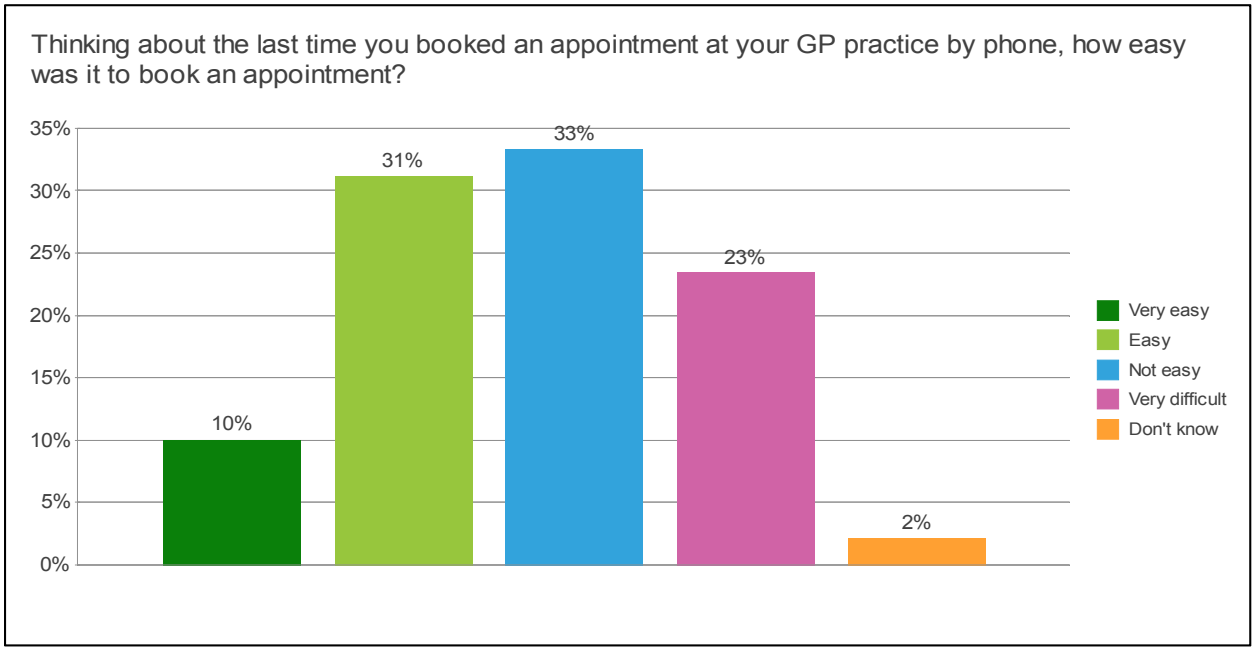



31% rated the time it took for the phone to be answered, good or excellent, whereas 33% felt the response time to be poor or very poor.

### Survey Comment

*'Last time I phoned I waited 47 minutes to speak to the receptionist'*

## Q6) Thinking about the last time you booked an appointment at your GP Practice by phone, how easy was it to book an appointment?




41% felt that it was easy or very easy to book an appointment, while 56% found it very difficult or not easy. Across all age ranges at least 50% of respondents found difficulties in booking appointments over the phone. On further analysis it was found that people in the over 65 age grouping found it slightly more difficult than those below 65.

On breaking these figures down by individual practice we found that the poorest performing practice only had 19% of respondents happy with booking appointments over the phone.

## Survey Comments

*"I find the automated system doesn't help you to choose the doctor you want-he is never available"*

*"Don't like the appointment arrangements.8.00am till 8.30am - many times when you get through they are all taken so you have to try again the next day."*

*"It's very difficult to get an appointment. The phone line is very busy and when you do get through there are no appointments left, which is why I have had to use the walk-in centre"*

*"Could call you at home if somebody doesn't turn up (or cancels) their appointment so I could use their appointment for that day if I would like to and aren't doing anything that day."*

## Healthwatch Comment / Recommendation

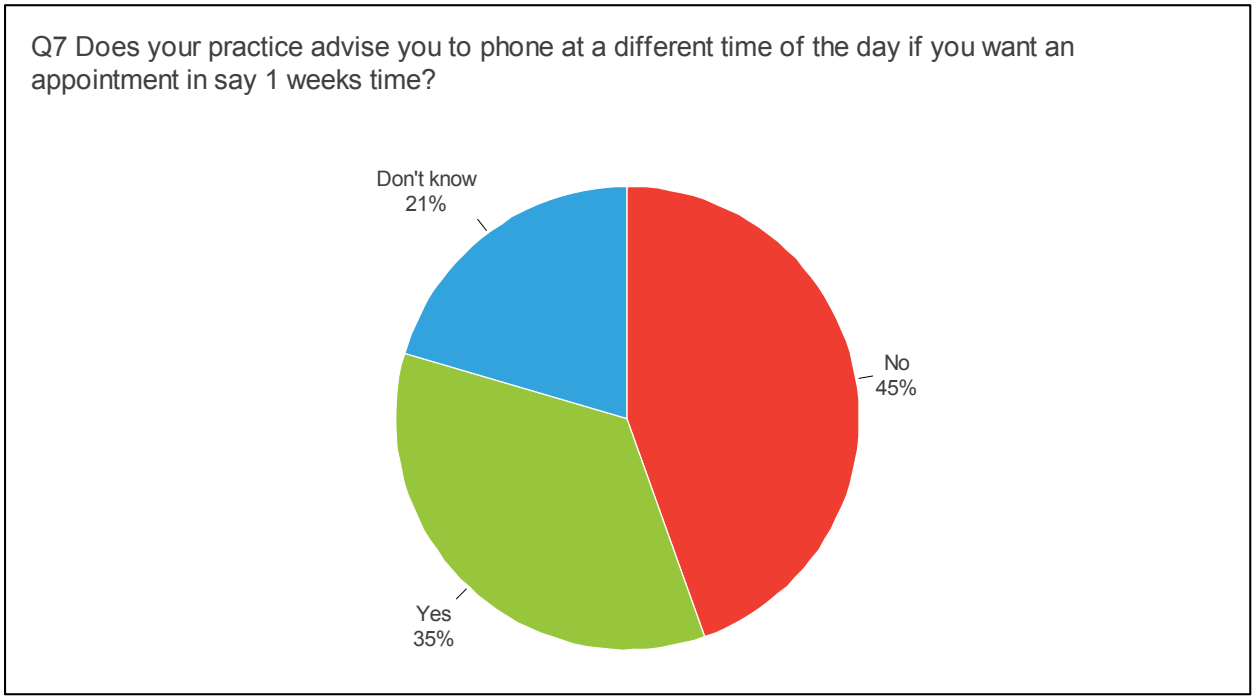
This may be a function of the phone systems at the practices. The systems take the call, but then put the caller in a queue, often involving a waiting time which can cause some frustration.

This is probably the most contentious area within the survey responses, and the one where we believe improvements can be made.

It is clear from the responses that some systems appear to be working much better than others. Telephone booking systems should be reviewed and compared across the borough and good practice should be identified and shared.

Ease of use and accessibility for patients should be the key consideration.

## Q7) Does your practice advise you to phone at a different time of the day if you want an appointment in say 1 week's time?

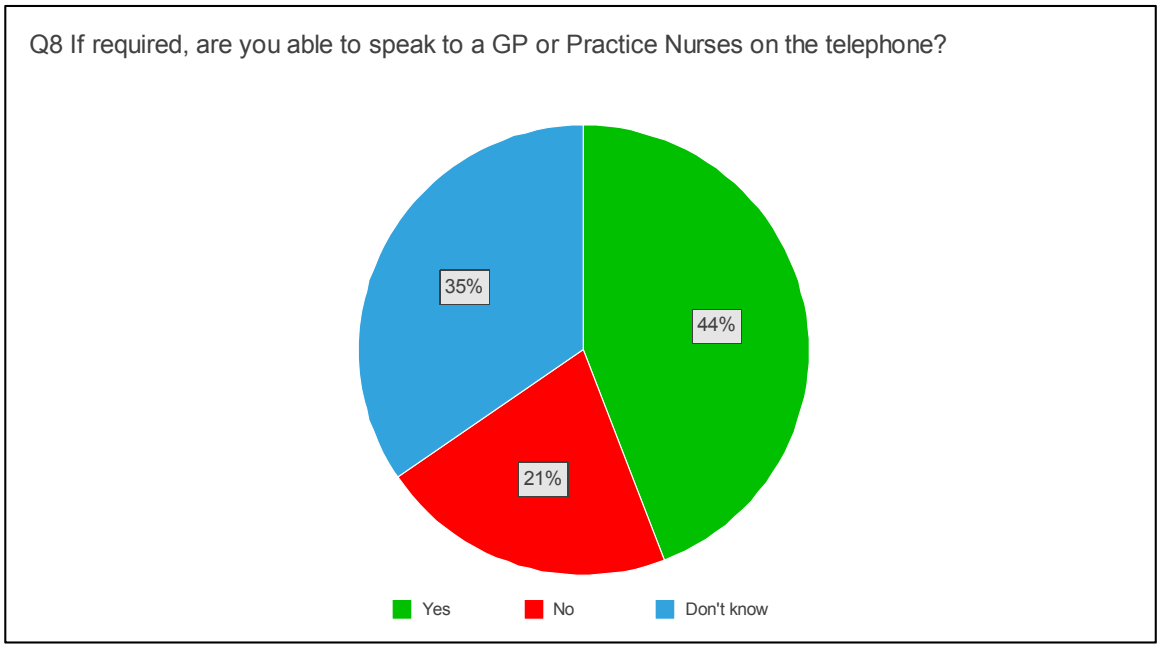



35% of practices advise to ring at a different time of the day for an appointment in a week's time. 21% reported "Don't know" in response to this question.

### Survey comment

*"It is also difficult to make a non-urgent appointment with a GP up to 2 weeks in advance."*

## Q8) If required are you able to speak to a GP or Practice Nurse on the phone?



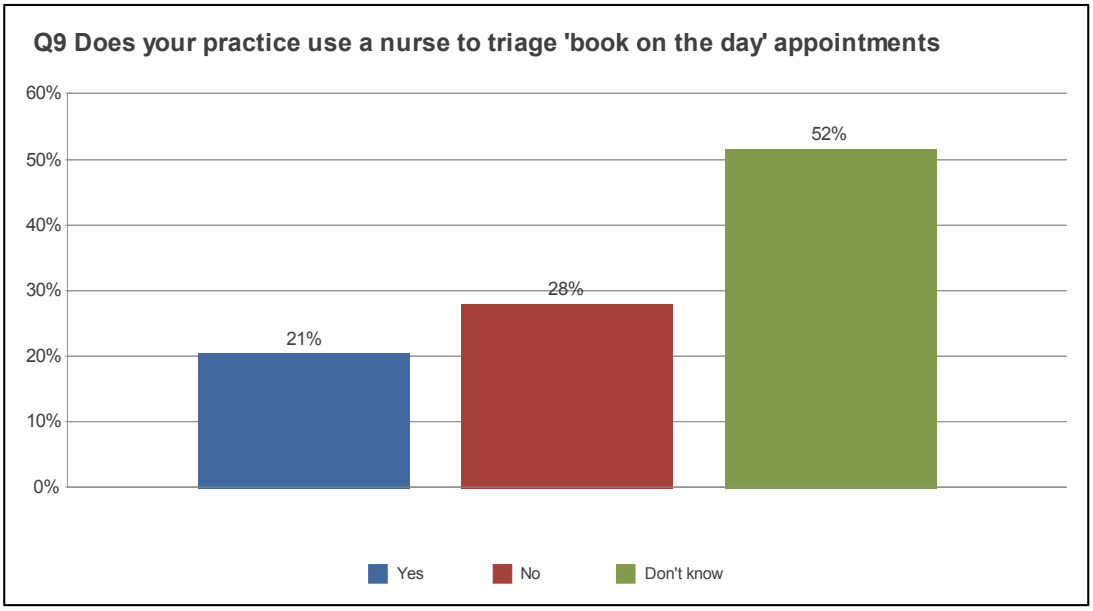

While 44% said they were able to speak to a GP/Nurse, 21% responded "no" and 35% responded "Don't know".

## Healthwatch Comments

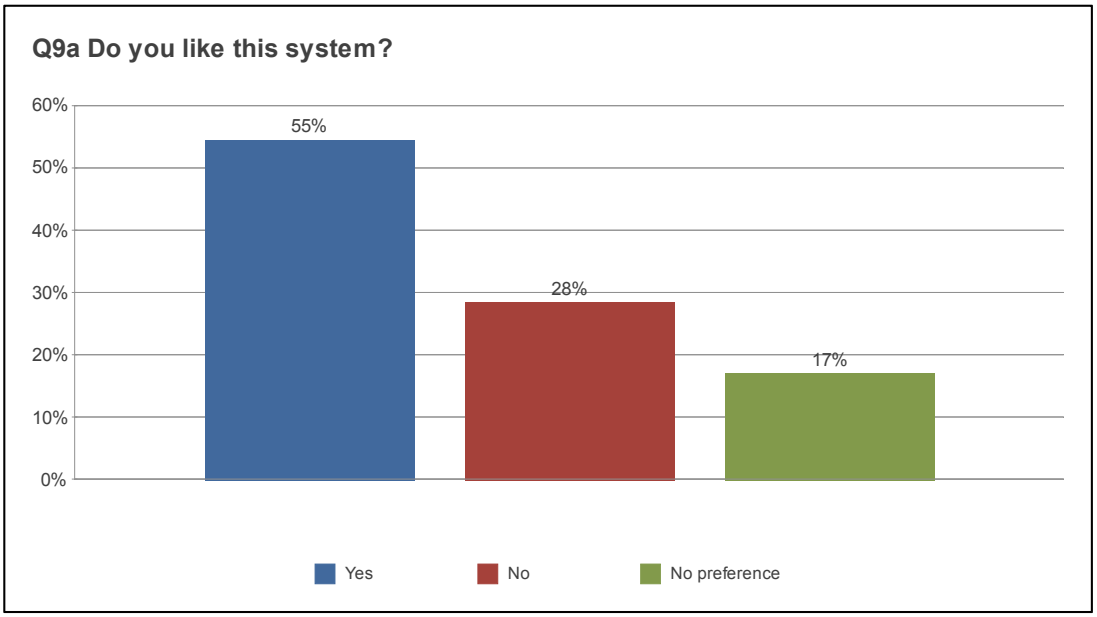
We looked a little deeper into the answers received on this question. Across all but one practice we received 'yes' and 'no' answers to this question. There may be a number of factors for this:

- Lack of information / awareness of the services provided by the practice
- It may also reflect some confusion about what triage is and how the triage systems work at some practices.
- The willingness of GPs and Patients to use a telephone consultation may be a factor.

## Q9) Does your practice use a nurse to triage 'book on the day' appointments?




## Q9a) If you answered 'Yes' do you like this system?




## Survey comment

*"Triage makes you feel like you have to justify an appointment, makes you wait to get a phone call and doesn't let you see the doctor you want"*

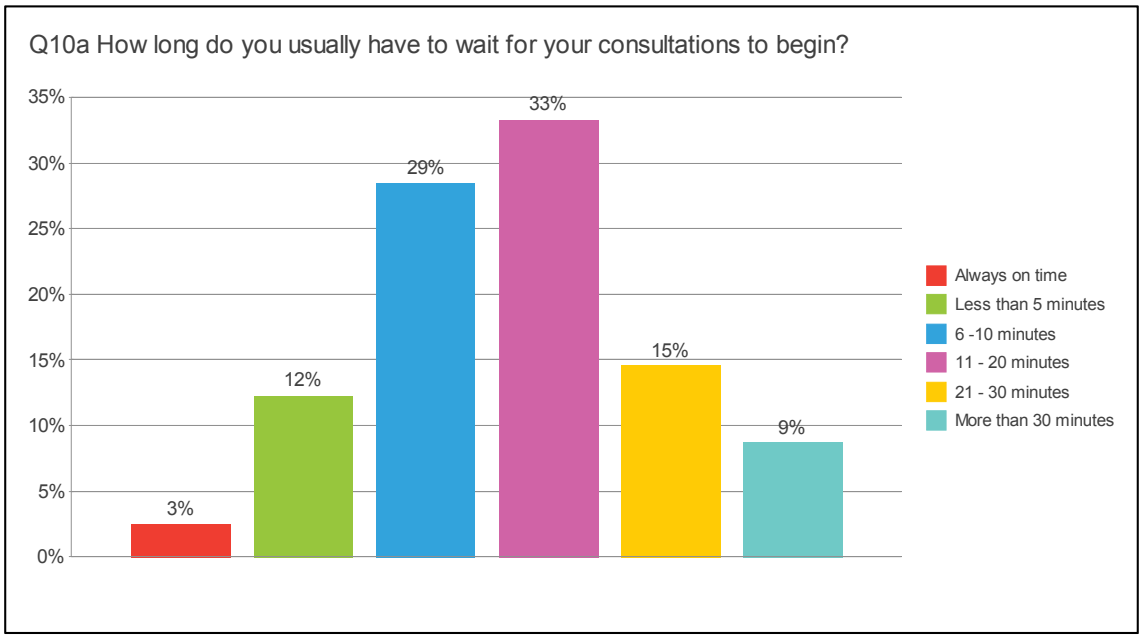
## Healthwatch Comment

As with the answers to Q8 there appears to be some confusion amongst the public as to what triage is and whether it is offered at every practice. 21% indicated that a nurse was used to triage "book on the day" appointments, and 52% replied, "Don't know".

Triage systems have not been running for long, and there appears to be some resistance to a Nurse rather than a Doctor triage.

As can be seen from the answers to Q9a, of those people who've used the 'Triage' system, there is an almost 2 to 1 majority who like the system.

## Q10a) How long do you usually have to wait for your consultations to begin?




44% of people reported a waiting time of ten minutes or less while 24% reported having to wait more than 20 minutes to see the GP.

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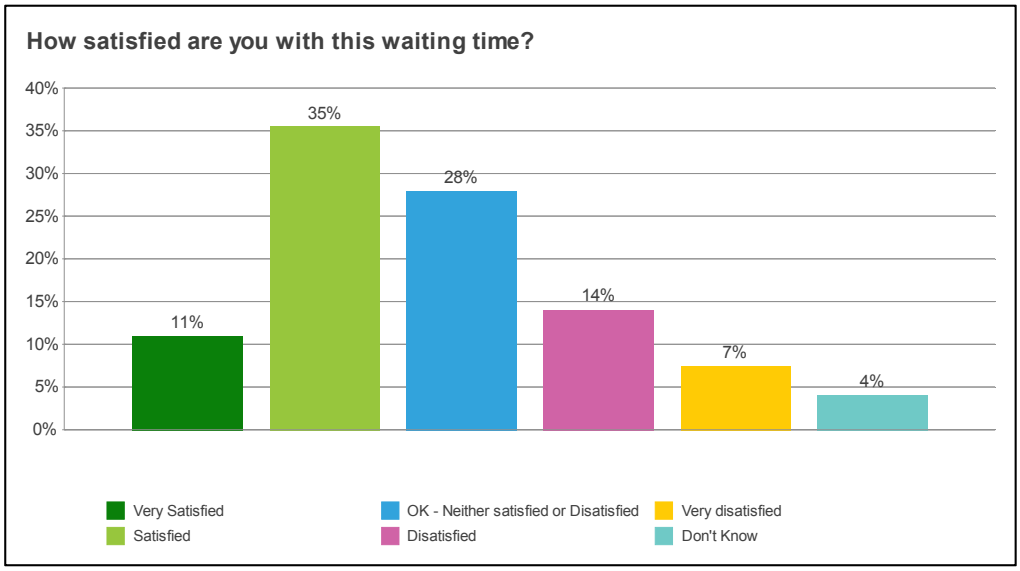
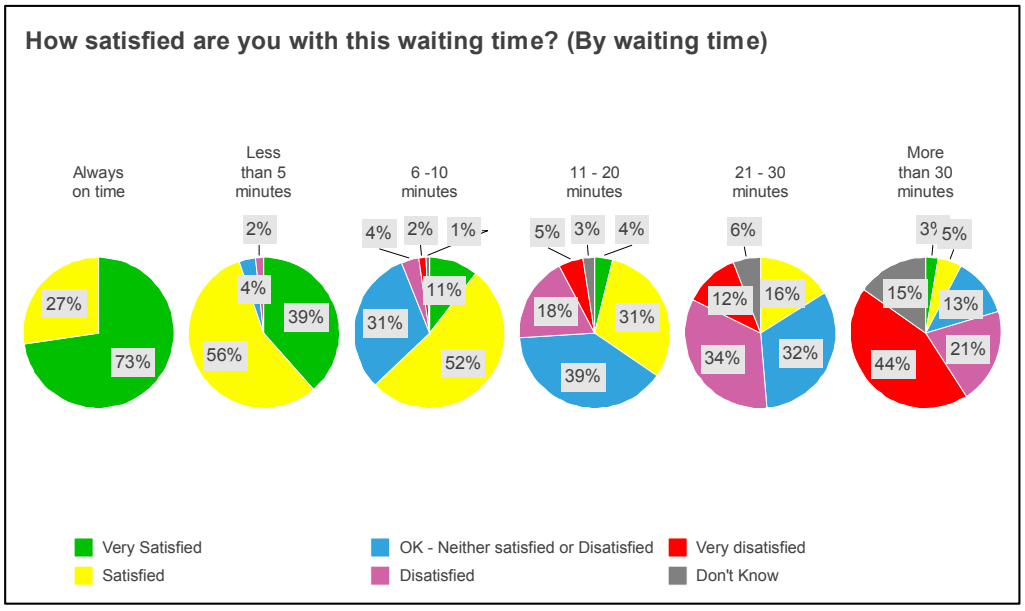
## Q10b) How satisfied are you with this waiting time?



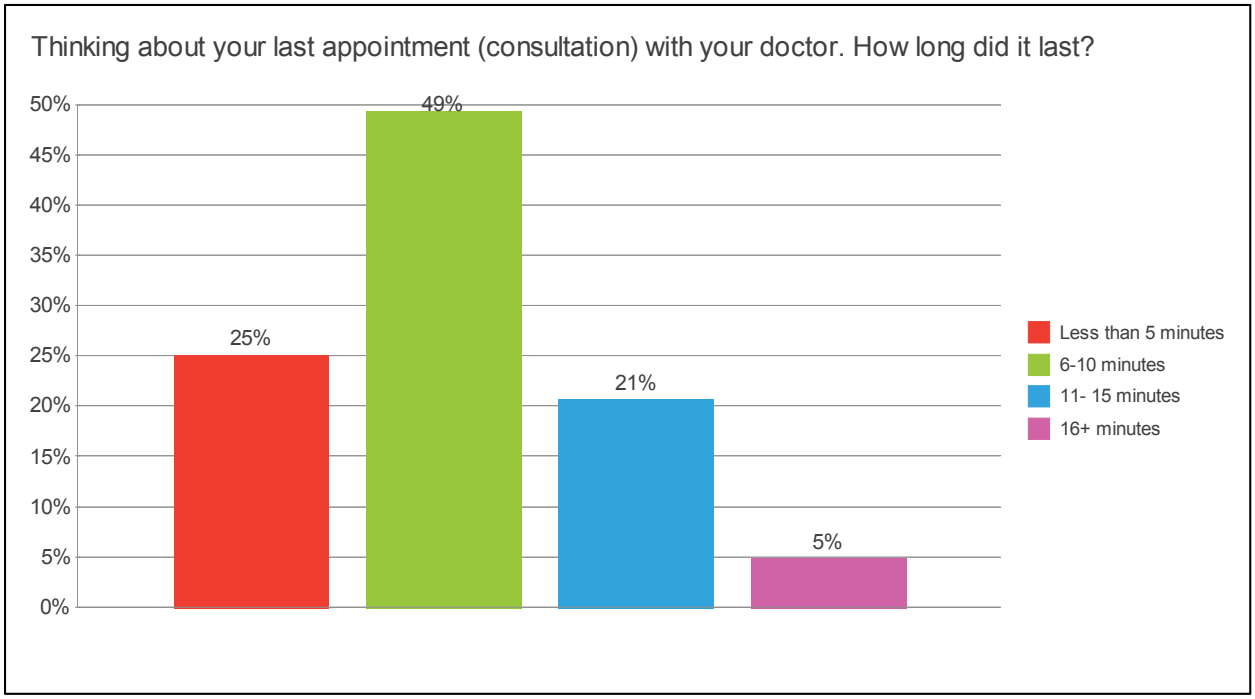

The overall satisfaction rates are shown above. 46% stated that they were 'satisfied' or 'very satisfied' with the time they had to wait as opposed to 21% who were 'dissatisfied' or 'very dissatisfied'. While these statistics were useful to give an overall rating we felt we needed to look deeper into the answers. We broke this question down by looking at the amount of time waited and the satisfaction rate with that length of time.




## Healthwatch Comment

As can be seen from the chart above, patients are generally tolerant of waiting times of up to 10 minutes, as they appreciate the Doctor is seeing other patients who perhaps require that extra attention. Beyond 10 minutes the dissatisfaction rate grows quite quickly. Delays can happen, that is a fact of life. Making sure that people are told the reason for the delays allows them a choice, wait or re-book for another time. People like to be kept informed!

## Q11) Thinking about your last appointment with your doctor. How long did it last?




49% of consultations lasted 6-10 minutes and 25% lasted less than five minutes which seemed to be balance off against the 26% of appointments that lasted longer than 10 minutes

## Survey Comments

*"GPs never have enough time for you. You can only see a doctor for "one" problem in "one" visit-no more"*

*"My Practice has a person centred commitment to patient care and communication"*

*"The Doctors at my surgery are all good and I don't mind who I see"*

## Healthwatch Comment / Recommendation

The single complaint per consultation rule has caused some concern among patients. Some practices have a "double appointment" system but this not a common process.

Double slots should also be made available and promoted to People with a Learning Disability/Learning Difficulty in order for them to have enough time to ask and answer questions.

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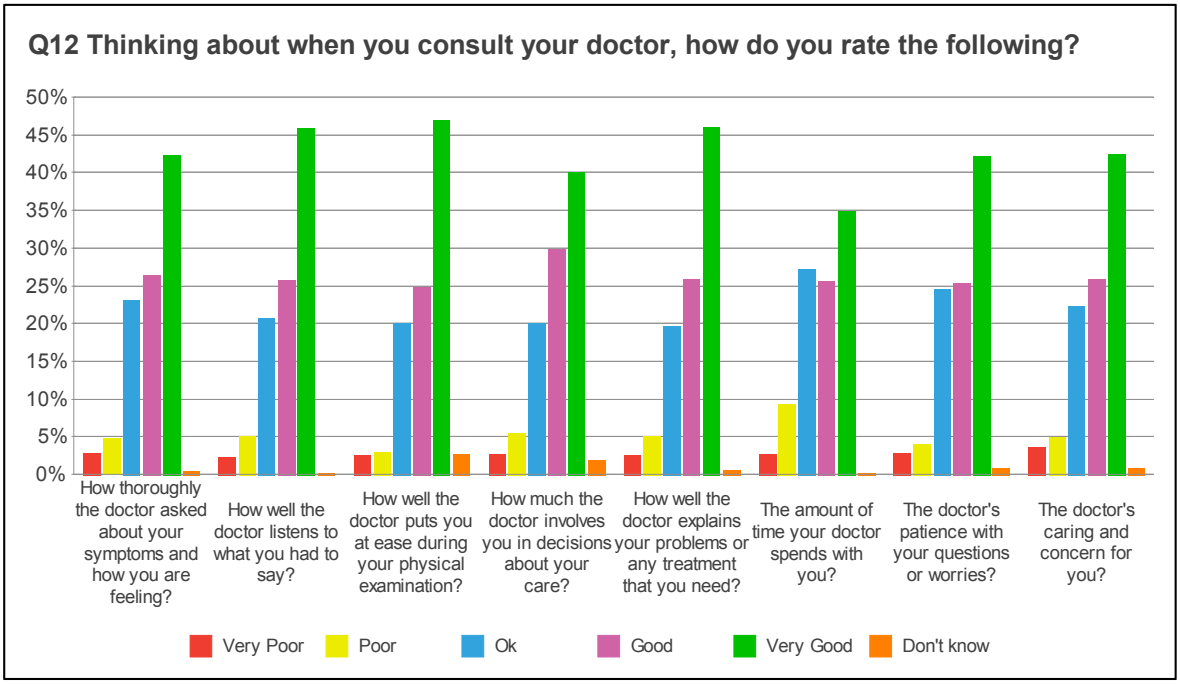
## Question 12 asked a series of questions on how people rated their GP on eight aspects of the consultation.

Some people commented that it was hard to assess this because they did not see the same GP at each appointment. Patients reported that they like to see one particular GP in order to build up a relationship and knowledge of their medical history.

## Q12) Thinking about when you consult your doctor, how do you rate the following?




## 12a) How thoroughly the Doctor asked about your symptoms and how you are feeling.

68% rated their doctor 'Good' or 'Very Good' while 8% rating their doctor as 'Poor' or Very Poor'

## 12b) How well the Doctor the Doctor listens to what you had to say.

72% rated their doctor 'Good' or 'Very Good' while 7% reported 'Poor' or 'Very Poor'.

## 12c) How well the Doctor put you at ease during your physical examination

72% rated their doctor 'Good' or 'Very Good' while 6% reported 'Poor' or 'Very Poor'.

## 12d) How much the Doctor involves you in decisions about your care

70% rated their doctor 'Good' or 'Very Good' while 8% reported 'Poor' or 'Very Poor'.

### 12e) How well the Doctor explains your problems or any treatment that you need

72% rated their doctor 'Good' or 'Very Good' while 8% reported 'Poor' or 'Very Poor'.

### 12f) The amount of time your Doctor spends with you

61% rated their doctor 'Good' or 'Very Good' while 12% reported 'Poor' or 'Very Poor'.

### 12g) The Doctor's patience with your questions or worries

67% rated their doctor 'Good' or 'Very Good' while 7% reported 'Poor' or 'Very Poor'.

### 12h) The Doctor's caring and concern for you

69% rated their doctor 'Good' or 'Very Good' while 9% reported 'Poor' or 'Very Poor'.

## Survey Comments

*"I am very happy with my GP Practice"*

*"Dr X is a brilliant Doctor"*

*"It depends on the doctor I get as to how happy with the service I am -the last doctor I saw was good and listened, so I reflected that in my answer. However some doctors at my practice don't listen as well."*

## Healthwatch Comment

Generally, our local GP's are rated really highly by their patients, when they can get to see them! As can be seen from the figures for this set of questions, the satisfaction ratings for the Doctors in Halton Practices are all high, ranging from 61% to 72% 'good' or 'very good'. The lowest 'positive' ratings were to do with the amount of time spent with the Doctor and this is no doubt a result of the high demand for face to face consultation. This repeated the general response given to Question 11.

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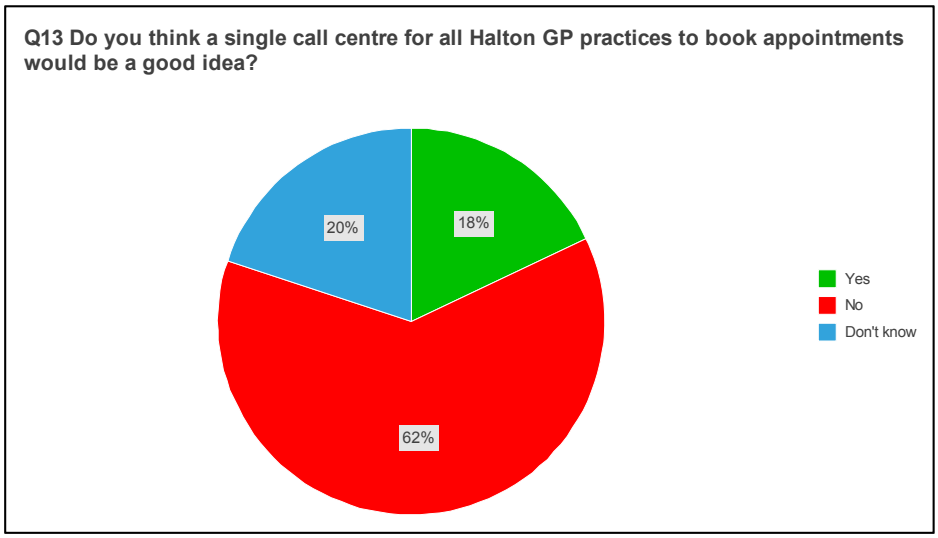
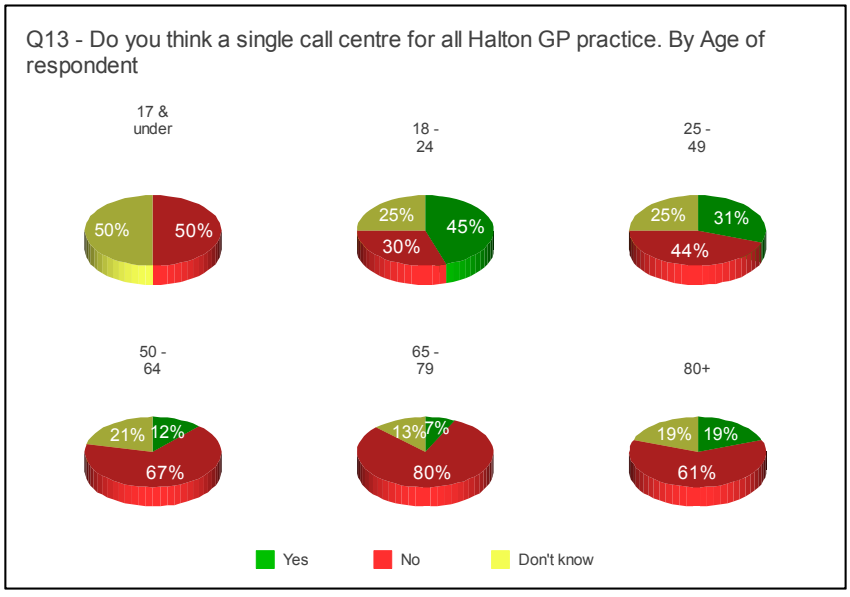
## Questions 13 to 19 concern patient views regarding booking appointments.

## Q13) Do you think a single call centre for all Halton GP practices to book appointments would be a good idea.




62% did not like this proposal. Possible causes:

- Could be insufficient information, existing problems of booking appointments are multiplied up if more people are trying to get through to one centre.
- Do not know if number of phones in the call centre will be sufficient to get through any better than current situation.
- How will the number of phones needed be assessed?
- Will on-line booking be affected by a call centre?
- Will on-line appointment booking allow patients to book appointments at other practices?



When we looked at the responses by each age group it revealed:

- age 65-79 80% thought it was a bad idea
- age 50-64 67% thought it was a bad idea
- age 25-49 44% thought it was a bad idea
- age 18-24 45% thought it was a good idea

Possible reasons could be that older people prefer to see their own doctor or visit a practice they are familiar with.

Whereas younger people do not mind which doctor they see and access to treatment may be their main priority.

## Survey Comment

*'On the centralised appointment booking point I've put 'don't know'. If such a service was to work better than the present one I'd whole heartedly approve of it!'*

## Healthwatch Comment/Recommendation

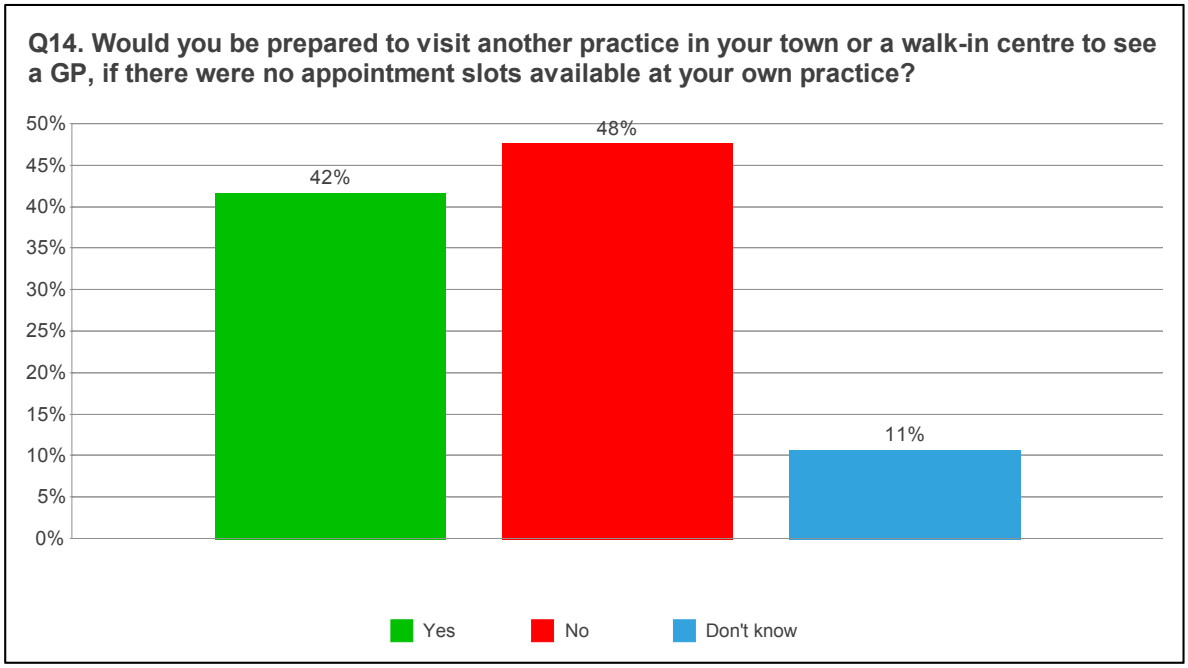
CCG to take on board patient views on this question. Mitigate patient impact if this proposal is to proceed.

Despite the shortcomings with the telephone booking systems, people are comfortable contacting their own GP Practice for appointments. Unless there are obvious benefits to the patient, (i.e. getting an appointment when they want and with who they want), we can't see a majority of people supporting this.

Whilst Healthwatch understands the predicted shortage of GPs over the longer term, the general public of Halton may not be aware of this.

If the single call centre option was to proceed, more in depth information showing the key reasons should form part of publicity material. Including consultation with interested parties so that all concerned fully understand the reasoning behind the initiative.

## Q14) Would you be prepared to visit another practice in your town or a walk-in centre, if there were no appointment slots at your own practice.




48% would not wish to visit another practice or walk-in centre.

## Healthwatch Comment

There are a few possible reasons for the 48% 'no' response.

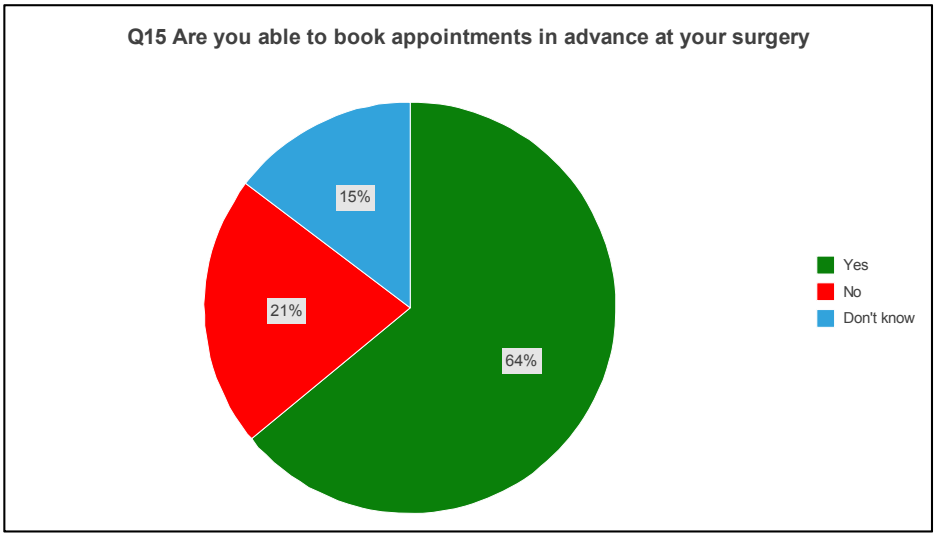
- A fear that their medical records wouldn't be available if they visited another practice or the walk-in centre.
- Some patients, particularly older patients, prefer seeing their own doctor.
- Patients with more complex health conditions, or those without access to a car may prefer to wait and see their own GP.
- Patients who don't have access to a car may also have concerns about travelling to another practice, or the walk-in centre.

There is a hearts & minds battle to win with the public if this proposal and that of the soon to launch urgent care centres are to succeed. The benefits to the public need to be actively promoted.

## Survey Comment

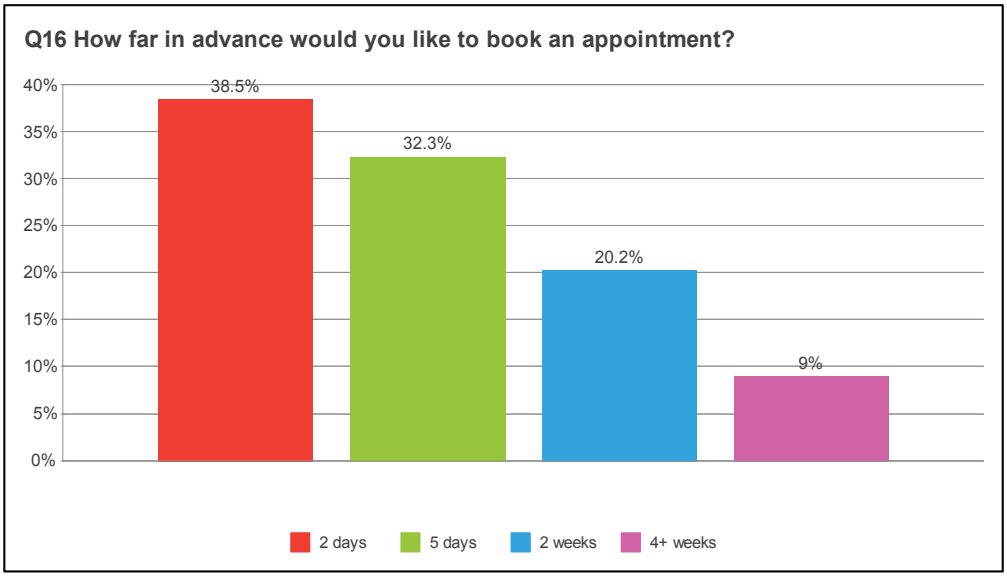
*'I find it impossible to get to see a doctor at this surgery... Our practice routinely directs me toward the walk-in centre.'*

## Q15) Are you able to book appointments in advance at your surgery for non-urgent appointments.




64% of patients said they were able to book in advance at their surgery for non-urgent appointments.

## Q16) How far in advance would you like to book an appointment.




Nearly 71% would like to be able to book a non-urgent appointment within 1 week, 30% would like to be able to book longer than 1 week in advance.

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## Survey Comments

*'Do not like that you are put through to an automated service to try and get an appointment. When you do it is usually for 3 weeks in advance so you have to visit in person at opening time to try and obtain an earlier appointment'*

*'I find the automated system doesn't help you to choose the doctor you want – he is never available'*

*'It is also difficult to make a non-urgent appointment with a GP for up to 2 weeks in advance. My last appointment I had to wait 4 weeks!'*

*The next available appointment was 2 weeks later and this was with a practice nurse so I just accepted it.*

## Healthwatch Comment / Recommendation

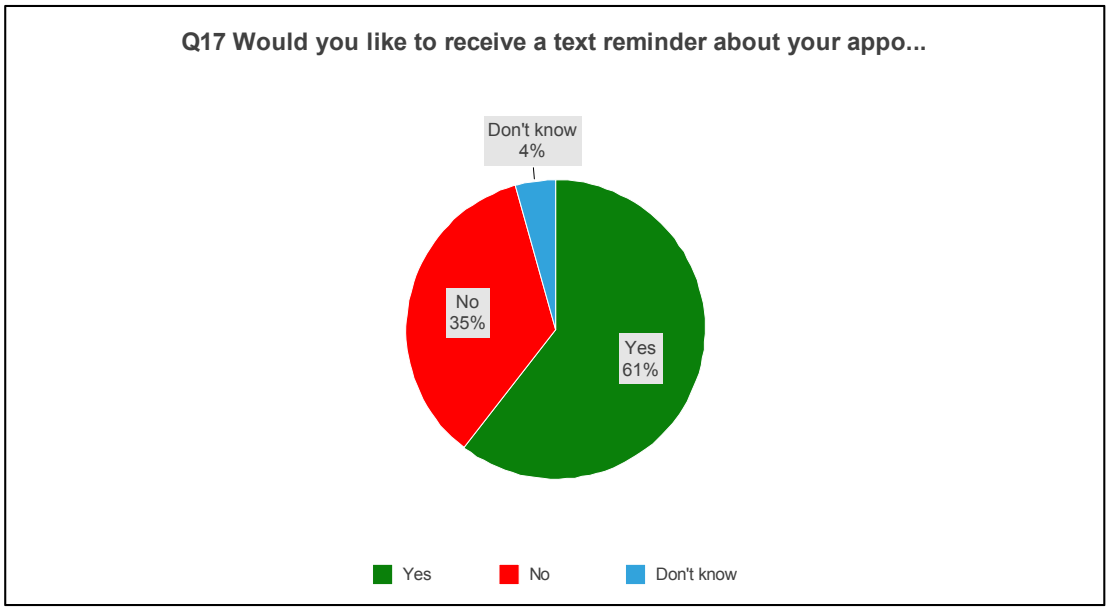
From the responses received there seems to be some confusion over this service. Patients at the same practices gave different answers. Some said they could make advance appointments, some said they couldn't and as always some people were unsure.

We'd like to see clear information on whether patients can make advance appointments, and more importantly, how to make advance appointments.

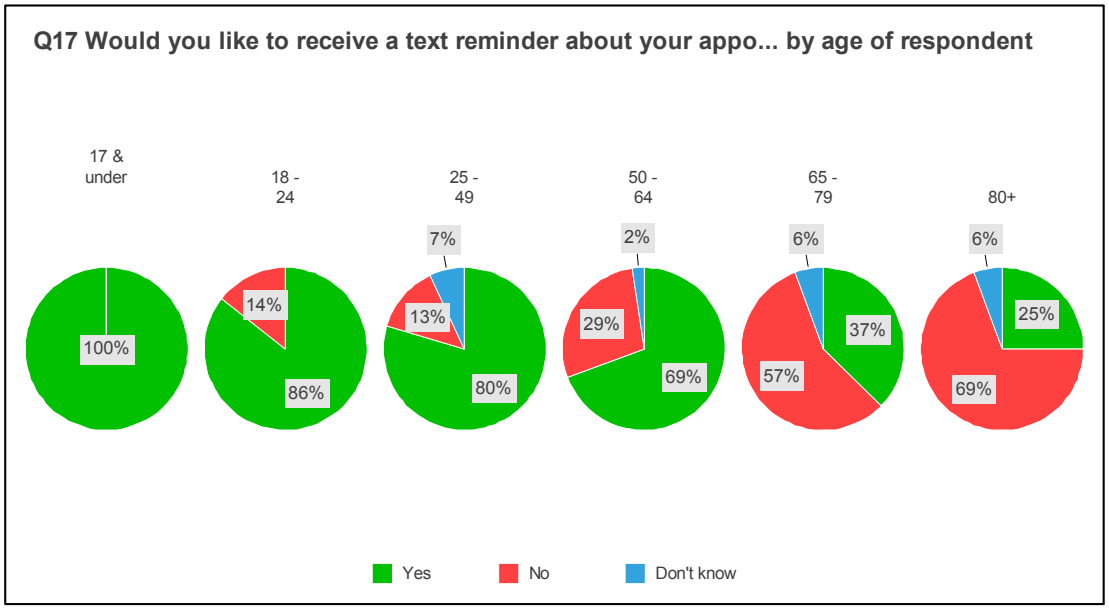
We are aware that the DNA (Did Not Attend) rate increases with advance appointments and we feel that this is something that individual patients need to take responsibility for as well. Text reminders for advance appointments may reduce the rates of DNA.

Presumably the 21% who said their practice doesn't offer advance appointments end up accessing their GP by using the urgent same day appointment system?

## Q17) Would you like to receive a text reminder about your appointment.




61% of patients would like the option of a text reminder for their appointment.

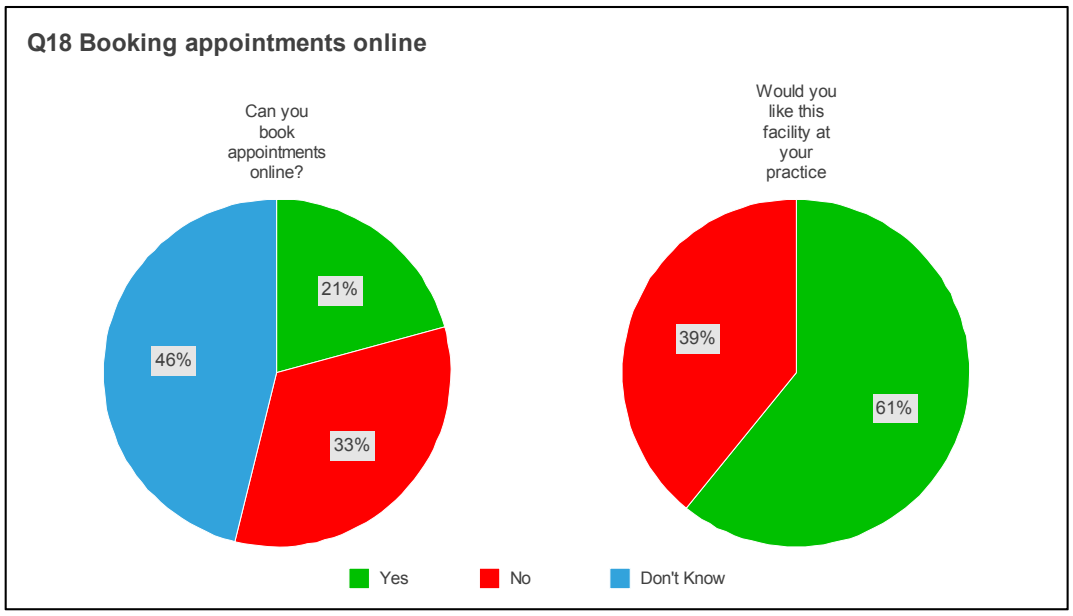



## Healthwatch Comment / Recommendation

Breaking the responses down by age group, (see chart above), we can see that this option is favoured mainly by the under 65's. We would expect it to be optional to sign up to a text reminder service so people would have the choice as to whether to take advantage of this service or not.

Currently not all practices offer this service. In those that have, not all people are aware of them or have signed up for it yet. Those practices that don't yet have this facility should actively look into providing this service.

## Q18a) Can you book appointments on line?




Only 21% of patients said they were able to book appointments online. Our background research has shown that currently 60% of local practices offer this facility.

46% of patients did not know if appointments could be booked on line.

Those people who answered 'No' or 'Don't Know' were asked a supplementary question 18b

## Q18b) If not would you like this facility at your practice?

61% of those who answered 'No' or 'Don't Know' to question 18a would like to have the option of online appointment booking.

## Q18a&b) Healthwatch Comment / Recommendation

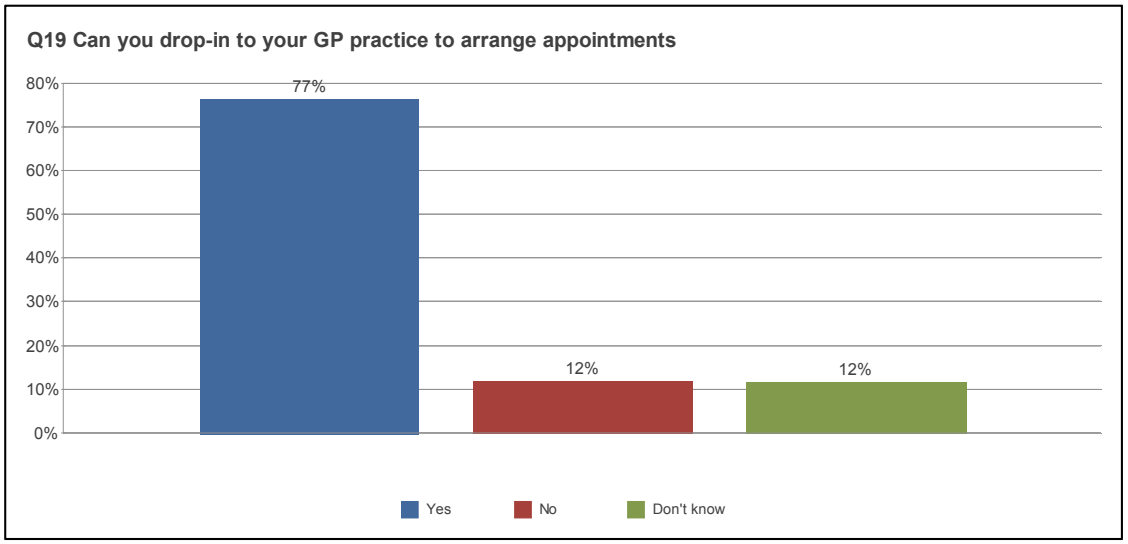
Information regarding on-line booking may not be currently advertised in the practices. GP practices should raise awareness with patients of this facility.

Recognising that we live in an 'online' age, it will become increasingly important to offer online booking for appointments.

Healthwatch Halton is aware that from April 2015, all GP practices will have to offer patients the opportunity to book appointments online, order repeat prescriptions online, and have access to their medical records online. According to our research 10 out of 17 local practices currently have an online appointment booking service operating. More needs to be done to make sure the systems used will be user friendly and encourage patients to take advantage of the online service.

Practices should always remember though that not all patients will have internet access, therefore online booking should be just one of a range of ways that patients can book appointments.

## Q19) Can you drop in to your GP practice to arrange appointments?




77% of patients can drop in the practice to book appointments. It is not clear if this applies to same day booking between 8am to 8.30am or dropping in to book a non-urgent appointment any time of the day? Additionally not all patients may have access to a telephone.

However, the facility is good!

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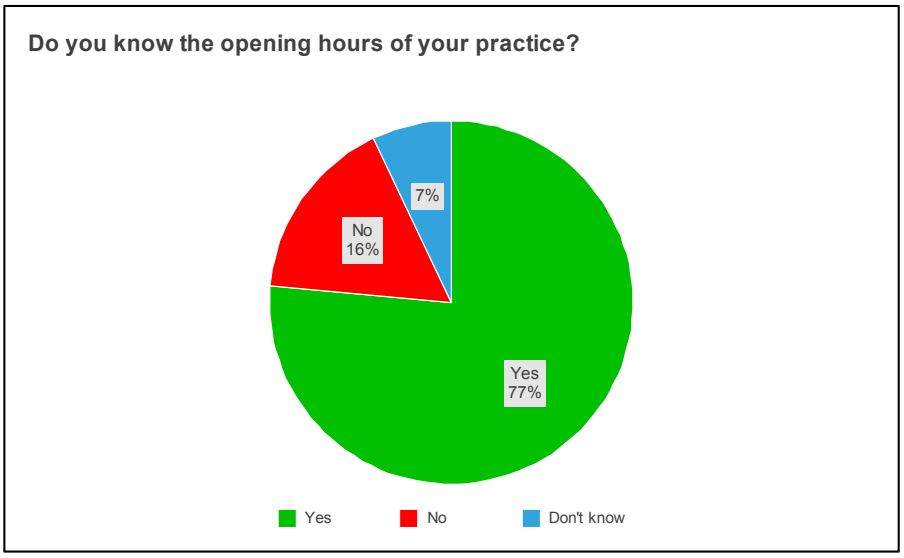
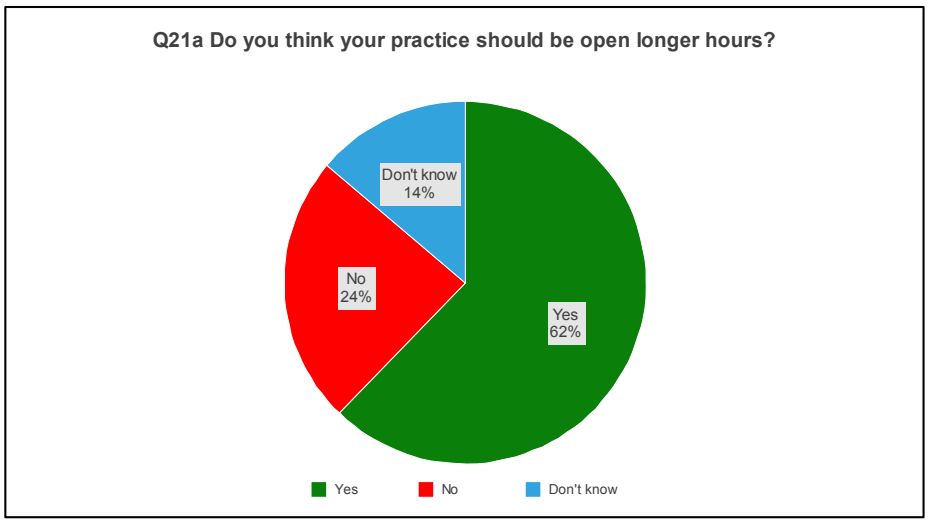
## Questions 20 and 21 provide patient feedback on the opening hours of GP practices.

### Q20) Do you know the opening hours of your practice?



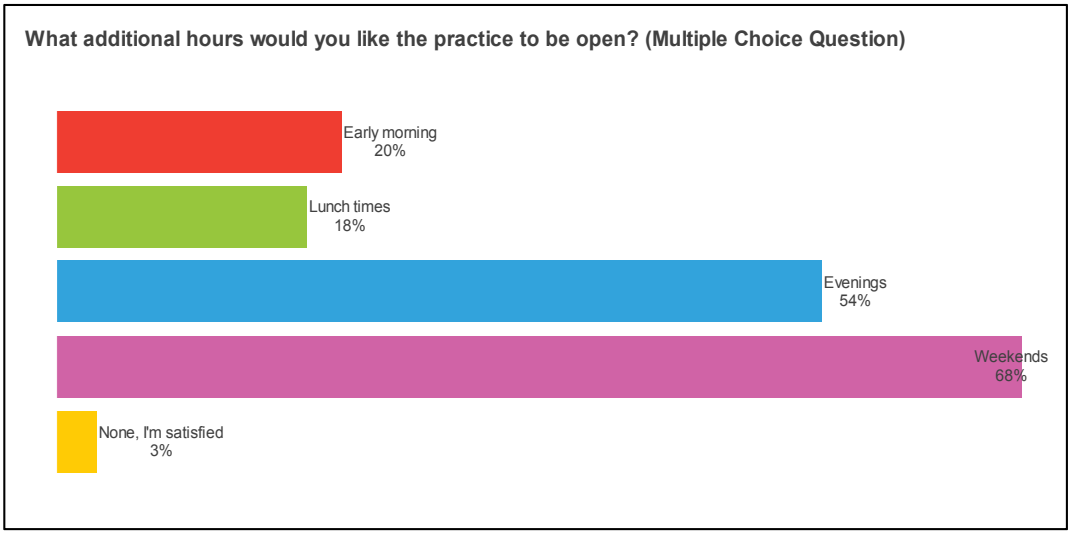

77% of those surveyed knew the opening hours of the practice.

### Q21a) Do you think your practice should be open longer?




62% of respondents wanted longer opening hours at practices. We followed up this question with a supplementary question for those who answered 'Yes'.

## Q21b) What additional hours would you like the practice to be open? (Multiple Choice Question)




Of those people who wanted their practice open longer hours, the most popular option was weekend opening, followed by evening opening.

## Healthwatch Comment / Recommendation

While we are pleased to see that the vast majority of patients know the opening hours of their local GP we are concerned that almost 1 in 4 people aren't aware of the opening hours.

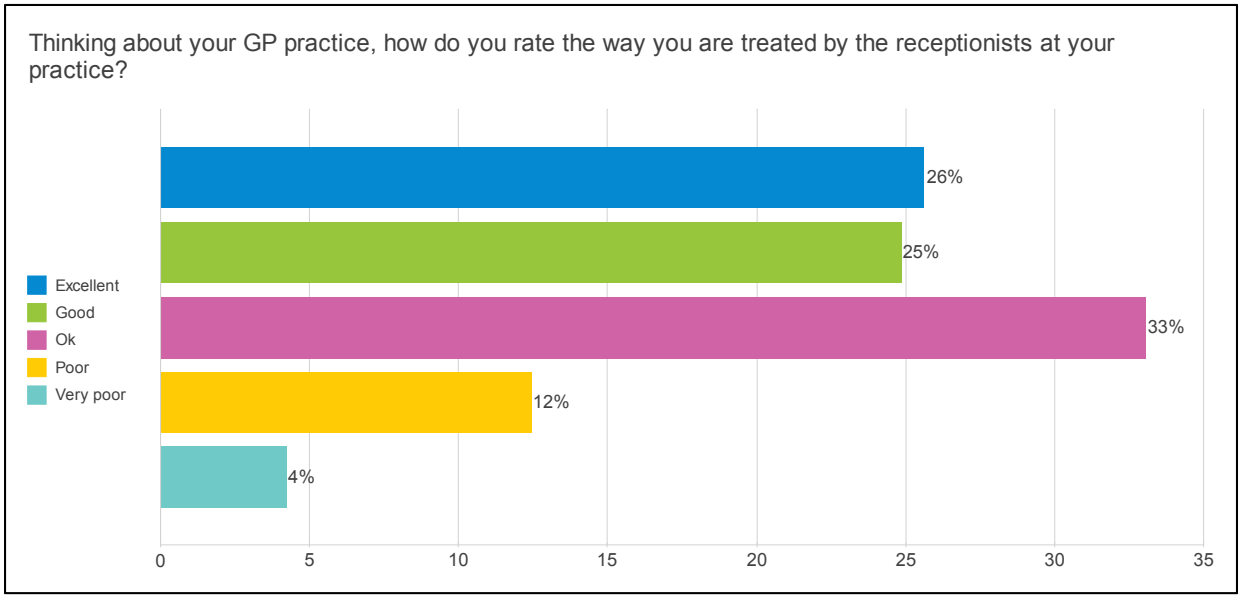
Consideration to be given to longer GP practice opening times. With changing work patterns etc. for many people it isn't always easy to arrange appointments at times to suit. We would like to see research carried out into the options for increased opening hours.

Review GP practice opening hours to ensure that additional opening hours are widely available in the borough, if not uniformly across the borough.

Practices should consult with their patients, possibly through their PPG, to identify popular methods of booking appointments and adopt a variety of the most popular methods so that patients have choice in how they can book an appointment: including in person, by phone, by text and online booking. The particular needs of those, for example with visual impairment or deafness, should be adequately accommodated for within these options.

It would also be of a benefit to see a list of opening hours of GP practices, as well as those of the walk-in centre and minor injuries unit, published on a regular basis within the local press.

## Q22) Thinking about your GP practice, how do you rate the way you are treated by the receptionist at your practice?




- 51% of respondents rated the way they were treated by the reception staff as 'excellent' or 'good'.
- 16% of respondents rated the way they were treated by the reception staff as 'poor' or 'very poor'.
- 33% of respondents rated the way they were treated by the reception staff as 'ok'.

## Survey Comments

*'The receptionists at times can be abrupt, intrusive, unhelpful and unprofessional.'*

*'Some of the reception staff are really nice and helpful, some are not and refuse to give you an appointment unless you beg'*

*'The staff are very friendly and very helpful'*

*'I sigh inwardly when I call up and I recognize this particular receptionist as I know I will have a battle on my hands to get an appointment.'*

*'The receptionists are always pleasant and chatty'*

*'Receptionists need to understand that the patients are customers not a hindrance'*

## Healthwatch Comments / Recommendations

Breaking these figures down by each practice shows up a wider variance, with 6 practices receiving less than a 50% 'good' or 'very good' rating for their reception staff.

We understand that reception staff are 'on the front line' when dealing with patients, who by definition will generally not be feeling too well when they contact the practice. Allowing for this, we still find that too many patients receive a poor level of customer service.

NHS England's 'Improving General Practice – A Call to Action, Phase 1 Report', published in March 2014, stated, *'we will develop quantifiable ambitions for improving overall patient experience of general practice services. This will focus on improving experience of access to services, which we know in turn is linked to convenience of getting an appointment, ease of getting through on the phone and the helpfulness of receptionists.'*

We look forward to these ambitions becoming a reality.

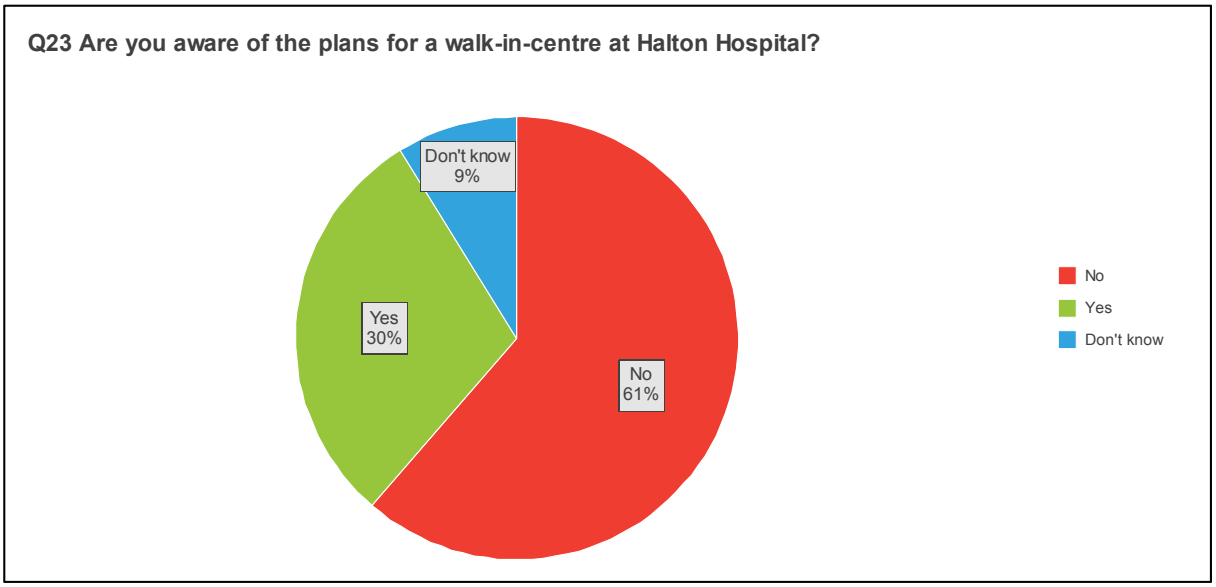
There are obviously some very good reception staff working in our local practices, we'd just like to see a more consistent level of good customer service for all patients across Halton.

We would support one of the approaches listed in Appendix A of NHS England's, 'Improving General Practice – A Call to Action'[7], being adopted locally, namely,

*'A group of practices pool their resources to plan and deliver relevant professional development for their staff. This can easily be aligned with existing priorities for service improvement, and integrated into wider moves to establish a culture of continual learning and improvement. It is easier to ensure it is relevant to the needs of primary care and may be cheaper and more convenient than external CPD opportunities.'*

[7] NHS England – Improving General Practice – A call to action Phase 1 report March 2014 - http://www.england.nhs.uk/wp-content/uploads/2014/03/emerging-findings-rep.pdf

## Q23) Are you aware of the plans for a walk-in-centre at Halton Hospital?




30% of respondents said they were aware of plans for a walk-in centre/Urgent Care Centre at Halton Hospital.

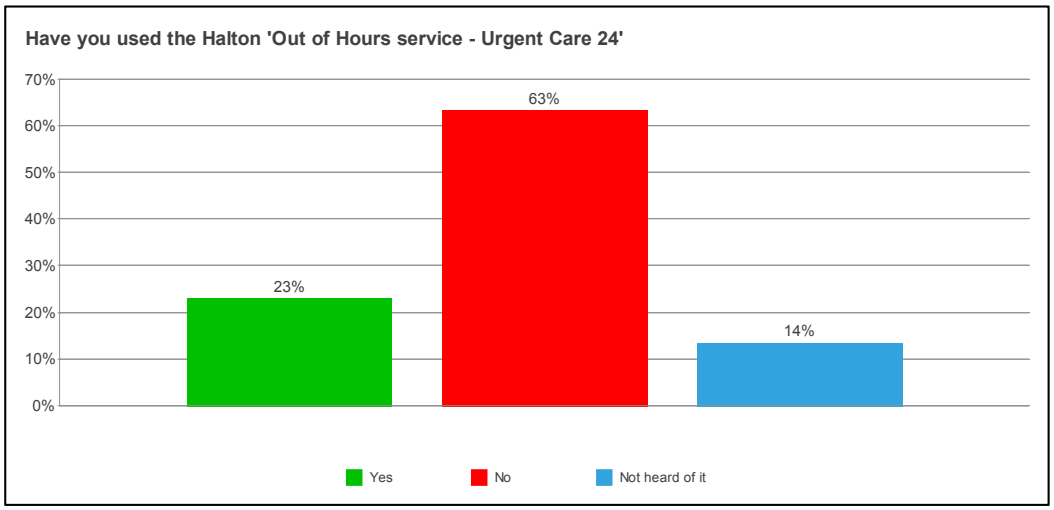
## Healthwatch Comment/Recommendation:

Currently the only 'Walk-in Centre' for Halton is based in Widnes. There are plans underway to open two new 'Urgent Care Centres (UCC)', one in Runcorn & one in Widnes by 2015.

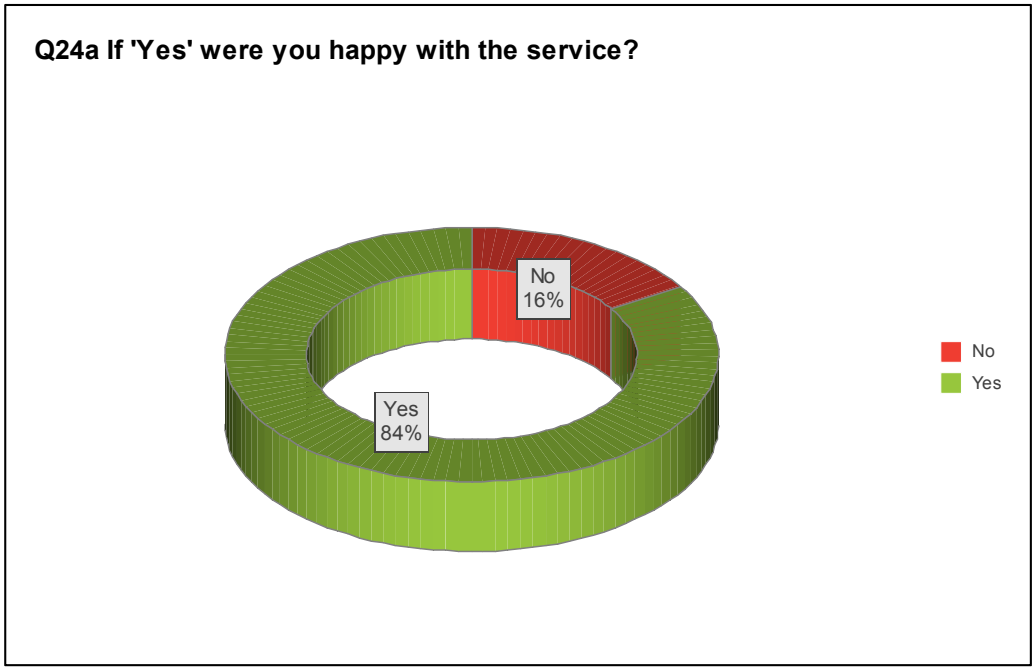
The Widnes UCC will replace the Widnes Walk-in Centre and the Runcorn UCC will be based in Halton Hospital, replacing the existing Minor Injuries Unit.

In the run up to these two units opening, we would like to see a borough wide awareness raising campaign to ensure members of the public know what services they will provide and how and when to access the services.

## Q24) Have you used the Halton "Out of hours service - Urgent Care 24" in the last 12 months?

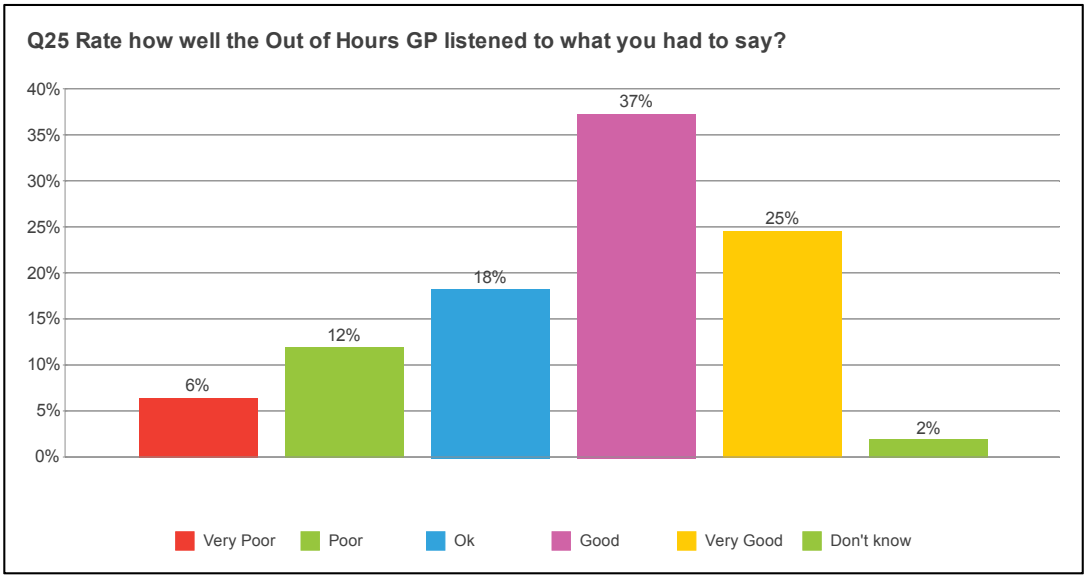



## Q24a) If yes, were you happy with the service.




Of the 23% of patients who had used the Out of Hours service, 84% were happy with the service.

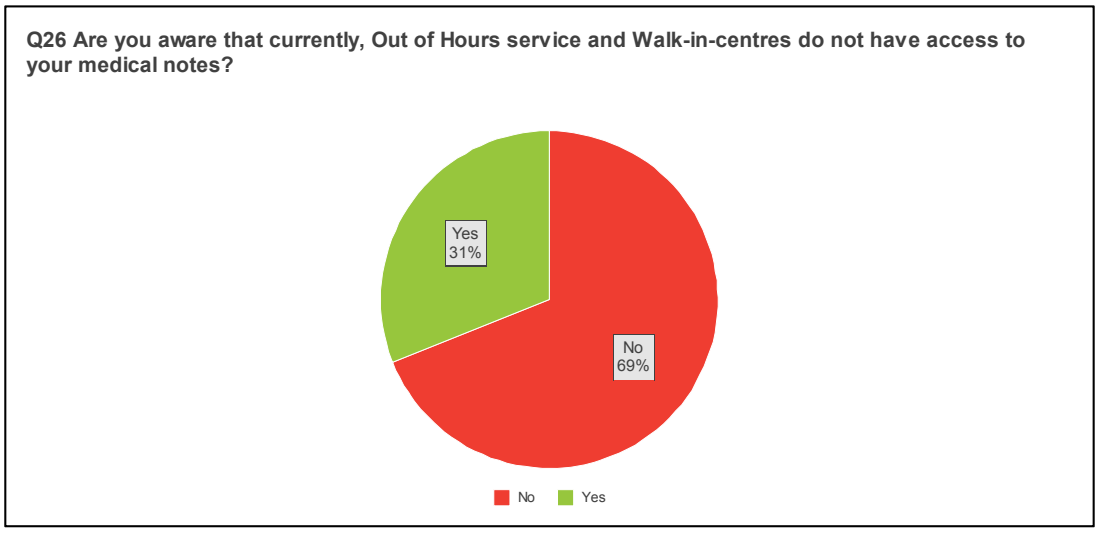
## Q25) Thinking about when you've used the Out of Hours service, how do you rate how well the Out of Hours GP listen to what you had to say?



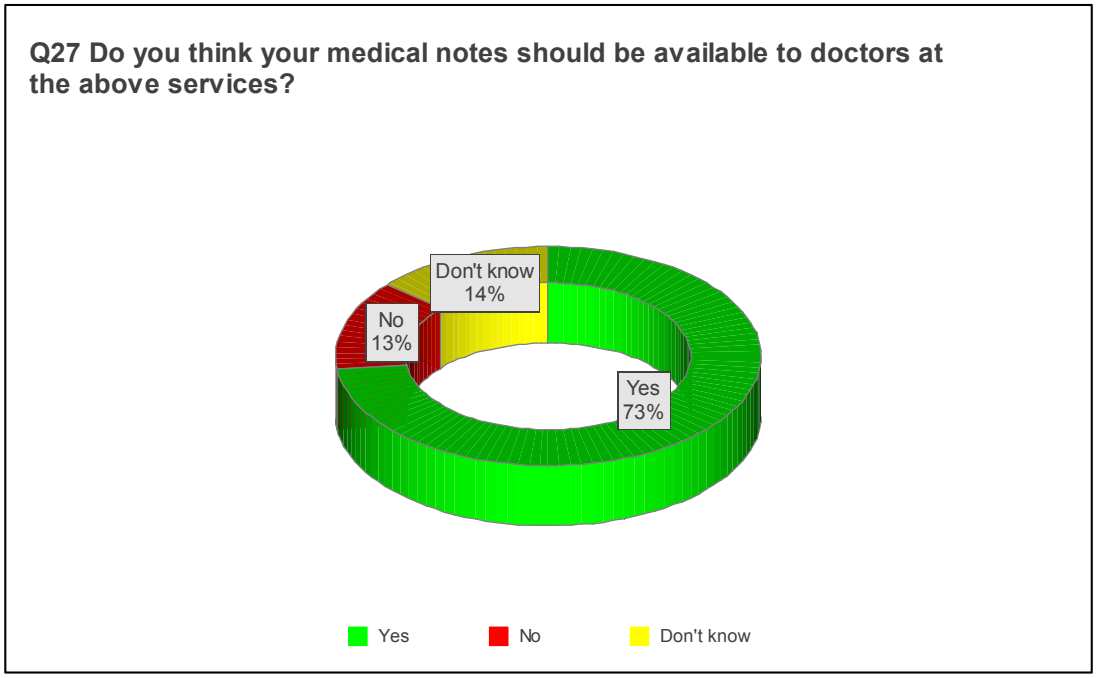

Question 25 was a supplemental question for those people who had used the Out of Hours service during the previous 12 months. While 84% of people were happy with the overall level of service (Q24a), only 62% of patients rated the GP as 'good' or 'very good' at listening to what they had to say (Q25).

18% of patients rated how the GP listened to what they had to say as 'Poor' or 'Very poor'. A further 18% answered 'Ok'.

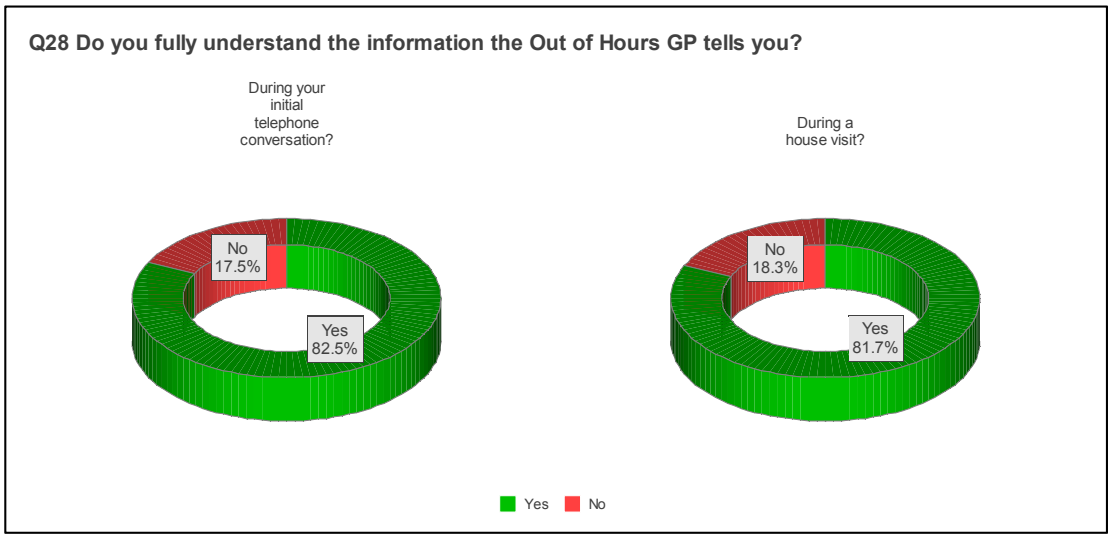
## Q26) Are you aware that currently, Out of Hours service and Walk-in Centres do not have access to your medical notes.



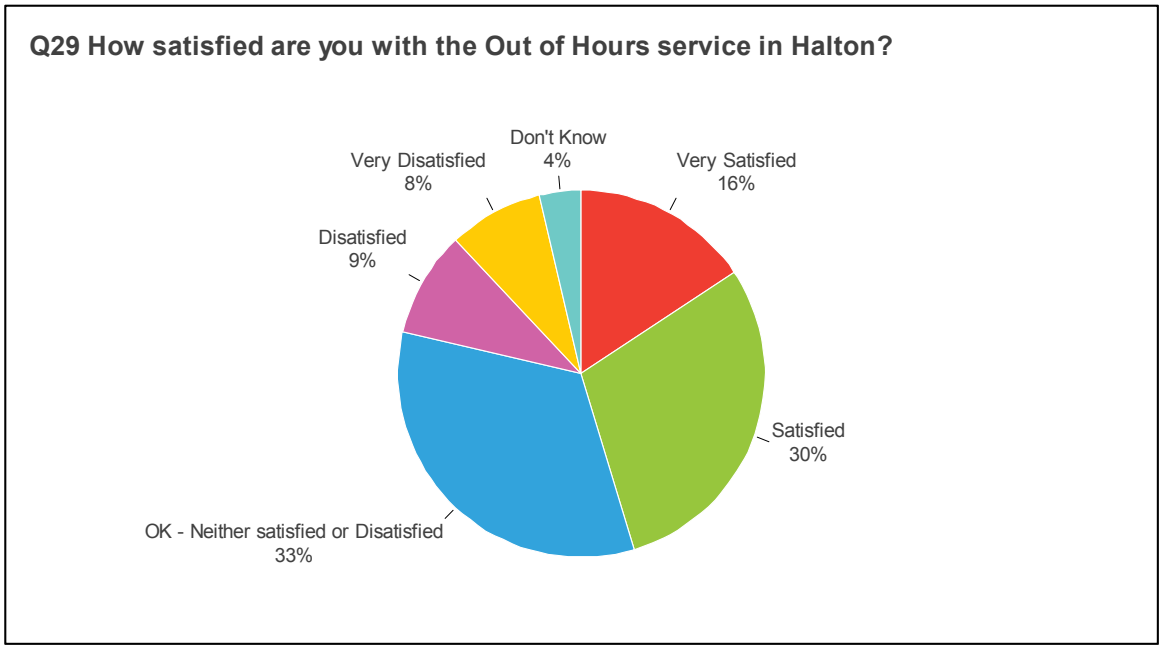
## Q27) Do you think your medical notes should be available to the doctors at the above services?




## Q.28a & b Do you fully understand the information the Out of Hours GP tells you? a) During your initial telephone conversation? b) During a house visit?



## Q.29 How satisfied are you with your Out of Hours service in Halton?




## Healthwatch Comment – Out of Hours Service (Q24, Q25, Q28, Q29)

Overall the satisfaction rate with the Out of Hours (OOH) service was good with 84% being happy with the service (Q24a) and 62% being happy with how the OOH GP (Q25) listened to their concerns.

While we are very pleased to note that the majority of people find the service clear and easy to access there are still a significant percentage of people who are finding the service fails to meet their needs.

Whereas Q24 asked for a 'Yes' or 'No' answer to see if people were happy with the OOH service, Q29 broke this down into a wider scale of satisfaction. 46% were 'satisfied' or 'very satisfied' with the service, but we still had a figure of 17% who felt let down by the service.

The responses to Q28 show that 18% of people do not fully understand the information the Out of Hours GP tells them either during their initial telephone conversation or during a house visit (Q28a & b). Why would this be? Why would they not understand the information given to them?

Health Professionals should be aware that many patients do not understand medical terms or jargon. Medical Conditions etc. should be explained in easily understood terms.

The public expectations of modern business environments desire performances to be greater than Ok. Therefore we expect there is work to do for improvement in this service.

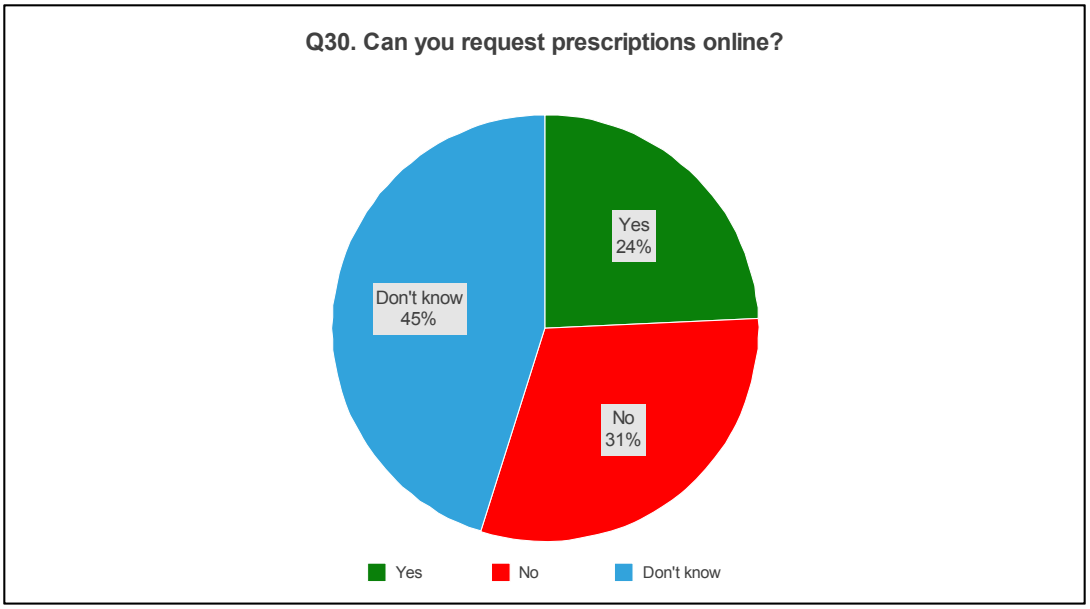
## Healthwatch Comments (Q26 & Q27)

Less than 1 in 3 people (Q26) were aware that their medical records weren't available for the Walk-in Centres and Out of Hours service.

From the responses to Q27 we can see that a large majority of patients, 73%, would like a system in place that would allow the Out of Hours service and Walk-in Centre / Urgent Care Centres to have access to their medical notes to aid their consultation and diagnosis.

This would presumably spill over to proposals to pool GP practices covered in Q14. Potentially this would require all GPs serving a particular pool of patients to have access to patient notes for that pool.

## Q 30a) Can you request prescriptions on line?




## Survey Comment

*'In theory you can book appointments and order prescriptions online but the security is ridiculous. I bank and shop online with no problem but cannot log on to the new system. They ask over 5 security questions and it makes it impossible for me to get online, even as a regular computer user.'*

## Healthwatch Comment / Recommendation

Just under 1 in 4 people said they were able to request repeat prescriptions online. Yet our survey, Q30b, shows 75% of respondents would like this option.

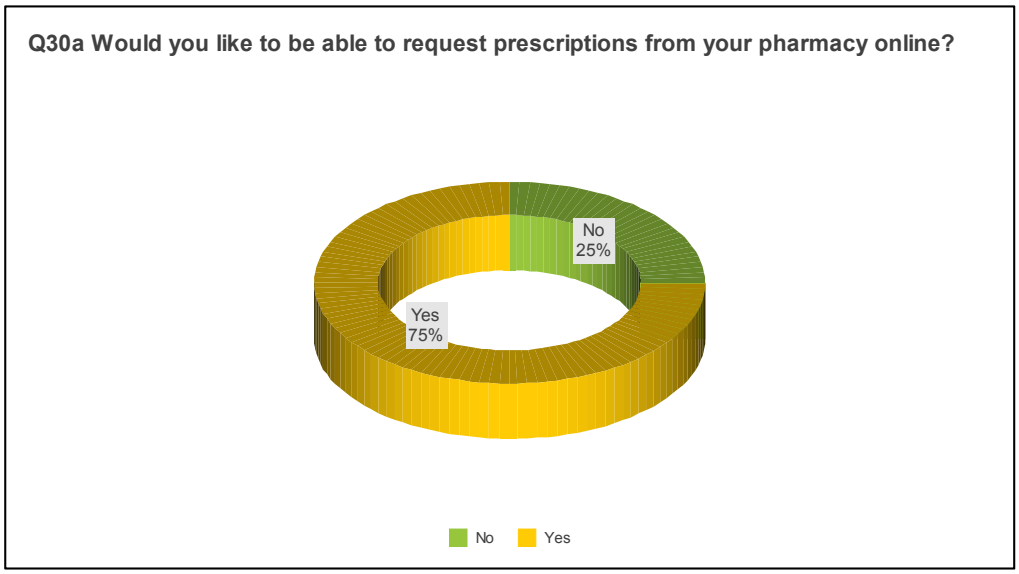
Healthwatch Halton is aware that from April 2015, all GP practices will have to offer patients the opportunity to order repeat prescriptions online.

According to our background research 60% of local practices have introduced online ordering for repeat prescriptions. It seems that a lot of patients at practices in the 60% aren't yet aware of this service. For those practices that already offer this facility it appears there is still a lot of work to do to make patients aware of it.

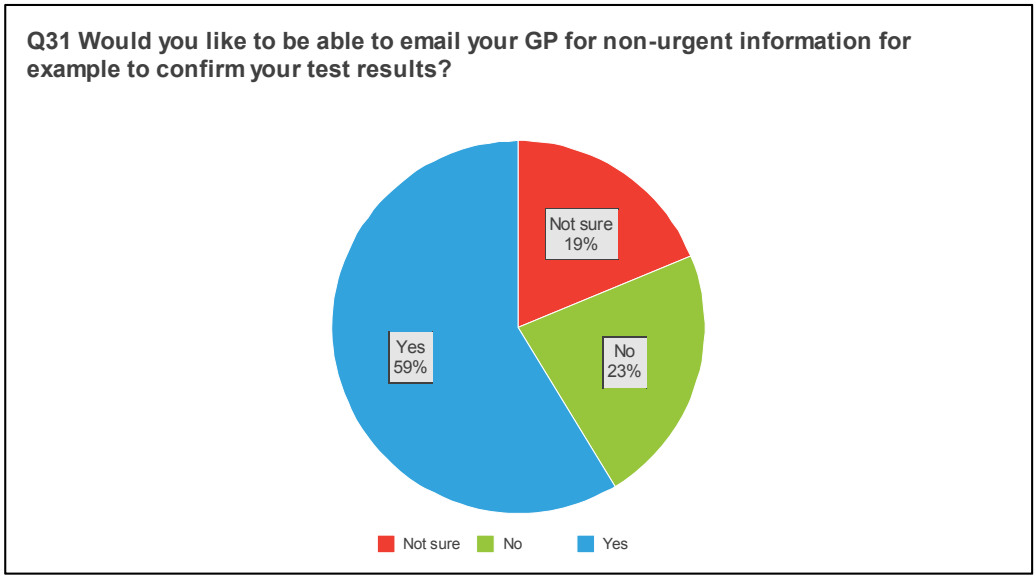
For those practices that are planning to implement this by April 2015 we would recommend that they actively promote this new facility for patients as widely as possible.

As with telephone appointment system, accessibility and ease of use for patients is paramount.

## Q 30b) If not would you like this facility at your practice?



## Q31) Would you like to be able to email your GP Practice for non-urgent information, for example to confirm your test results?




59% of respondents would like the option to be able to email for non-urgent information. When we looked at responses from the under 50 age group those in favour rose to 77%.

## Healthwatch Comment / Recommendation

As with our comments to Q18 we would encourage practices to actively look into this option.

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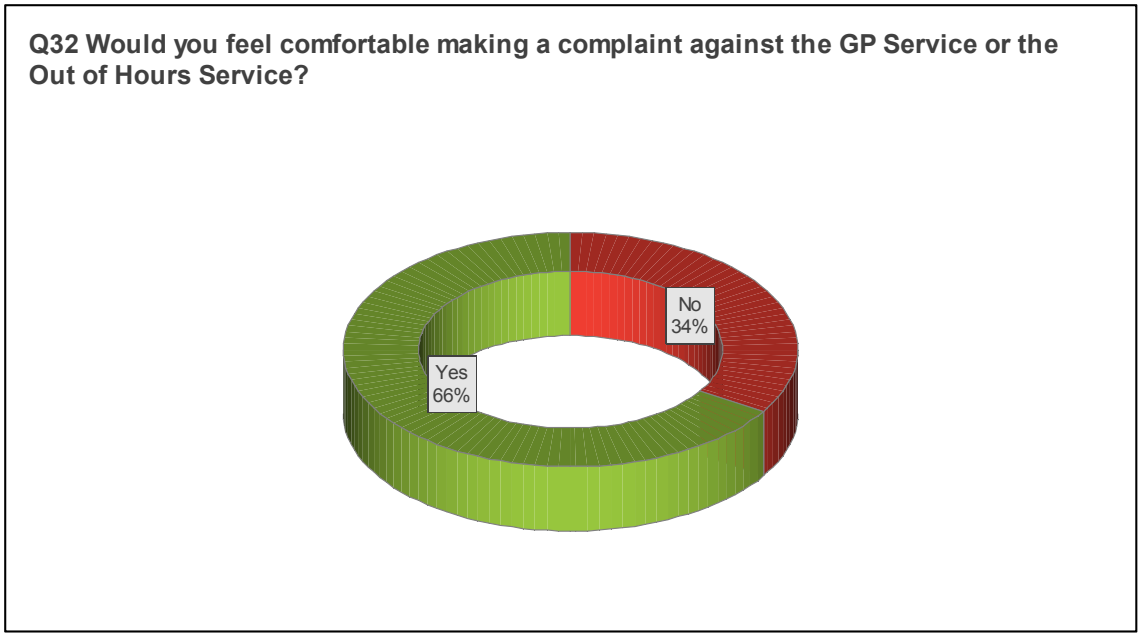
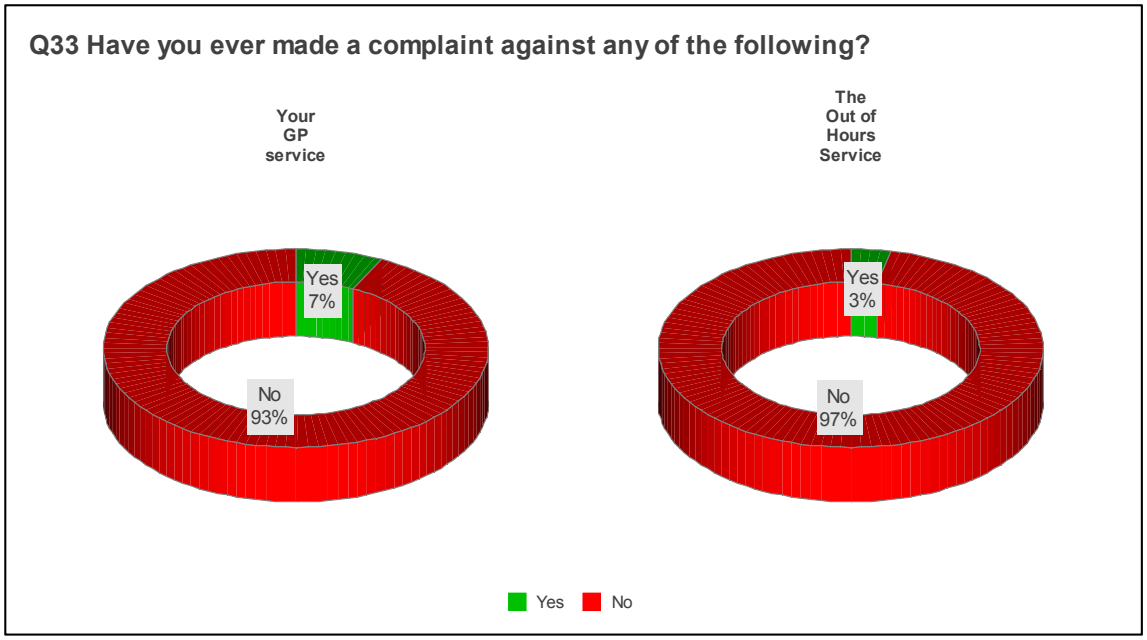
## Questions 32 to 35 cover the complaints system, our comments and recommendations are at the end of this section.

## Q 32) Would you feel comfortable making a complaint against a GP Service, or the Out of Hours Service?




## Q33) Have you made a complaint against any of the following?




Whereas 18% of people were unhappy with the OOH service only 3% had ever made a complaint against it. The figures for complaints about the GP service are more broadly in line with the percentages given in answer to Q12.

## Q 33c) If 'Yes' were you happy with the way your complaint was dealt with?


Almost 1 in 3 respondents were unhappy with the way their complaint was handled.

We asked those people who answered 'Yes' to Q33c why they weren't happy. Some of the comments are listed below.

### Survey Comments

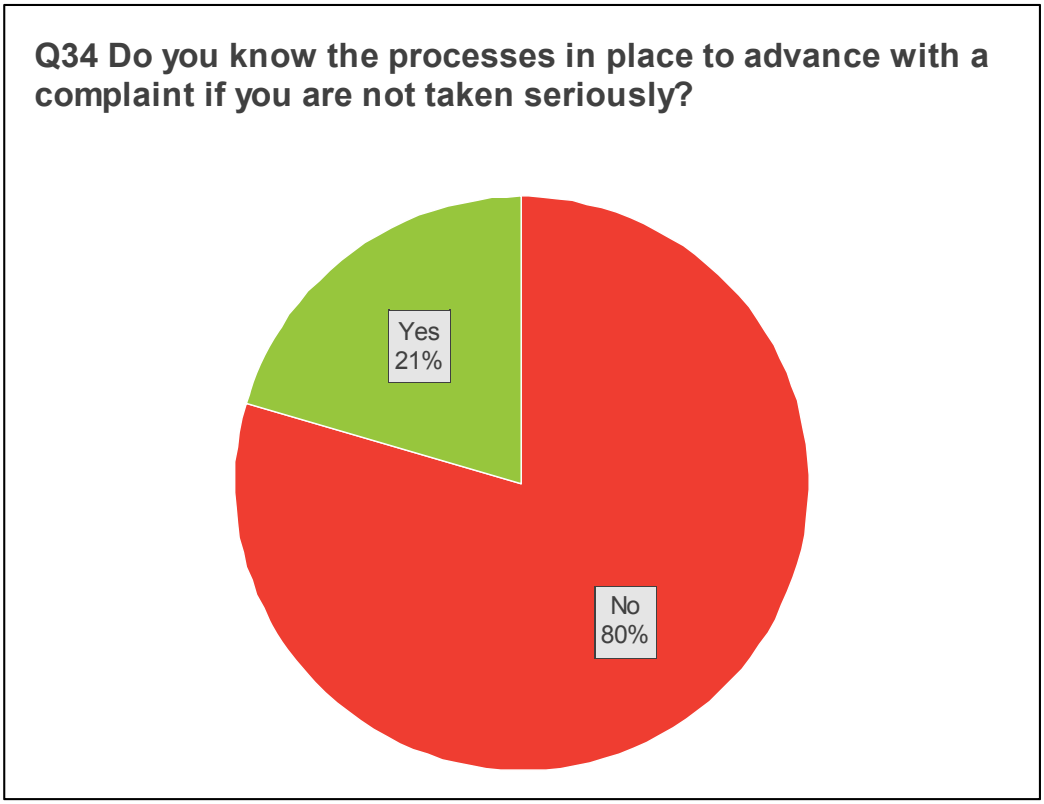
*'There was lengthy correspondence with Chief Executive and no outcome.'*

*'Say that a person higher up would call you back, and not once did.'*

*'After a complaint about a surgery receptionist – "the way she spoke to me" – I was assured I would be contacted, but was not.'*

*'No reply from emails'*

## Q 34) Do you know the process in place to advance with a complaint if you are not taken seriously?




## Q 35a) If you had as complaint to make about a service who would you make it to initially?

## Healthwatch Comment / Recommendation – Q32 to Q35

While there is a majority at 66% who would be comfortable making a complaint, over 1 in 3 people would feel uncomfortable making a complaint. Almost a third of the respondents also said they were not happy with how their complaint - concerning GP services - was dealt with. We find this unacceptable, we believe these levels of dissatisfaction would not be tolerated in other organisations/businesses.

This echoes research carried out by Healthwatch England Research in October 2013[8] which showed that 1 in 3 people report having experienced or knowing someone who has experienced poor care. Yet a YouGov survey, commissioned by Healthwatch England, of 2076 UK adults showed that less than half of those who had a bad experience between 2010 and 2013 actually did anything to report it.

As with our comments on previous answers, there are many reasons people don't complain about poor service. The results of the Healthwatch England 'You Gov' survey showed that 2 in 5 (43 per cent) said this was because they didn't know how to complain or provide feedback and half (49 per cent) said it was because they lacked confidence that their complaint would be dealt with effectively or thought

Ideally, it should be a straight forward process to raise a complaint with a local service, currently it is anything but.

We would like to see a simplified complaints process. One which would allow members of the public to easily raise any concerns they may have. We would also suggest that training of a consistently high standard is offered to all relevant staff in GP practices on complaints handling and customer service.

[8] **Health and care complaints system is 'utterly bewildering' for people** – 20th March 2014 http://www.healthwatch.co.uk/news/health-and-care-complaints-system-utterly-bewildering-people

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## Q 36) Any other comments?

The 'Cloud' diagram below highlights the most commonly used words in the comments received for Q36.


We've listed a few of the survey comments below.

*'I think more slots for appointments are needed.'*

*'Would like to be able to speak to the doctor him/herself if need be. Receptionist should not give their own recommendations regarding if a doctor is needed or not. Be more understanding of carers needing to book appointments that fit in with them to sort out someone to sit in while they attend.'*

*'Out of hours provision is not as good as before the change.'*

*'The receptionists think they are God and have terrible attitudes.'*

*'On the whole, services in my GP's are excellent. Receptionists always very helpful and cheerful.'*

*'I am very satisfied with my local GP Practice – it is easy to get to and the staff are friendly and very helpful. My GP is familiar with my medical history. I would not change or go to any other practice.'*

*'I think the NHS on the whole has brilliant and committed staff who deserve to be recognised as such. Considering the size and complexity of the NHS I think they do very well on the whole and people are treated well.'*

*'Trying to get an appointment at my Practice is like winning the Lottery!'*

## Acknowledgements:

Healthwatch Halton Task and Finish Team: Roy Page, Paul Cooke, Sue Ellison, Bernadine Mitchell

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Desmond Chow (Halton CCG)

NHS England

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The 491 people who took the time and effort to be a part of our survey.

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**REPORT TO:** Health Policy & Performance Board

**DATE:** 13th January 2015

**REPORTING OFFICER:** Strategic Director, Communities

**PORTFOLIO:** Health & Wellbeing

**SUBJECT:** Performance Management Report 2014-15 Quarter 2

**WARD(S)** Borough-wide

## 1.0 PURPOSE OF THE REPORT

1.1 This Report introduces, through the submission of a structured thematic performance report, the progress of key performance indicators, milestones and targets relating to Health in Quarter 2 of 2014-15. This includes a description of factors which are affecting the service.

In addition, Appendix 1 of the report contains a progress update concerning the implementation of all Directorate high-risk mitigation measures that are relevant to the remit of this Board.

## 2.0 RECOMMENDATION: That the Policy and Performance Board:

**i) Receive the Quarter 2 Priority Based report**

**ii) Consider the progress and performance information and raise any questions or points for clarification**

**iii) Highlight any areas of interest or concern for reporting at future meetings of the Board**

## 3.0 SUPPORTING INFORMATION

3.1 The Policy and Performance Board has a key role in monitoring and scrutinising the performance of the Council in delivering outcomes against its key health priorities. Therefore, in line with the Council's performance framework, the Board has been provided with a thematic report which identifies the key issues in performance arising in Quarter 2, 2014-15.

4.0 **POLICY IMPLICATIONS**

4.1 There are no policy implications associated with this report.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 There are no other implications associated with this report.

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

6.1 **Children & Young People in Halton**

There are no implications for Children and Young People arising from this report.

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

There are no implications for Employment, Learning and Skills arising from this report.

6.3 **A Healthy Halton**

The indicators presented in the thematic report relate specifically to the delivery of health outcomes in Halton.

6.4 **A Safer Halton**

There are no implications for a Safer Halton arising from this report.

6.5 **Halton's Urban Renewal**

There are no implications for Urban Renewal arising from this Report.

7.0 **RISK ANALYSIS**

7.1 Not applicable.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 There are no Equality and Diversity issues relating to this Report.

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

None under the meaning of the Act.

**Health Policy & Performance Board Priority Based Report**

**Reporting Period:** Quarter 2: 1st July 2014 – 30th September 2014

## 1.0 Introduction

This report provides an overview of issues and progress against key service area objectives and milestones and performance targets, during the second quarter of 2014/15; for service areas within the remit of the Health Policy and Performance Board. These areas include:

- Prevention & Assessment
- Commissioning & Complex Care (including housing operational areas)
- Public Health

## 2.0 Key Developments

There have been a number of developments within the second quarter which include:-

**COMMISSIONING & COMPLEX CARE SERVICES**

**Housing**

**HCA Affordable Homes Programme 2015/18**
The funding bids made by LHT, Plus Dane, and HHT to the Homes and Communities Agency that were reported last quarter have been approved in their entirety. This will result in 365 new dwellings for affordable rent being constructed across 19 sites in Halton.

Nearly 50% of the national Programme funds have been reserved for subsequent in year bids, and we will seek to take advantage of this as and when opportunities arise to maximise housing delivery through continued joint working with local Housing Associations.

**Property Pool Plus Housing Allocations Policy**
Revisions to the policy made necessary by the Localism Act, new Regulations concerning Armed Forces personnel and a new Code of Guidance are in the process of being endorsed by the Cabinets of the five local authorities participating in this sub regional scheme. Full details of the changes were reported to Halton's Executive Board on the 4th September. It is envisaged the changes will be implemented by January 2015 after a period of staff training.

**Widnes Homeless Hostel**
The tender for the provision of housing support at the new Widnes hostel has closed and submissions have now been evaluated. The second stage presentation and interviews will be held on 11th and 12th November 2014 and the contract is due to be awarded in December 2014.

**Floating Support Services**
The tender process has commenced for the provision of Generic and Mental Health housing-related floating support services.

**Physical and Sensory Disability Services**

Choice, control, Inclusion is the commissioning strategy for adults age 18-64 living with disability whilst SeeHear focusses on the needs of those living with sensory impairment. These strategies set out the priorities for service development over the next five years. Executive Board have endorsed both strategies. They will be taken through CCG governance in November. Oversight of implementation will be through the Better Care Board which reports to the Executive Board and CCG Governing Body.

**Keyring Community Living Network**

Executive Board have approved the establishment of a pilot network in Halton. The Keyring model is a network of vulnerable people who need some support including mutual support to live safe and fulfilling lives in the community with an emphasis on enablement rather than dependence on high levels of support. Implementation is now underway and a full evaluation will be undertaken at the at the end of Year 2.

**Mental Health**

Operation Emblem was set up as a project between Cheshire Police and the 5Boroughs Partnership – and supported by the Halton Mental Health Delivery Group – to manage and reduce the numbers of people in the borough who were being detained under Section 136 Mental Health Act 1983 (this is the provision which allows the police to detain a person found in a public place who appears to them to be mentally disordered, and who may pose a risk to themselves or others). The numbers of people detained under this provision were higher than anywhere else in the county, and the project was designed to support police officers by providing a triage service from a Community Psychiatric Nurse. Since the project began, numbers of people detained in Halton have reduced significantly, which means that there are fewer inappropriate detentions, and that a greater proportion of people are receiving appropriate mental health support at the point that they need it. The effectiveness of this project is being closely monitored by the Halton Mental Health Delivery Group and the Cheshire, Halton and Warrington Strategic Mental Health Partnership.

The Mental Health Crisis Care Concordat was published by central government in February 2014. It is intended to encourage all key partners to work together to reduce the numbers of people who find themselves in mental health crisis, and to improve the types of service and speed of response to such people. All key organisations are asked to sign up to a local declaration that they will work together to achieve these aims by December 2014, and to develop a related action plan by March 2015. Locally a small task and finish group, accountable to the Mental Health Delivery Group, has been set up to take this forward. the Cheshire, Halton and Warrington Strategic Mental Health Partnership is also working with key partners to deliver the aims of the Concordat and this will provide opportunities to work across boundaries to deliver more flexible responses.

In previous Quarterly Monitoring Reports, accounts have been given of the development of the pilot project for the Mental Health Outreach Team to work with a number of local GP surgeries to support people at an earlier stage in their mental health experience. This programme continues to provide promising results, with evidence that the interventions from the team have led to improved confidence and wellbeing, reductions in use of primary and secondary health services and better engagement by people with their own communities. As a result, work is currently being undertaken to establish whether the programme can be widened to the whole of the borough and made permanent.

**Other developments within the Commissioning and Complex Care Division**

Emergency Duty Team (EDT): this service was established as a partnership with St Helens Borough Council in 2007. Warrington Borough Council has made request to join the partnership and this, along with the substantial changes in service delivery and responsibilities since 2007, has triggered a review of the functions and structure of the service. A further report on this matter will be brought to the Board in due course.

## PREVENTION & ASSESSMENT

### Making It Real

We have developed a steering group to take forward the 'Making it real' marking progress towards personalised, community based support in relation to the 'Personalisation' agenda. This helps check our progress an decide what we need to do to keep moving forward to deliver real change and positive outcomes with people. We met with members of the TLAP programme (Think Local Act Personal) and they helped us facilitate a 'Making It Real Live" event that took place on the 4th of June. The event was well attended and involved people using services, a wide cross sector of partners and other agencies, including the independent sector and voluntary agencies. From the event we developed an action plan and identified leads to take forward task finish groups which the steering group will oversee. A follow up event will be held in December 2014 to update those attending the original event.

### Learning Disability Nursing Team

The team continue to work proactively with individuals, their family, carers and professionals such as GPs, allied Health professionals etc.
Progress:

- The team continue to seek the view of customers on their experiences with team members. These are in easy read format and show consistently positive results
- A recent audit has been completed of Nurse triages, and completed assessments completed by the team, has shown a high standard of health support and dynamic thinking/working is being offered to Halton residents.
- A nursing team member has delivered Learning Disability awareness training to the dignity and safeguarding champions at Warrington Hospital to support people with learning disabilities accessing the acute trust. The feedback from this was very positive
- The Big Health Day took place in September, which was a great success. Cancer screening was covered along with demonstrations of checking breasts and testicles and cervical smear tests. A dentist and dental hygienist demonstrated good oral hygiene. Mental well-being was covered including emotions.
- The team have been completing peer observations and management observations to ensure the service provided is of a high quality.
- A team member has been training carers alongside the Health Improvement Team to support people with a learning disability to make healthy lifestyle choices
- Team members have been working with GPs to look at their learning disability register and cleanse the data.

- To support the transition of an individual from an inpatient setting, visits have taken place with potential placements and providers to ensure the placement is of high quality with good outcomes and timely support for the individual.

**Winterbourne View**

Winterbourne View Review Concordat: Programme of Action was published by the Department of Health in December 2013. Halton CCG and Council have developed a localised action plan – this will continues to be monitored through the Learning Disability Partnership Board and HCCG Quality and Integrated Governance Committee. Assurance is provided to NHS England as per the Concordant Action Plan.

- The Council has continued to work with health colleagues to review all out of area placements regardless of funding arrangements.
- Halton's Winterbourne Strategic task group set up to ensure those placed out of area are managed and monitored appropriately with professionals tasked with reassessing those individuals to enable them return to Halton this meeting meets quarterly. This work has been on-going with successful placements now achieved locally with the co work of the care management teams, health colleagues and the Positive Behaviour team. The out of area action plan is monitored by the complex care board with quarterly updates.
- Joint Health and Social Care Learning Disability 2014/15 validation and assurance to be completed (early 2015).
- Bryon Unit 5 Borough Partnership Inpatient bed usage currently being monitored - usage for 2013/14 was 10 inpatient admissions; usage for 2014/15 to date is 2 admissions. The usage in 2013/14 was higher than previous years, which meant more individuals accessed an inpatient facility. A review of admissions has taken place to understand rationale and appropriateness of the admissions. The usage in 2014/15 is consistent with previous years prior to 2013/14 and continues to be monitored on a monthly basis.

**PUBLIC HEALTH**

Good progress has been made in implementing the alcohol Health & Wellbeing Board action plan. As part of the alcohol strategy development work a refreshed action plan for 2014-15 has been developed and signed up to by all partners. The Public Health Annual Report has this year focused on alcohol and what we have achieved and an Alcohol Reduction Strategy has been written.

The Halton Healthy Weight management care pathways for children and adults is under review and opportunities to enhance provision being identified.

Uptake remains good for HPV vaccination against cervical cancer. Changes to the national schedule for HPV vaccination may further improve opportunities to improve uptake locally.

The Family Nurse Partnership team has been recruited and will start to work with first time teenage mothers in November 2014.

All of the planned redesign of the falls service, falls training and triage has been completed ahead of schedule. A falls business case has now been developed to consider

the impact of additional funding and preventative interventions to further reduce the level of falls at home as well as the readmission rates.

## 3.0 Emerging Issues

3.1 A number of emerging issues have been identified during the second quarter that will impact upon the work of the Directorate including:-

**COMMISSIONING & COMPLEX CARE**

**Housing**

Halton's Housing network continues through the Efficiency Review process. Day Services are due to start a new commercial venture in Simms Cross Widnes. Adult Placement Service has put forward service development proposals to increase the support for people with Dementia.

**Mental Health Services**

As a part of the work on the Mental Health Crisis Care Concordat, an approach has been made to a North West university to engage in research about two aspects of the use of the Mental Health Act: the experience for the patient of the assessment and detention process, and an understanding of the steps that could have been taken earlier in the person's life which might have avoided the need for detention in hospital at a later stage. Although very sensitive, this research should assist the delivery of more personalised and dignified use of the Act, and in improving practice may well help people to seek support at an earlier stage in the life of their mental health condition. A better understanding of the types of intervention that would have helped earlier in people's lives should help with improved targeting of preventive services.

Work has been taking place with Warrington Borough Council to introduce into Halton a successful scheme to divert people with mental health needs from the criminal justice system. The Support 4 Change programme screens people who are passing through the criminal justice system, and where appropriate provides support and structured follow-up to people who are vulnerable because of mental health issues, a learning disability or drugs and/or alcohol problems. Funding has been secured for 12 months and the service has already begun in Halton, with three staff in place. This will be reported on in subsequent Quarterly Monitoring Reports.

**PREVENTION & ASSESSMENT**

**The Personal Budgets Outcomes and Evaluation Tool (POET)**

POET has been developed over a number of years by In Control and the Centre for Disability Research at Lancaster University. Its aim is to provide a national benchmark on the impact that personal budgets are having on people's lives. The Care Services Minister Norman Lamb has recommended that all councils should be checking people's experiences of using personal budgets, through tools such as POET. Staff have been identified to complete the surveys with people and carers using services. Halton

completed the evaluation tool last year. This year's work will contribute to the 'Making it Real' follow up event in December 2014.

**PUBLIC HEALTH**

E cigarettes are an issue. They are not yet regulated and cannot be used as a quit tool.

## 4.0 Risk Control Measures

Risk control forms an integral part of the Council's Business Planning and performance monitoring arrangements. During the development of the 2014/15 Business Plan, the service was required to undertake a risk assessment of all key service objectives with high risks included in the Directorate Risk Register.

As a result, monitoring of all relevant 'high' risks is undertaken during Quarter 2 and Quarter 4.

## 5.0 Progress against high priority equality actions

There have been no high priority equality actions identified in the quarter.

## 6.0 Performance Overview

The following information provides a synopsis of progress for both milestones and performance indicators across the key business areas that have been identified by the Communities Directorate. The way in which the Red, Amber and Green, (RAG), symbols have been used to reflect progress to date is explained at the end of this report.

***Commissioning and Complex Care Services***

**Key Objectives / milestones**

| Ref | Milestones | Q2 Progress |
|---|---|---|
| CCC1 | Continue to monitor effectiveness of changes arising from review of services and support to children and adults with Autistic Spectrum Disorder. **Mar 2015.** (AOF 4) | ✓ |
| CCC1 | Continue to implement the Local Dementia Strategy, to ensure effective services are in place. **Mar 2015.** (AOF 4) | ✓ |
| CCC1 | Continue to implement 5Boroughs NHS Foundation Trust proposals to redesign pathways for people with Acute Mental Health problems and services for older people with Mental Health problems. **Mar 2015** (AOF 4) | ✓ |
| CCC1 | The Homelessness Strategy be kept under annual review to determine if any changes or updates are required. **Mar** | ✓ |

| | | |
|---|---|---|
| | **2015. (AOF 4, AOF 18)** | |
| CCC2 | Ensure Healthwatch is established and consider working in partnership with other Councils to deliver this. **Mar 2015 (AOF 21)** |  |
| CCC3 | Undertake on-going review and development of all commissioning strategies, aligning with Public Health and Clinical Commissioning Groups, to enhance service delivery and continue cost effectiveness, and ensure appropriate governance controls are in place. **Mar 2015. (AOF 21 & 25)** |  |

***Key Performance Indicators***

**Supporting Commentary**

**CCC 1 Services / Support to children and adults with Autism**
The Autism Strategy group continues to monitor the progress of the Autism Strategy 2012 – 2016 action plan.

**CCC 1 Dementia Strategy**
Progress against the strategy delivery plan will now be monitored through the newly established Mental Health Oversight Board. In Q2 the Case Finding Pilot has started and the 'ground work' for the establishment of a Halton Dementia Action Alliance has been initiated.

**CCC1 Mental Health**
Work continues with the 5BP NHS Foundation Trust to review inpatient and community services for older people with mental health problems. An options appraisal should be available to elected Members over the coming months.

**CCC1 Homelessness Strategy**
The 2013/18 Homelessness Strategy was approved by Executive Board on 27th March 2014. Designated sub groups will continue to meet on a bi monthly basis to discuss and implement the strategic action plan. The focus is presently around improving the monitoring & performance of the service, with further emphasis to develop prevention initiatives around Health.

**CCC 2 HealthWatch**
Healthwatch continues to develop and events for local residents are scheduled. Discussion with partner Councils related to advocacy services are underway to ensure the best possible service is delivered.

**CCC 3 Review and development of commissioning strategies to align with Public Health and Clinical Commissioning Groups**
Work in this area is progressing as scheduled. The Integration Agenda continues to move towards greater alignment around governance and the integrated approach to performance management.

***Key Performance Indicators***

| Ref | Measure | 13 / 14 Actual | 14 / 15 Target | Q2 Actual | Q2 Progress | Direction of travel |
|---|---|---|---|---|---|---|
| CCC 4 | Adults with mental health problems helped to live at home per 1,000 population | 2.64 | 3.5 | **2.54** | ✓ | ↓ |
| CCC 5 | The proportion of households who were accepted as statutorily homeless, who were accepted by the same LA within the last 2 years (Previously CCC 6). | 0 | 1.2 | **0** | ✓ | ↑ |
| CCC 6 | Number of households living in Temporary Accommodation (Previously NI 156, CCC 7). | 11 | 12 | **12** | ✓ | ↑ |

**Supporting Commentary**

**CCC 4 Adults with mental health problems helped to live at home per 1,000 population**
This figure is likely to improve in the next Quarter as the work from the pilot project by the Mental Health Outreach Team (MHOT) into GP surgeries is included. The pilot focusses on early intervention, support, and reablement for people with mental health problems who are in primary care services. GPs make referrals to MHOT for one-to-one support with individuals. Work is also taking place to refocus the social work service to ensure that more people are supported within primary care.

**CCC 5 The proportion of households who were accepted as statutorily homeless, who were accepted by the same LA within the last 2 years**
Halton forms part of the Merseyside Sub Regional, No Second Night Out scheme which is proven to be a successful resource and fully utilised across the Merseyside Authorities. . The service provides an outreach service for rough sleepers and has successfully worked in partnership with Halton to identify and assist this vulnerable client group. The Authority will continue to strive to sustain a zero tolerance towards repeat homelessness within the district and facilitate reconnection with neighbouring authorities.

**CCC 6 Number of households living in Temporary Accommodation**
The Housing Solutions Team has taken a proactive approach to preventing homelessness. There are established prevention measures in place and the Housing

Solutions team will continue to promote the services and options available to clients. The changes in the TA process and amended accommodation provider contracts has had a positive impact upon allocation placements. The emphasis is focused on early intervention and further promotes independent and sustainable living. The improved service process has developed stronger partnership working and contributed towards an effective move on process for clients. The Authority will strive to sustain the reduced TA provision.

***Prevention and Assessment Services***

**Key Objectives / milestones**

| Ref | Milestones | Q2 Progress |
|---|---|---|
| PA 1 | Fully implement and monitor the effectiveness of the complex care pooled budget **March 2015.** (**AOF 2,3,4,10,21)** | ✓ |
| PA 1 | Continue the integrated provision of frontline services including multidisciplinary teams, care homes, safeguarding services and urgent care **March 2015** (**AOF 2,3,4,10,21)** | ✓ |
| PA 1 | Develop a Care Management Strategy to reflect the provision of integrated frontline services for adults **March 2015** (**AOF 2,3,4,10,21)** | ✓ |
| PA 1 | Work within adult social care to focus on preventative service to meet the needs of the population **March 2015** (**AOF 2,3,4,10,21)** | ✓ |
| PA 1 | Develop an integrated approach to the delivery of Health and Wellbeing across Halton **March 2015** (**AOF 2,3,4,10,21)** | ✓ |
| PA 2 | Continue to establish effective arrangements across the whole of adult social care to deliver personalised quality services through self-directed support and personal budgets **March 2015 (AOF 2, 3,4,10,21)** | ✓ |
| PA 2 | Continue to review the quality of commissioned services and continue to develop the role of the integrated safeguarding unit **March 2015 (AOF 2, 3,4,10,21)** | ✓ |

**Supporting Commentary**

**PA 1 Complex care pooled budget**
The Boards associated with the pooled fund have changed their names to the Better Care Board and the Better Care Executive Commissioning Board to reflect the addition of the Better Care Fund from April 2015. The boards continue to monitor the work of the fund to meet the key strategic objectives and the use of the financial resources. The pool fund is project to have a slight underspend at the end of year.

**PA 1 Integrated provision of frontline services**
The Care Homes project has been agreed for permanent staffing. The evaluation demonstrated the need for additional resources to improve the quality of care with nursing and pharmacy staff in recruitment process. Work continues with GP practices, community nursing and social care on the delivery of the multi-disciplinary approach for those with complex needs. Additional resources have been released from central government to support increased demand during the winter period. This includes significant investment in the 2 acute hospitals, support for the ambulance service, additional beds in the community and support for the developing Urgent Care Centres.

**PA 1 Develop a Care Management Strategy**
Early draft of Care Management strategy now completed and finalised draft aimed to be delivered November 2014.

**PA 1 Work within Adult Social Care focussing on Preventative Services**
The Initial Assessment Team continues to develop close working with Sure Start/Bridge Building, Telecare and also offering better sign posting.

**PA 1 Develop an integrated approach to the delivery of Health and Wellbeing across Halton**
On target for completion.

**PA 2 Personalisation/Self-directed Support**
To ensure effective arrangements for 'Personalisation' across adult social care, we have developed a steering group to take forward the 'Making it Real' agenda. TLAP (Think Local Act Personal) supported us to facilitate a 'Making It Real Live" event that took place on 4th June. From the event we developed an action plan and have now identified leads to take forward task finish groups which the steering group will oversee. A follow up event will be held in December 2014 to update those attending the original event.

**PA 2 Integrated Safeguarding**
We are currently developing a care and safeguarding dashboard to enable professionals to receive up to date information across the Halton.

***Key Performance Indicators***

| Ref | Measure | 13 / 14 Actual | 14/15 Target | Q2 Actual | Q2 Progress | Direction of travel |
|---|---|---|---|---|---|---|
| PA 2 | Numbers of people receiving Intermediate Care per 1,000 population (65+) | 81.31 | 82 | **38.2** | ✓ |  |
| PA 3 | Percentage of VAA Assessments completed within 28 days | 87.69% | 85% | **85.3%** | ✓ |  |
| PA 7 | Percentage of items of equipment and adaptations delivered within 7 working days | 96.3% | 97% | **96.4%** | ✓ |  |

**Supporting Commentary**

**PA 2 Numbers of people receiving Intermediate Care per 1,000 population (65+)**
Although referral numbers are slightly down when comparing Q2 14/15 with Q2 13/14, we are on course to meet this target.

**PA 3 Percentage of VAA Assessments completed within 28 days**
We have exceeded the target.

**PA 7 Percentage of items of equipment and adaptations delivered within 7 working days**
On line to meet this target**.**

***Public Health***

**Key Objectives / milestones**

| Ref | Milestones | Q2 Progress |
|---|---|---|
| PH 01 | Work with the public and service providers to raise awareness of the early signs and symptoms of bowel, breast and lung cancer so we can identify it an early stage in the population. **March 2015** | ✓ |
| PH 01 | Reduce obesity rates in the local population, thereby reducing the incidence of bowel cancer through promoting healthy eating and screening programmes for adults and | ? |

| | | |
|---|---|---|
| | children via a range of services. **March 2015** | |
| PH 01 | Meet the target for the take up of HPV vaccination in girls 11-13, to reduce cervical cancer rates by working proactively with the School Nursing Service and GPs. **March 2015** |  |
| PH 01 | Work proactively with GPs, all service providers, Alcohol Liaison Nurses, teachers in schools to reduce the number of people drinking to harmful levels and alcohol related hospital admissions given the rise in pancreatic and liver cancer rates. **March 2015** |  |
| PH 02 | Facilitate the Early Life Stages development which focusses on a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, and health, well-being and parenting advice for ages 2½ years and 5 years. **March 2015** |  |
| PH 03 | Working with all service providers, implement the action plan to reduce falls at home in line with the Royal Society for the Prevention of Accidents (ROSPA) guidance as outlined in the new Falls Strategy **March 2015** |  |
| PH 05 | Implement the Mental Health and Wellbeing Programme in all schools and provide training for GP Practices and parenting behaviour training in the Children's Centres. **March 2015** |  |

**Supporting Commentary**

**PH 01 Raise awareness of Bowel, Breast and Lung Cancer**
This is a priority for Halton Health & Wellbeing Board and sits within its underlying action plans. The national Be Clear on Cancer campaign continues to be rolled out with a team of volunteers working with local people. We are working closely with Halton Clinical Commissioning Group (CCG) to develop additional early detection programmes along the lines of a Cancer Rehabilitation programme.

We do not yet have easy access to staging data from the local hospitals. GP practices have been supported to conduct the cancer audit.

**PH 01 Reduce Obesity Rates**
A range of weight management services are delivered for children and adults on an individual or group level, such as the fresh start programmes, active play and introduction to solid food parties. The Halton Healthy Weight management care pathways for children and adults is under review and opportunities to enhance provision being identified.

**PH 01 Reduce Cervical Cancer Rates**
Uptake remains good for HPV vaccination. Changes to the national schedule for HPV vaccination may further improve opportunities to improve uptake locally.

**PH 01 Reduce the number of people drinking to harmful levels**
An alcohol harm reduction strategy for Halton has been developed and is due to be launched during alcohol awareness week (17-23 November). The strategy was developed in partnership with colleagues from health, social care, education, voluntary sector, police and the community safety team.

The strategy will set out actions across the life course to reduce alcohol related harm and reduce hospital admissions. Good progress has been made related to reducing under-18 admission rates locally. Alcohol health education sessions are being delivered in all local schools.

**PH 02 Facilitate Early Life Stages development**
The healthy child programme continues to be delivered across Halton, conducting screening, immunisations and health reviews. The Family Nurse Partnership team has been recruited and will being to start with first time teenage mothers in November 2014.

Work is underway to ensure the safe transition of the Health Visiting service and Family Nurse Partnership to be commissioned by the Local authority by October 2015.

**PH 03 Falls Reduction Action Plan**
All of the planned redesign of falls service, falls training and triage has been completed ahead of schedule. A falls business case has now been developed to consider the impact of additional funding and preventative interventions to further reduce the level of falls at home as well as the readmission rates.

**PH 05 Mental Health and Wellbeing Programme**
A review of all local mental health and wellbeing provision is underway to ensure that there are consistent, high quality services available.

A new mental health and wellbeing action plan is in progress, informed by the Mental Health and Wellbeing Strategy.

***Key Performance Indicators***

| Ref | Measure | 13/14 Actual | 14/15 Target | Q2 | Current Progress | Direction of travel |
|---|---|---|---|---|---|---|
| PH LI 01 (SCS HH 7) | Mortality rate from all cancers at ages under 75 (previously PH LI 04 [2013/14],NI 122) | 145.1 July 13 to June 14 | 140 | Not available measured annually. | ? | ⇔ |
| PH LI 02 | A good level of child development | 37% | 40% | Not available measured annually. | ? | ⇔ |

| | | | | | | |
|---|---|---|---|---|---|---|
| PH LI 03 New SCS Measure Health 2013-16) | Falls and injuries in the over 65s (Public Health Outcomes Framework) (previously PH LI 06 [2013/14]) | 2,850.4 (Jan 13 – Dec 13) | 2,847 | 2,796.3 (Jul 13 – Jun 14) |  |  |
| PH LI 04 | Admissions which are wholly attributable to alcohol AAF=1, rate per 100,000 population. | 947.5 (2013/14) | 1,038 | N/A | N/A | N/A |
| PH LI 05 | Mental Health: Self-reported wellbeing (previously PH LI 08, 2013/14) | N/A | 69% | N/A | N/A | N/A |

**Supporting Commentary**

**PH LI 01** There has been a small reduction in the death rate from cancer, but it is too early to say if this trend will continue. The recently updated cancer action plan will tackle this.

**PH LI 02** This is a combined health and children's indicator which includes personal, social and emotional development; physical development; and communication and language) and the specific areas of mathematics and literacy. We cannot measure performance against last year as the way the indicator is measured has changed. This area is a challenge for Halton. The increase in the Health Visiting Service should contribute to improving the figures.

**PH LI 03** Performance has been positive in the quarter due to a number of key interventions from the falls strategy now being in place:

- Increased training for professionals
- New training for members of the public
- Increased screening
- New triage into intermediate care
- More capacity within falls assessments

**PH LI 04** Haven't received data for Q2 2014/15. Halton has a new Alcohol Strategy & action plan and is now an Alcohol Action Area. Rates for under 18s are reducing.

**PH LI 05** o data available yet. A wide range of programmes are in place for mental health The CAMHS service has been reviewed and we are out to tender for a new service.

## APPENDIX 1 – Financial Statements

**COMMISSIONING & COMPLEX CARE DEPARTMENT**

**Revenue Budget as at 30th September 2014**

| | Annual Budget £'000 | Budget To Date £'000 | Actual To Date £'000 | Variance To Date (overspend) £'000 |
|---|---|---|---|---|
| Expenditure | | | | |
| Employees | 7,463 | 3,573 | 3,521 | 52 |
| Premises | 304 | 158 | 159 | (1) |
| Supplies & Services | 1,905 | 922 | 922 | 0 |
| Carers Breaks | 423 | 312 | 309 | 3 |
| Transport | 170 | 79 | 77 | 2 |
| Contracts & SLAs | 149 | 57 | 53 | 4 |
| Payments To Providers | 3,816 | 1,555 | 1,556 | (1) |
| Emergency Duty Team | 103 | 26 | 25 | 1 |
| Other Agency Costs | 795 | 320 | 312 | 8 |
| **Total Expenditure** | **15,128** | **7,002** | **6,934** | **68** |
| Income | | | | |
| Sales & Rents Income | -384 | -202 | -225 | 23 |
| Fees & Charges | -173 | -99 | -72 | (27) |
| CCG Contribution To Service | -810 | -405 | -374 | (31) |
| Reimbursements & Grant Income | -663 | -155 | -156 | 1 |
| Transfer From Reserves | -848 | 0 | 0 | 0 |
| **Total Income** | **-2,878** | **-861** | **-827** | **(34)** |
| **Net Operational Expenditure** | **12,250** | **6,141** | **6,107** | **34** |
| **Recharges** | | | | |
| Premises Support | 192 | 80 | 80 | 0 |
| Transport | 436 | 218 | 218 | 0 |
| Central Support Services | 1,685 | 842 | 842 | 0 |
| Asset Charges | 76 | 38 | 38 | 0 |
| Internal Recharge Income | -1,685 | 0 | 0 | 0 |
| **Net Total Recharges** | **704** | **1,178** | **1,178** | **0** |
| **Net Departmental Total** | **12,954** | **7,319** | **7,285** | **34** |

**Comments on the above figures:**

Net operational expenditure is £34,000 below budget profile at the end of the first quarter of the financial year.

Employee costs are currently £52,000 below budget profile. This results from savings made on vacant posts, specifically in relation to Mental Health and Day Services. These posts have now either been filled, or are in the process of being filled. It is therefore not anticipated that the spend below budget profile will continue at this level for the remainder of the financial year, and will not impact on the 2015/16 budget year.

Income is below target to date. There is an anticipated shortfall on Fees & Charges income due to the temporary closure and refurbishment of a homeless facility. Additionally, income received from the Clinical Commissioning Group is projected to be below target. This income relates to Community Health Care funded packages within Day Services and the Supported Housing Network. The income received is dependent on the nature of service user's care packages, and is out of the direct control of the service. This shortfall is partly offset by an over-achievement of trading income from Day Services ventures, which is reflected in income above target to date of £23,000 for Sales and Rents.

At this stage in the financial year, it is anticipated that a balanced budget overall will be achieved for the year. Whilst income is projected below target, this will be offset by in-year savings in other areas, principally staff turnover savings, Day Services trading income, and the Bredon respite contract.

**Capital Projects as at 30th September 2014**

| | 2014/15 Capital Allocation £'000 | Allocation To Date £'000 | Actual Spend To Date £'000 | Allocation Remaining £'000 |
|---|---|---|---|---|
| ALD Bungalows | 100 | 0 | 0 | 100 |
| Lifeline Telecare Upgrade | 100 | 0 | 0 | 100 |
| Halton Carer's Centre Refurb. | 50 | 10 | 10 | 40 |
| Section 256 Grant | 55 | 0 | 0 | 55 |
| Community Capacity Grant | 216 | 0 | 0 | 216 |
| **Total Spending** | **521** | **10** | **10** | **511** |

**PREVENTION & ASSESSMENT DEPARTMENT**

**Revenue Budget as at 30th September 2014**

| | Annual Budget £'000 | Budget To Date £'000 | Actual To Date £'000 | Variance To Date (underspend) £'000 |
|---|---|---|---|---|
| Expenditure | | | | |
| Employees | 6,510 | 3,230 | 3,166 | 64 |
| Other Premises | 63 | 21 | 18 | 3 |
| Supplies & Services | 1,044 | 75 | 76 | (1) |
| Aids & Adaptations | 113 | 67 | 80 | (13) |
| Transport | 8 | 4 | 5 | (1) |
| Food Provision | 28 | 14 | 15 | (1) |
| Other Agency | 23 | 10 | 11 | (1) |
| | 885 | 0 | 0 | 0 |
| **Transfer to Reserves** | | | | |
| Contribution to Complex Care Pool | 17,971 | 7,734 | 7,733 | 1 |
| **Total Expenditure** | **26,645** | **11,155** | **11,104** | **51** |
| Income | | | | |
| Other Fees & Charges | -232 | -116 | -127 | 11 |
| Reimbursements & Grant Income | -1,007 | -68 | -74 | 6 |
| Transfer from Reserves | -2,485 | 0 | 0 | 0 |
| Capital Salaries | -39 | 0 | 0 | 0 |
| Government Grant Income | -155 | -125 | -125 | 0 |
| CCG Contribution to Service | -520 | -412 | -415 | 3 |
| **Total Income** | **-4,438** | **-721** | **-741** | **20** |
| | | | | |
| **Net Operational Expenditure** | **22,207** | **10,434** | **10,363** | **71** |
| **Recharges** | | | | |
| Premises Support | 221 | 111 | 111 | 0 |
| Asset Charges | 210 | 0 | 0 | 0 |
| Central Support Services | 1,980 | 942 | 942 | 0 |
| Internal Recharge Income | -419 | 0 | 0 | 0 |
| Transport Recharges | 50 | 22 | 25 | (3) |
| **Net Total Recharges** | **2,042** | **1,075** | **1,078** | **(3)** |
| **Net Departmental Total** | **24,249** | **11,509** | **11,441** | **68** |

**Comments on the above figures:**

In overall terms, the Net Operational Expenditure for the second quarter of the financial year is £67,000 under budget profile excluding the Complex Care Pool.

Employee costs are currently showing £64,000 under budget profile. This is due to savings being made on vacancies within the department, in particular Care Management. Some of these vacancies have been advertised and are expected to be filled in the coming months, however if not appointed to the current underspend will continue to increase beyond this level.

Expenditure on Aids and Adaptations is £13,000 over budget profile in the second quarter. Aids and Adaptations continue to be a pressure area as more people are supported within their own homes.

Overall income has for the second quarter, over achieved by £20,000. Lifeline income is £11,000 higher than anticipated at budget setting time, however this is offset by an increase in transport recharges of £3,000 for diesel, vehicle repairs, tyres and casual hire. This trend is expected to continue for rest of the financial year.

A detailed analysis of the Complex Care Pool is shown below:

**COMPLEX CARE POOL**

**Revenue Budget as at 30th September 2014**

| | Annual Budget £'000 | Budget To Date £'000 | Actual To Date £'000 | Variance To Date (overspend) £'000 |
|---|---|---|---|---|
| Expenditure | | | | |
| Intermediate Care Services | 3,491 | 1,317 | 1,309 | 8 |
| End of Life | 192 | 103 | 103 | 0 |
| CHC Assessment Team | 255 | 0 | 0 | 0 |
| Sub Acute | 1,788 | 873 | 868 | 5 |
| Joint Equipment Store | 532 | 202 | 202 | 0 |
| Intermediate Care Beds | 596 | 94 | 94 | 0 |
| Adult Care: | | | | |
| Residential & Nursing Care | 20,146 | 8,413 | 8,369 | 44 |
| Domiciliary & Supported Living | 9,854 | 4,830 | 4,800 | 30 |
| Direct Payments | 3,293 | 2,018 | 2,180 | (162) |
| Day Care | 457 | 202 | 194 | 8 |
| **Total Expenditure** | **40,604** | **18,052** | **18,119** | **(67)** |
| **Income** | | | | |
| Residential & Nursing Income | -4,920 | -2,567 | -2,625 | 58 |
| Community Care Income | -1,552 | -563 | -578 | 15 |
| Direct Payments Income | -189 | -102 | -97 | (5) |
| Other Income | -285 | -285 | -285 | 0 |
| CCG Contribution to Pool | -12,784 | -6,423 | -6,423 | 0 |
| Reablement & Section 256 Income | -2,903 | -378 | -378 | 0 |
| **Total Income** | **-22,633** | **-10,318** | **-10,386** | **68** |
| | | | | |
| **Net Divisional Expenditure** | **17,971** | **7,734** | **7,733** | **1** |

**Comments on the above figures:**

The overall net expenditure budget is £1,000 under budget profile at the end of the second quarter.

Intermediate Care Services includes spend for the Therapy & Nursing Teams, Rapid Access Rehabilitation and Reablement. A number of invoices relating to Intermediate Care Services for the period have not yet been received so close monitoring will be undertaken throughout the next quarter to ascertain an accurate position moving forward.

The number of clients in receipt of residential & nursing social care from April this year has increased by 1%. The number of clients in receipt of domiciliary social care (including supported living) from April this year has decreased by 5%, this is due in part, to 38 clients moving to Direct Payments.

The number of clients in receipt of a Direct Payment has substantially increased in the first half of the year and this is due to the renegotiation of the Domiciliary Care contracts. Clients who were receiving domiciliary care have now opted to take a Direct Payment and new clients who have never received a package of care taking the option of a Direct Payment. The increase is expected to continue into the next quarter and this should result in a further reduction in the numbers for domiciliary care.

Due to expenditure by nature, being volatile and fluctuating throughout the year depending on the number and value of new packages being approved and existing packages ceasing trends of expenditure and income will be scrutinised in detail throughout the next quarter of the year to ensure a balanced budget is achieved at year-end and in order to identify pressures that may affect the budget in the short to medium term.

The budgets across health and social care have been realigned to reflect the expenditure and income in the previous year.

**Capital Projects as at 30th September 2014**

| | 2014/15 Capital Allocation £000 | Allocation To Date £000 | Actual Spend To Date £000 | Allocation Remaining £000 |
|---|---|---|---|---|
| Disabled Facilities Grant | 500 | 250 | 149 | 351 |
| Energy Promotion | 12 | 6 | 6 | 6 |
| Stair lifts (Adaptations Initiative) | 250 | 125 | 119 | 131 |
| RSL Adaptations (Joint Funding) | 200 | 100 | 89 | 111 |
| **Total Spending** | **962** | **475** | **357** | **605** |

**PUBLIC HEALTH DEPARTMENT**

**Revenue Budget as at 30th September 2014**

| | Annual Budget £'000 | Budget To Date £'000 | Actual To Date £'000 | Variance To Date (underspend) £'000 |
|---|---|---|---|---|
| **Expenditure** | | | | |
| Employees | 1,718 | 866 | 812 | 54 |
| Supplies & Services | 152 | 53 | 47 | 6 |
| Other Agency | 20 | 20 | 17 | 3 |
| **Contracts & SLA's** | 5,682 | 2,200 | 2,200 | 0 |
| Transfer to Reserves | 707 | 0 | 0 | 0 |
| **Total Expenditure** | **8,279** | **3,139** | **3,076** | **63** |
| **Income** | | | | |
| Other Fees & Charges | -49 | -34 | -30 | (4) |
| Sales Income | -26 | -20 | -18 | (2) |
| Reimbursements & Grant Income | -3 | 0 | 0 | 0 |
| Government Grant | -8,749 | -2,187 | -2,187 | 0 |
| Transfer from Reserves | -200 | 0 | 0 | 0 |
| **Total Income** | **-9,027** | **-2,241** | **-2,235** | **(6)** |
| **Net Operational Expenditure** | **-748** | **898** | **841** | **57** |
| **Recharges** | | | | |
| Premises Support | 50 | 25 | 25 | 0 |
| Central Support Services | 2,135 | 230 | 230 | 0 |
| Transport Recharges | 25 | 9 | 9 | 0 |
| **Net Total Recharges** | **2,210** | **264** | **264** | **0** |
| **Net Departmental Total** | **1,462** | **1,162** | **1,105** | **57** |

**Comments on the above figures:**

In overall terms, the Net Operational Expenditure for the second quarter of the financial year is £57,000 under budget profile.

Employee costs are currently £54,000 under budget profile. This is due to savings being made on vacancies within the department. Some of the vacant posts, specifically in relation to trading standards have now been filled, therefore it is not anticipated that this underspend will increase throughout the remainder of the financial year.

# APPENDIX 2 – Explanation of Symbols

Symbols are used in the following manner:

| Progress | | Objective | Performance Indicator |
|---|---|---|---|
| **Green** |  | Indicates that the objective is on course to be achieved within the appropriate timeframe. | *Indicates that the annual target is on course to be achieved.* |
| **Amber** |  | Indicates that it is uncertain or too early to say at this stage, whether the milestone/objective will be achieved within the appropriate timeframe. | *Indicates that it is uncertain or too early to say at this stage whether the annual target is on course to be achieved.* |
| **Red** |  | Indicates that it is highly likely or certain that the objective will not be achieved within the appropriate timeframe. | *Indicates that the target will not be achieved unless there is an intervention or remedial action taken.* |

**Direction of Travel Indicator**

*Where possible performance measures will also identify a direction of travel using the following convention*

| | | |
|---|---|---|
| **Green** |  | *Indicates that* **performance is better** *as compared to the same period last year.* |
| **Amber** |  | *Indicates that* **performance is the same** *as compared to the same period last year.* |
| **Red** |  | *Indicates that* **performance is worse** *as compared to the same period last year.* |
| **N/A** | | *Indicates that the measure cannot be compared to the same period last year.* |

**REPORT TO:** Health Policy and Performance Board

**DATE:** 13th January 2015

**REPORTING OFFICER:** Director of Public Health

**SUBJECT:** Sustainable Community Strategy Progress Report April- September 2014

**PORTFOLIO:** Health and Wellbeing

**WARDS:** Borough wide

## 1.0 Purpose of Report

1.1 To provide a summary of progress on the health and wellbeing priority for Halton's Sustainable Community Strategy from April- September 2014.

## 2.0 RECOMMENDATION: That the Board note the contents of the report

## 3.0 Sustainable Community Strategy (SCS) for Halton 2011-2026

3.1 A key role for local authorities and their partners is to produce a Sustainable Community Strategy (SCS) for their area. The strategy aims 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.

3.2 The current SCS for Halton runs from 2011- 2026 and addresses five key priorities for the Council and its partners. These are:

- A Healthy Halton
- Employment, Learning and Skills in Halton
- A Safer Halton
- Children and Young People in Halton
- Environment and Regeneration in Halton

3.3 Progress on Sustainable Community Strategy priorities is reported on a half-yearly and annual basis. Appendix 1 sets out progress for April 2014- September 2014 for the Healthy Halton priority.

## 4.0 POLICY IMPLICATIONS

4.1 The Sustainable Community Strategy for Halton is central to the Council's policy framework. It provides the primary vehicle through which the Council and its partners develop and communicate collaborative actions that will positively impact upon the communities of Halton.

## 5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 There are no direct policy implications as a result of this report, however, the wider implementation of Sustainable Community Strategy priorities may have an impact on budgets. Implications of these will be reported where applicable.

## 6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

This report deals directly with the delivery of the Council's strategic priorities.

## 7.0 RISK ANALYSIS

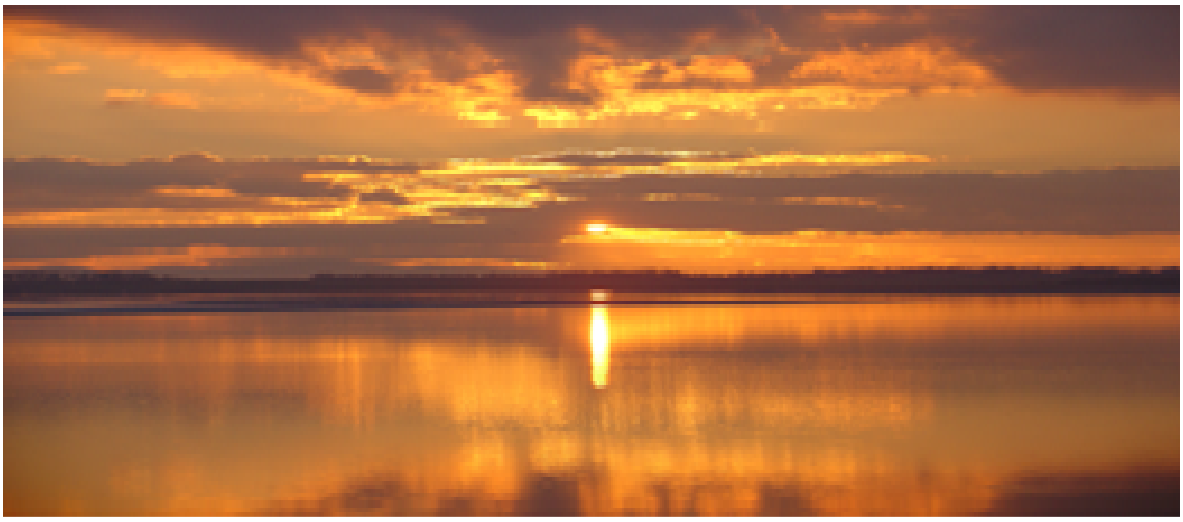
7.1 The key risk is a failure to improve the quality of life for Halton's residents in accordance with the objectives of the Sustainable Community Strategy. This risk can be mitigated thorough the regular reporting and review of progress and the development of appropriate actions where under-performance may occur.

## 8.0 EQUALITY AND DIVERSITY ISSUES

8.1 One of the guiding principles of the Sustainable Community Strategy is to reduce inequalities in Halton.

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

**Document**: Halton's Sustainable Community Strategy
**Place of Inspection**: 6th Floor, Municipal Building, Widnes
**Contact Officer**: Lisa Driscoll, Principal Policy Officer



# Halton Sustainable Community Strategy 2011 - 2026

Progress Report: Period April to September 2014

This report provides a summary position of progress in relation to the delivery of the Strategic Priority Area of

**Health and Wellbeing**

The purpose of this mid-year report is to provide information concerning the progress that has been made in effecting positive change for the relevant strategic priority of the Strategic Partnership Board. It will be complemented by an annual report which will also provide additional information regarding the achievement of annual targets for each of the specific measures contained within the Halton Sustainable Community Strategy.

| Page | Ref | Descriptor | 2014 / 15 Target | Direction of travel |
|---|---|---|---|---|
| | HH1 | Child development | 40% |  |
| | HH2 | Mortality from all cancers at ages under 75 | 140 |  |
| | HH3 | Falls and injuries in the over 65s (Public Health Outcomes Framework) | 2,847 |  |
| | HH4 | Admissions which are wholly attributable to alcohol AAF=1, rate per 100,000 population | 1,038 | Data not rec'd |
| | HH5 | Mental Health: Self-reported wellbeing (NEW) | 69% | Data not yet available |
| | CYP1 | Falling Levels of infant mortality | 4.7 |  |
| | CYP2 | Reduce the percentage of children who are obese in Year 6 | Reduce by 1% per annum based on 10/11 actual |  |
| | CYP3 | Increase the number of children being breastfed at 6-8 weeks | 24% |  |
| | CYP5 | Reduce under 18 conception rate (Rolling average) | 56.3 |  |
| | CYP8 | Increase the percentage achieving 'good level of development average' total points for cohort. | 55% |  |

## Key activities and Successes

## Child Development

**Healthy Child Programme**

The healthy child programme continues to be delivered across Halton, conducting screening, immunisations and health reviews. The Family Nurse Partnership team has been recruited and will begin to start with first time teenage mothers in November 2014.

Work is underway to ensure the safe transition of the Health Visiting service and Family Nurse Partnership to be commissioned by the Local authority by October 2015.

**Breastfeeding**

All mothers have access to breastfeeding peer support, and baby welcome premises continue to be available across the borough. Work continues on achieving BFI stage 3, with the community midwifery team, and St Helens and Knowsley Hospital Trust have achieved stage 3 (the final stage). Whilst the percentage of women breastfeeding at 6-8 weeks in Halton has stayed the same as this time last year, since Q1 2010/11 it has increased by 11.3%.

**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.

**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, Addaction 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.

## Prevention and Early Detection of Cancer

A local Cancer Strategy has recently been developed and sets out key actions to address this priority. Recent activity includes:

**Be Clear on Cancer**
The national Be Clear on Cancer campaign continues to be rolled out with a team of volunteers working with local people. We are working closely with Halton CCG to develop additional early detection programmes along the lines of a Cancer Rehabilitation programme.

**Weight Management**
A range of weight management services are delivered for children and adults on an individual or group level, such as the fresh start programmes, active play and introduction to solid food parties. The Halton Healthy Weight management care pathways for children and adults is under review and opportunities to enhance provision identified.

**HPV Vaccination**
This vaccination protects girls from cervical cancer in later years. Uptake remains good for HPV vaccination. Changes to the national schedule for HPV vaccination may further improve opportunities to improve uptake locally.

## Reduction in the number of falls in adults

All of the planned redesign of the falls service, falls training and triage have been completed ahead of schedule. A falls business case has now been developed to consider the impact of additional funding and preventative interventions to further reduce the level of falls at home as well as the readmission rates.

Performance has been positive in the quarter due to a number of key interventions from the falls strategy now being in place.

- Increased training for professionals
- New training for members of the public
- Increased screening
- New triage into intermediate care
- More capacity within falls assessments

## Prevention and Early Detection of Mental Health conditions

A review of all local mental health and wellbeing provision is underway to ensure that there are consistent, high quality services available. A Tier 2 service has recently been commissioned jointly between Public Health and Halton CCG to provide training for staff in schools, to recognise children at risk, to provide a website for the public and counselling to therapy, and support for professionals working with children and young people. In addition it will provide cognitive behavioural support to families with morbidly obese children and training to staff on how to work with families whose children have this condition.

Screening of new mothers for early detection and treatment of maternal depression is underway. There is improved support for families to deal positively with toddlers. There is training of school nurses in how to identify children and young children at risk of developing mental health conditions and offer low level counselling and support with referral to specialist services, e.g. Ad Action, GP, CAMHS.

We are running workshops to train teaching staff in how to communicate with children on social and emotional issues using evidence based interventions, e.g. SEAL and developing resources and packs for teachers on gender, identity, confidence and aspirations.

The Widnes Vikings are working on anti-cyber bullying training with Halton Health Improvement Team. All schools are being enrolled on the Healthitude programme which covers social and emotional health as well as healthy eating, drinking, tobacco and drugs.

For adults we are concentrating on early identification of for those with mild to moderate mental health problems using an improved range and use of self-help and other non-medical interventions to improve levels of self-reported wellbeing. We have commissioned Halton CAB to offer a bespoke package on support to people with mental health conditions so they can navigate the welfare system. We have also commissioned the CAB to provide financial literacy training in the community as we recognise debt is a major source of anxiety and concern.

For older people in care homes we are working with staff on implementing Guidelines in How to Identify Treat and Refer Older People with Low to Moderate Depression in Care Homes and for those that receive domiciliary care.

A new mental health and wellbeing action plan is in progress, informed by the Mental Health and Wellbeing Strategy.

## Reduction in the harm from alcohol

The number of alcohol-specific admissions in under 18s has continued to decrease in Halton, and has therefore narrowed the gap with the England average. Halton has also seen the

greatest decrease in the rate of under 18 admissions out of all the local authorities in Merseyside.

An alcohol harm reduction strategy for Halton has been developed and is due to be launched during alcohol awareness week (17-23 November). The strategy was developed in partnership with colleagues from health, social care, education, voluntary sector, police and the community safety team. The strategy will set out actions across the life course to reduce alcohol related harm and reduce hospital admissions. Good progress has been made related to reducing Under 18 admission rates locally. Alcohol health education sessions are being delivered in all local schools.

As part of the alcohol strategy development work a refreshed action plan for 2014-15 has been developed and signed up to by all partners.
Work on preventative activities continues within Halton, for example:

- An education campaign around alcohol and pregnancy is currently being developed.
- Halton midwives, health visitors & early years staff have been trained in alcohol Information and Brief Advice (alcohol IBA).
- Halton schools & college have been provided with alcohol awareness education sessions.
- The VRMZ mobile outreach bus and street based teams engage young people in hotspot areas 6 days a week and provide information, advice and guidance on alcohol to children and young people.
- Staff working with Children and Young People (CYP) trained in alcohol Information and Brief Advice (alcohol IBA).

## Key Challenges

**E- Cigarettes**

E Cigarettes are an issue at both a national and local level. The exact prevalence of E cigarettes locally is unknown, however, in line with the national picture the local 4 week stop smoking quit rate has dropped since their introduction. It is important to note that E Cigarettes have not been passed by the Department of Health as a quit tool as they have varying amounts of nicotine, sometimes as much as a cigarette.

## Equalities, Engagement and Cohesion

- **Holding a Halton Alcohol Inquiry**
  We are looking to recruit up to 20 local people to try and answer the question ‘What would make it easier for people to have a healthier relationship with alcohol?’ We want to hear from a wide range of people to create local recommendations for action

on the issues that matter to them. The recommendations will then be used to inform and advise what is done about this issue in Halton. The project is being run by community engagement specialists Our Life and funded by Halton Council.

- **Expert Patient Programme**
  Work is currently underway with the CCG on the Expert Patient Programme helping people to manage long term conditions.

- **Men's Sheds Programme**
  We are currently working alongside Halton Haven on the Men's Shed project. This project works with bereaved men to improve mental health and wellbeing. Led by the men themselves, Men's Sheds are a concept rather than a physical building and provide a range of activities including; photography, gardening, computers and cooking.

- **Minimum Unit Pricing**
  The North West Directors of Public Health, supported by local Health and Wellbeing Boards, are supporting the introduction of a Minimum Unit Price of 50p per unit of alcohol. Evidence shows that MUP is an effective measure in addressing alcohol-related harm.

- **Health Inequalities**
  In order to reduce health inequalities, the Health and Wellbeing Board is currently working in collaboration with GPs to identify the 40% of the Halton population who do not access GP services. Evidence shows that this approach can have the biggest impact on reducing the inequalities gap, by identifying those at risk and targeting effective interventions to prevent and improve ill health and reduce premature mortality.

- **<u>Due North: the report of the Inquiry on Health Equity for the North</u>**
  *`Due North: the report of the Inquiry on Health Equity for the North'*, (available from:http://www.cles.org.uk/news/inquiry-publishes-due-north-report-on-health-equity/), is the outcome of an independent inquiry, commissioned by Public Health England, to examine health inequalities affecting the North of England.
  The report highlights that the North of England has persistently had poorer health than the rest of England and that this gap has continued to widen over four decades. Also, there is a gradient in health across different social groups within the North: on average, poor health increases with increasing socio-economic disadvantage, resulting in the large inequalities in health between social groups that are observed today.
  At it's meeting on 12th November, Halton's Health and Wellbeing Board will consider the following recommendations from the report:
  a) Lobbying Central Government for greater devolution of powers and resources to cities and local government

b)Tackling poverty and economic inequality
c) Developing a social value approach to procurement
d) Promoting healthy development in early childhood
e) Developing the capacity of local communities to engage with and influence local decision-making
f) Addressing premature mortality through primary care, with a focus on improving treatment and outcomes among older people living with long-term conditions

- **CAB – Financial Literacy**
  A project is currently underway with Halton CAB to improve the financial literacy of local people in order to equip them to deal with and avoid financial challenges. As debt and financial difficulty is one of the main causes of depression and other mental illness, the project will contribute towards addressing the Health and Wellbeing Strategy priority of Prevention and Early detection of mental health conditions.

- **Prevention and Early Detection of Cancer**
  We are continuing to work with Halton CCG and partners, particularly around the Primary Care Plan and in the identification of best practice.

**REPORT TO:** Health Policy & Performance Board

**DATE:** 13th January 2015

**REPORTING OFFICER:** Strategic Director, Communities

**PORTFOLIO:** Strategic Director, Communities

**SUBJECT:** Update on the Care Act

**WARD(S)** Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To Update Health Policy and Performance Board on what changes are involved with the new Care Act on our local progress.

2.0 **RECOMMENDATION: That: the report be noted**

3.0 **SUPPORTING INFORMATION**

3.1 In May 2014, the Care Bill received Royal Assent and became the Care Act 2014. Some elements come into effect from April 2015; others come into effect from April 2016.

The Care Act aims to reform the care and support system into one that:

- Focuses on people's well-being and support to help them remain independent for as long as possible.
- Introduces greater national consistency in access to care and support.
- Provides better information to help people make choices about their care.
- Gives people more control over their care.
- Improves support for carers.
- Improves the quality of care and support.
- Improves the integration of different services.

3.2 The changes coming into effect in April 2015 which impact directly on the Council include:

- A duty to provide prevention, information and advice services
- A national minimum threshold for eligibility for both service users and carers.
- The entitlement for carers to assessment, support services and review equal to that of the service user

- The right for people who pay for their own care to receive advice and support planning.
- A universal system for deferred payments for residential care.

3.3 The changes coming into effect from April 2016 which impact directly on the Council include:

- A cap on the costs that people have to pay to meet their eligible needs.
- A 'care account' giving people with eligible social care needs an annual statement of their progress towards reaching the cap, whether their care is organised by the local authority or not.
- Extending the financial support provided by the local authority by raising the means test threshold for people with eligible needs.

3.4 The significance of the Care Act should not be underestimated as it replaces much of the legislation that has governed Adult Social Care since 1948. In total it replaces 13 pieces of Primary legislation, 13 pieces of secondary legislation and 3 pieces of statutory guidance.

3.5 To oversee the implementation of the Care Act in Halton, we have established an overarching Care Act Strategic Group chaired by Operational Director Prevention and Assessment. The strategic group in turn oversees six sub-groups each working to their own implementation plan that includes working towards completion of reviewing relevant documents, policies, considering training and workforce development, charging and cost implications as well as understanding and identifying potential risks. A brief summary of each of the subgroups is included in this report.

3.6 To support the implementation a grant of £125,000 has been provided and this has been used in the following three ways:

- A full-time policy officer who has now been recruited.
- A full-time post in finance to support all financial implementation of the changes in the Care Act
- £25K to support joint working with Liverpool City region.

3.7 In addition there are two regional groups that have been established and we are currently aligning our local work to ensure that there is no duplication.

- North-West regional ADASS group – we have representation on this group and they are an excellent source of information, communication and sharing best practice. This has included carrying out local stocktakes and workforce readiness surveys.

- Liverpool City Region group – this group is looking at a range of areas with each authority taking an overall lead for one subject, Halton will be leading on prevention.

Updates from each of these regional groups are presented on a monthly basis to the Halton Care Act Strategic Group. In addition we will be working with the two regional groups to assess and analyse all of the upcoming National Guidance for implementation that will be produced and circulated during November.

3.8 As part of the initial implementation of the Care Act we have completed three self-assessments to determine our readiness for the changes. The first self-assessment was completed in August and shows that we were on track at this point, this assessment was repeated in September and shows that we are again progressing well in all areas.

The third self-assessment relates to workforce readiness and has been submitted to Skills for Care, although there are some areas that need more attention the general analysis of our performance is positive.

3.9 Updates from Sub-groups

**Prevention**

Key developments and work streams:

- Advocacy: A draft advocacy hub is currently being developed and should be completed by early November
- Staff consultation: work in relation to mapping existing information services.
- Draft prevention model
- Information model: development of a new information model is underway; this piece of work is being co-produced with Halton OPEN and Halton Disability Partnership.

3.10 **Assessment & Eligibility**

There are a number of requirements for assessment and eligibility that need to be in place prior to full implementation in April 2015. A self-assessment template has been developed and the assessment sub-group is currently working through each of the areas to establish our current performance, areas of change and new processes within the Act. The subgroup is specifically working on the development of Policy, Procedures and Practice in the following areas:

- The total extent of current and future needs for care and support
- What need is eligible for both adults and carers and how these can be met subject to a financial assessment
- Care and support planning with active involvement from the

service user
- Changes required in the review process
- Processes in relation to transition to adult care and support for children, young carers and child's carers.

3.11 **Charging and Financial assessment**

Currently work is underway to assess all of the charging implications of the Care Act to ensure full implementation by April 2015. Key areas that are currently being considered and worked upon:

- Deferred payments process will change and will require additional work and there will be a requirement for a policy which is currently not in place.
- There are changes to the financial assessment for people who have a property; work is underway to estimate the numbers of people affected by this, also there will need to be changes to IT to accommodate the differences.
- Carefirst 6 provider is carrying out a presentation in October to look at all of IT solutions in relation to the Care Act. Need to ensure someone from Care Management attends.
- There will need to be a change to the domiciliary and residential care policy in light of the new aspects of the Care Act.

3.12 **Safeguarding**

A comprehensive action plan has been developed to give support and guidance for the Adults Safeguarding Board in relation to the Care Act. The action plan was developed through an agreed self-assessment. This self-assessment recognises that Halton has either completed or is on course to complete 16 of the 26 actions covered, 5 are achievable with some additional support and 5 are classed as either not started or significantly behind target date. The risk areas are:

1. Review the Halton Safeguarding Adults Board Serious Case Review (Safeguarding Adult Review) Policy to ensure that it incorporates all relevant requirements from the Care Act and guidance.
2. Develop and implement an engagement plan to ensure agencies are robustly engaged, supported and able to respond to their responsibilities to take part in Safeguarding Adult Reviews
3. Review the mechanism and effectiveness of agencies implementation of recommendations from Safeguarding Adult Review.
4. Require all agencies that will have a statutory duty under the Care Act to report against their contribution to the Board and the delivery of the plan for the Annual Report
5. Develop and implement a multi-agency communications

strategy in relation to safeguarding, making use of social media.

3.13 **Integration and partnership working**

A stocktake in relation to integration and partnership working will take place over the next two months. This stocktake will focus on the six key areas:

1. Integration, cooperation and partnerships
2. The boundary with the NHS
3. Delayed transfer of care
4. Working with housing authorities and providers
5. Working with employment and welfare services
6. Delegation of local authority functions.

The stocktake will be reported through the Care Act Steering Group and any risk factors identified and reported to Senior Management Team.

3.14 **Carers**

Currently we're negotiating with the carers Centre a service re-design to support our implementation of the Care Act, Better Care Fund and GP Enhanced Services. The re-design concentrates on;

i. The identification of carers' at the earliest opportunity, specifically targeting groups considered to be 'seldom seen' or 'hidden' –
   - Older carers in poor health
   - Male carers aged over 65
   - Individuals providing over 50 hours of care per week
   - Those caring for individuals with mental health issues
   - Those caring for individuals with dementia
   - Those caring for individuals with a substance misuse and/or alcohol issue
   - Those caring for individuals with Learning Disabilities and/or Autism

ii. The provision of information, advice and guidance, complimenting similar services as provided by Halton Borough Council and NHS Halton CCG

iii. Signposting and referring carer's to the correct information, advice and support to ensure that they are not financially disadvantaged as a result of their caring role

iv. Supporting carers' to have their voice heard in decisions that affect them, and where appropriate, advocate on their behalf

v. Providing short term, intensive support to those carers identified by adult social care and health care services where there is a significant risk of 'carer breakdown'

vi. Expanding and diversifying the provision of activities and peer support for carers'

vii. Supporting carers' to take part in educational, training or work opportunities that they may feel excluded from because of their

caring responsibilities

viii. Providing a range of learning and development opportunities for carers', front line staff and the community

ix. Through a variety of methodologies, gathering and reporting on carer experiences of using mainstream health and social care services; and supporting carers to participate in the planning, commissioning and quality assurance of health and social care services

x. Developing an integrated 'one stop shop' approach to service delivery with specialist services such as Halton Borough Council's welfare rights, home equipment and telecare services, and NHS Halton Clinical Commissioning Group's mental health and well-being services.

## 4.0 POLICY IMPLICATIONS

4.1 Work is currently underway from each of the chairs to identify which local policies will be affected by the Care Act. Once identified a plan for consultation and amendment will be developed.

## 5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 Work is ongoing in relation to understanding the full financial implications of the Care Act.

## 6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

### 6.1 Children & Young People in Halton

The Care Act places new duties on Local Authorities to manage the transition between children's and adults services.

### 6.2 Employment, Learning & Skills in Halton

No implications

### 6.3 A Healthy Halton

The aim of the Care Act is to support people to maintain their own health and independence for as long as possible.

### 6.4 A Safer Halton

No implications

### 6.5 Halton's Urban Renewal

## 7.0 RISK ANALYSIS

7.1 Each of the sub-group leads will identify and report potential risks of

implementation of the Care Act.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 These will be completed for each policy change that is completed as part of the overall implementation of the Care Act.

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

None under the meaning of the Act.

**REPORT TO:** Health Policy and Performance Board

**DATE:** 13th January 2015

**REPORTING OFFICER:** Strategic Director, Communities

**PORTFOLIO:** Health and Wellbeing

**SUBJECT:** Mental Health Champion Quarterly report

**WARD(S)** Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To provide an update to PPB on mental health related activity undertaken by Halton Borough Council and NHS Halton Clinical Commissioning Group (CCG).

2.0 **RECOMMENDATION: That**

1) **The contents of the report be noted; and**

2) **Members direct any comments/questions to the Director for Transformation.**

3.0 **SUPPORTING INFORMATION**

3.1 It should be noted that Mental Health services in Halton are under huge pressure. Nationally the wait times and need for Mental Health services have risen to an all time high. Halton is no different and we have a significant challenge to ensure our services (both preventative and treatment) meet National standards. Work is underway to fully review all the adult and older peoples provision in line with parity of esteem. This review will be completed in March and will set the scene for the creation of a more effective, responsive service. Our ongoing consultation and co production of services will continue to help us shape service provision in partnership with users of services. However huge strides have been taken and below is an update of changes, updates and innovation underway.

3.2 **Award winning innovation**

Halton's Wellbeing Practice approach has gained National interest, recently winning a National Association of Primary Care (NAPC) award. This and other services offer a preventative approach to mental health, developing strategies for the public to improve their own resilience. The drive is to know incorporate parity

of esteem, meaning we meet the psychological requirements of patients as well as their physical. Work is underway with partners to improve the input of low level mental well being interventions in all primary care settings.

3.3 **Mental Health in GP Practices**

Training is provided to clinicians to enable them to manage mental health within their practice or community services. This training enables the GP or clinician to make best use of the approximately 10 minute consultation and glean vital information about the patient's well being to ensure correct referral and treatment is provided.

3.4 **Mental Health Wellbeing Nurse**

Halton CCG commissioned a Mental Health Wellbeing Nurse Team. This team of Nurses work primarily with the most venerable patients with complex issues. This population rarely utilise health care and therefore many health issues go undetected. The performance is very high, for example the team have picked up on risks associated with heart disease , diabetes etc offering a truly preventative service.

3.5 **Halton CCG service provision**

Appendix 1 has summary of just some of the service provision across the age ranges, commissioned by Halton CCG.

3.6 **New Governance Structure**

In order to support delivery of the All age Mental Health Strategy for Halton and the supporting All Age Action Plan a revised governance structure has been established to ensure robust oversight of delivery. A new Mental Health Oversight Group chaired by the Local Authority Mental Health Champion has been established and the inaugural meeting is on 13th January 2015. This group will hold to account the variety of other groups such as the Dementia Partnership Board, the Suicide Prevention group etc for delivery of their respective elements of the Strategy and Action Plan.

3.7 **Dementia Friendly Communities**

Halton Borough Council and Halton NHS Clinical Commissioning group have established a Halton Dementia Action Alliance (Halton DAA) in October 2014. This is in line with national dementia strategy recommendations and is an action of the Halton Dementia Strategy.
The Halton DAA will work with services, organisations and individuals across all sectors to promote 'dementia friendly practice', to improve outcomes for people living with dementia and their carers. Current membership includes organisations in primary and

secondary care, leisure services, trading standards, commissioned care provision , 3rd sector, CCG and the local authority.

Halton has recently (Dec 2014) achieved the 'working towards becoming a dementia friendly community' status through the Alzheimer's Society Dementia Friendly Communities recognition process.

For more information about the Halton Dementia Action Alliance and Dementia Friendly Communities please click on the link below
http://www.dementiaaction.org.uk/

3.8 **Admiral Nurses for Dementia**

The Halton Dementia Partnership Board has recently met with the Chief Admiral Nurse in England (Oct 2014) to explore the potential for investment in the Admiral Nurse service in Halton.

Admiral Nurses provide families with the knowledge to understand the condition and its effects, the skills and tools to improve communication, and provide emotional and psychological support to help family carers carry on caring for their family member.

Over the next few months the Board consider the business case for investment and the potential outcomes for people living with dementia, and their carers.

3.9 **In patient redesign project**

The local provider of the majority of mental health services to the borough 5 Boroughs Partnership Community Foundation Trust have developed a revised improved clinical model for in patient services. This work is on - going and has now been widened to incorporate review of community services to ensure the pathway for mental health services works well. This work will also incorporate the move to borough based services and support the direction of travel for primary care relating to neighbourhood hubs .

3.10 **Emotional Wellbeing services for children**

NHS Halton GCCG and Public Health in the Local Authority have worked together to deliver a revised specification for a Tier 2 level service to support young people with emerging emotional wellbeing and lower level mental health issues. The service is currently out to tender on The Chest and interviews for bidders will be held on 6th February 2015. There has been extensive engagement with young people around the specification and two young people will be on the interview panel.

3.11 **System Resilience funding**

NHS Halton CCG have secured £81k of additional funding from a recent bid for additional system resilience funding for mental health specifically. Two schemes were submitted (in conjunction with Warrington CCG with whom Halton shares operational delivery teams). The two schemes are increasing capacity in the Alternative to Hospital service and ensuring 24 hour nurse cover to the existing Psychiatric Liaison Service.

3.12 **The Mental Health Crisis Care Concordat**

The Mental Health Crisis Care Concordat was published by Central Government in late 2013. The concordat aims to encourage all services which provide support to people with mental health needs across a wide area to work closely together to reduce the likelihood of people reaching a mental health crisis. This includes health services, the police, housing authorities, social services and the private and voluntary sectors, all of whom are required to sign a pledge to achieve the aims of the concordat, and then develop and implement and action plan.

3.13 Locally, Halton has been working closely for some time with partners across the Cheshire footprint. A declaration has been developed and agreed across the partners, and an action plan is in development. Regular meetings are taking place to monitor progress. The overall process is being supported regionally by the Advancing Quality Alliance, a membership body consisting of Mental Health Trusts, Clinical Commissioning Groups and Local Authorities, and the Association of Directors of Adults Social Services is also actively promoting this work.

3.14 **Operation Emblem/ Street Triage**

Operation Emblem has been piloted across Halton and Warrington for 12 months and is commissioned by NHS Halton and Warrington CCGs. The objective of the service is to improve the response to individuals and their immediate families and improve the outcomes for individuals who come into contact with the police through early intervention referral to mental health services. The pilot has been very successful and reduced Section 136 by approximately 90% across the 2 boroughs. The CCGs are commissioning an independent evaluation of the service to understand all beneficiaries and outcomes achieved by the service.

3.15 **Liaison Psychiatry Service**

The extended Liaison Psychiatry Service was launched within Warrington and Halton Hospitals NHS Foundation Trust in August

2014. This service has been introduced to reduce waiting times in A&E, reduce length of stay and to reduce discharge to institutional care placements. Commissioners are working in partnership with the provider to monitor the service on a monthly basis, using performance data and qualitative information to review the service and understand that the service is achieving the desired outcomes.

3.16 **IAPT – Halton Psychological Therapies Service**

The Halton Psychological Therapies service is now provided by 5 Boroughs Partnership NHS Foundation Trust and went live on 1st August 2014. The service was launched with a considerable waiting list, however, action plans and recovery plans are in place to reduce the list and early performance data indicates that the service has begun to increase the access and recovery rates for Halton patients.

3.17 **Mental health service reviews**

There are a number of services which are currently commissioned by the Local Authority and Clinical Commissioning Group to support individuals with mental health issues in the community and transitioning out of secondary care. These services are; Mental Health Outreach Team (MHOT), Mental Health Social Worker team based at the Brooker centre, and various third sector providers including: Making Space, SHAP, plus Dane, Mind and Building Bridges.

It has been highlighted that there may be a need to review the service provided around mental health, and understand the current pathways, and patient experience. A small task group has been established and preliminary work has begun on this.

3.18 **Suicide Prevention strategy**

The final draft of the suicide prevention strategy will shortly be presented for Board level approval. The public health team have engaged with a wide range of stakeholders in this process and a task and finish group has been formed. The suicide prevention initiatives outlined within the strategy focus on increasing protective factors and reducing risk factors for suicide within Halton.

Key areas for action to prevent suicides include:

- Improving the mental health and wellbeing of Halton residents
- Promoting the early identification and support of people feeling suicidal
- Reducing the risk of suicide in known high risk groups
- Reducing access to the means of suicide
- Providing better information and support to those bereaved or affected by suicide

- Evaluating interventions, data collection and monitoring progress

Key activities linked to the strategy to reduce suicides locally include:

- Developing a local multi-agency suicide awareness campaign plan
- Developing a local training plan to deliver suicide awareness training for community members, local community groups and key professionals who interact with known groups at high risk of suicide
- Ensuring those identified as being at risk of suicide can access immediate support
- Reducing access to the means of suicide locally
- Continued support of Operation Emblem
- Commissioning a postvention service to ensure we have effective local responses to the aftermath of a suicide

3.19 **Support 4 Change:**

The Warrington Criminal Justice Liaison Service (CJLS) is an integrated, multi-professional and practitioner led mental health service. The service acts as a link between Health, Social Services and all Criminal Justice Agencies in their work with adults who have mental health needs or a learning disability, who find themselves at any stage of the criminal justice system.

In September 2014, additional funding from NHS England was successfully sought/awarded to expand the Support 4 Change service to cover Halton and Warrington In November 2014 Warrington Borough Council and Halton Borough Council commenced working together to provide the Support 4 Change service across Halton and Warrington. The magistrates' court covers Halton and Warrington, as does the Probation court staff. Therefore it has previously been confusing for the magistrates and Probation staff to consider recommending a Community Order for one area and not the other.

The aim is to offer intensive, innovative and assertive CJLS support, coupled, where appropriate, with an element of compulsion provided by a formal court order, to engage these offenders and to help them turn their lives around.

Funding for Warrington was originally until March 15 but because of delays in receiving the funding in the first place the pilot only started running in October 2012 so Warrington will tie their work into the pilot in Halton and this will run up until to September 2015.

4.0 **POLICY IMPLICATIONS**

4.1 The activity outlined has been directed by the overarching Mental Health Delivery Plan.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 Any financial implications associated with the activity outlined has been/ will be highlighted through the appropriate reporting channels.

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

**Children & Young People in Halton**

6.1 Emotional and mental health and wellbeing is a critical factor in supporting children and young people's social development, behaviour and resilience, educational attainment and achievement and life chances.

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

Good emotional and mental health and wellbeing is a vital factor for children, young people and adults accessing learning and future employment opportunities.

6.3 **A Healthy Halton**

Emotional and mental health services impact directly upon the health and wellbeing of adults, children and young people .

6.4 **A Safer Halton**

Those who do not experience good emotional and mental health and wellbeing are more likely to be subject to a range of risk factors that can impact negatively on community safety issues.

6.5 **Halton's Urban Renewal**

None identified at this time

7.0 **RISK ANALYSIS**

7.1 Failure to ensure that appropriate services to support emotional and mental health and wellbeing is likely to impact negatively on outcomes and life chances for local residents.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None identified at this time

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

None.

## Appendix 1 – Examples of service provision from Halton CCG

**Young people**

- Universal and Targeted Emotional Health and Well-being, educational sessions in youth clubs and community venues, across Halton.
- Tier 2 Emotional Health and Well-being service to all children and young people aged 5yrs to 19yrs.
- Emotional Health and Well-being service for Children in Care, through Barnardos.
- Young Addaction offer support to children and young people age 10yrs to 19yrs affected by parental mental illness
- Multi-agency training on mental health, dual diagnosis and self-harm.
- Robust specialist services Tier 3 support for young people with complex issues.

**Alternatives for adult and children**

- Wellbeing Enterprises deliver the NAPC award winning Community Wellbeing Practices initiative to all 17 GP practices in borough. Patients experiencing mild to moderate mental health problems are referred by the GP or health care worker for a personalised wellbeing review. Which includes one to one tailored support to identify any social problems at the root cause of mental health distress. The reviews also aim to unlock patients skills and talents in order to develop a personalised wellbeing plan - in which staff provide ongoing support to help patients to address underlying problems, achieve their goals and to connect with other sources of support available locally
- The outcomes evidence that 56% of patients report a reduction in their depression symptoms and 64% of patients improve their subjective mental and physical wellbeing levels as a result of their intervention.
- NHS Halton CCG commission wellbeing enterprises to work in partnership with local Mental Health providers (e.g. 5 Boroughs Partnership NHS Foundation Trust) to ensure patients who have been admitted to hospital because of mental health problems also receive wellbeing and social support to ensure they are fully repatriated into their community and receive appropriate community support from thier team and other partners.
- Wellbeing Enterprises provides the highly acclaimed 'Ways to Wellbeing' social prescribing programme. Social prescribing is about providing non medical sources of support to patients with mild to moderate mental health conditions. The team deliver educational and social support groups based on life skills training, cognitive behavioural principles, relaxation classes, sleep hygiene courses, confidence classes and community events that teach people how to stay resilient during difficult times.
- Wellbeing Enterprises CIC have received three years of funding to develop the first, comprehensive wraparound service for children and younger people on waiting lists for CAMHs services because of mild to moderate mental health problems. Children and young people in the borough who are waiting for specialist services will have access to life skills training based on cognitive behavioural principles as well as mindfulness and confidence training as an adjunct to main stay treatment. - which it is believed will better prepare younger people for clinical care and will improve outcomes. In addition to this There will be a series of community led projects run by and for children that enable them to

share their stories of recovery and to train young people up as peer supporters with a view to creating an informal ecosystem of mental wellbeing support.

**Marketing/prevention and anti stigma**

- NHS HALTON CCG Like Minds for better mental health in Halton was developed in partnership with the CCG, HBC and PPB to help tackle stigma associated with Mental Health.

- Drawing on the national Time For Change campaign, Like Minds took local people's stories and discussed their experiences with mental health and what they did to help them overcome or work towards overcoming their issues.

- The campaign was launched via a mixed media approach in October 2013, with a second phase focusing on loneliness in the over 55s being launched in October 2014 to coincide with World Mental Health Day.

- To date we have disseminated 10,000 materials across GP surgeries, pharmacies and other community venues. We received mass press coverage in the local media and have delivered approx. 50 training sessions to health professionals, schools and colleges that encompass the Like Minds campaign. We are currently in the process of training all school teachers in self harm using Sophie's story as a training aide- this to be completed by March 2015.

- The website dedicated to Like Minds www.haltonlikeminds.co.uk has received positive feedback via the online feedback form in terms of changing opinion of mental health and feeling more inclined to talk about mental health than they did before seeing the campaign.

**A quote from a member of public on the Like Minds campaign:**

*" I actually cried reading this, not because I was sad or upset.. Seeing stories like this written down made me see where was back then to where I am now. It was a happy cry, and the last time cried like that was when my son was born which made me cry more because I've gotten access to seeing him again. What I mean to say is thank you. I think it's great, I really*


*do!'*


**Loneliness and older people**

- The Halton loneliness strategy aims to make Halton a place without loneliness. We aim to achieve this by working with communities and professionals to identify people who are lonely and then tackling that loneliness with a range of interventions.

- These include visits from professionals and volunteers to try and engage the lonely person in activities in the community, simple Skype like devices to enable people to keep in touch with friends and loved ones, linking with existing tele-friending services such as Silverline and Call in Time, and encouraging schools to twin up with local care homes.

- Dementia Navigator Service, for people living with dementia and their carers. Service provides a listening ear, someone who understands, getting to root cause of social issues and providing tailored support to help them improve wellbeing. We also signpost patients to various sources of clinical and non clinical support.

- NHS Halton CCG are signed up as a Dementia friendly organisation and action alliance.

**REPORT TO:** Health Policy and Performance Board

**DATE:** 13th January 2015

**REPORTING OFFICER:** Simon Banks, Chief Officer CCG

**PORTFOLIO:** Health and Wellbeing

**SUBJECT:** Developing a Halton response to the NHS *Five Year Forward View*

**WARD(S):** Borough-wide

## 1.0 PURPOSE OF REPORT

1.1 On 23rd October 2014 NHS England, in partnership with five other national organisations involved in setting the strategic direction and regulatory framework for the NHS, published *Five Year Forward View*. On 4th December 2014 NHS Halton Clinical Commissioning Group (CCG) commenced a two month dialogue with local people and partners in regard to a Halton response to *Five Year Forward View*. Strategic decisions will need to be made by NHS Halton CCG Governing Body following *Five Year Forward View,* particularly in regard to new models of care.

## 2.0 RECOMMENDATION: That the Health Policy and Performance Board are invited to review and contribute to the document produced by NHS Halton CCG.

## 3.0 SUPPORTING INFORMATION

3.1 The *Five Year Forward View* was published on 23rd October 2014 and sets out a vision for the future of the NHS. It has been developed by the partner organisations that deliver and oversee health and care services including NHS England, Public Health England, Monitor, Health Education England, the Care Quality Commission and the NHS Trust Development Authority. Patient groups, clinicians and independent experts have also provided their advice to create a collective view of how the health service needs to change over the next five years if it is to close the widening gaps in the health of the population, quality of care and the funding of services.

3.2 The purpose of the *Five Year Forward View* is to articulate why change is needed, what that change might look like and how we can achieve it. It describes various models of care which could be provided in the future, defining the actions required at local and

national level to support delivery. Everyone will need to play their part – system leaders, NHS staff, patients and the public – to realise the potential benefits for us all. It covers areas such as disease prevention; new, flexible models of service delivery tailored to local populations and needs; integration between services; and consistent leadership across the health and care system.

3.3 The *Five Year Forward View* starts the move towards a different NHS, recognising the challenges and outlining potential solutions to the big questions facing health and care services in England. It defines the framework for further detailed planning about how the NHS needs to evolve over the next five years.

## 4.0 POLICY IMPLICATIONS

4.1 The *Five Year Forward View* highlights (www.england.nhs.uk/ourwork/futurenhs/) that the NHS has dramatically improved over the past fifteen years. Outcomes are better, waits are shorter and patient satisfaction is high. Nonetheless, quality of care can be variable, preventable illness is widespread and health inequalities are deep-rooted. The needs of patients are changing, new treatment options emerging and service pressures are building. There is a broad consensus on what a better future should look like, which needs new partnerships and approaches.

4.2 The *Five Year Forward View* states that the warnings of the Wanless Report were ignored, and a radical upgrade of prevention and public health is now needed. More control of their own care needs to be passed to people who need health services. Barriers between family doctors and hospitals, physical and mental health and health and social care need to be broken down.

4.3 A small number of radical new care delivery options will be supported, these options include:

- Multispecialty Community Provider
- Primary and Acute Care Systems
- Urgent and Emergency Care Networks
- Viable Smaller Hospitals
- Specialised Care
- Modern Maternity Services
- Enhanced Health in Care Homes

Whilst new care models will be developed and supported, *Five Year Forward View* states that the foundation of NHS care will remain list-based primary care. As part of this commitment there will be a 'new deal' for GPs.

4.4 To support these changes, the national leadership of the six signatory bodies to *Five Year Forward View* have committed to act more coherently together. They have also committed to providing meaningful local flexibility over payment rules, regulatory requirements and other mechanisms to support change and innovation.

4.5 To sustain a comprehensive, high-quality NHS, *Five Year Forward View* states that action will be needed on three fronts simultaneously – demand, efficiency and funding. Less impact or emphasis on any one of them will require compensating action on the other two. There is nothing in the analysis undertaken for *Five Year Forward View* that suggests that continuing with a comprehensive tax-funded NHS is not "intrinsically un-doable". Instead *Five Year Forward View* suggests that there are viable options for sustaining and improving the NHS over the next five years, provided that the NHS does its part, allied with the support of government and other partners.

4.6 At the North Tripartite Event on 4th November 2014, organised by NHS England, Monitor and the Trust Development Authority, there was clear message that *5 Year Forward View* requires a period of reflection but that this should be short. Delivery is expected from April 2015, with demonstrable congruence with our existing strategies and plans.

4.7 NHS Halton CCG is developing a Halton response to this NHS led strategic view. This will ensure that there is congruence with our 5 Year Commissioning Strategy, 2 Year Operational Plan, Better Care Fund and other initiatives that are shared with partners across the borough. The attached template (Appendix 1) takes the key statements made and actions suggested in *Five Year Forward View* to apply a "Halton lens" to enable comparisons to be made. Contributions to this document are invited from all our partners and will be actively sought through the Health Policy and Performance Board on 13th January 2015 and Health and Wellbeing Board on 14th January 2015. A final document will then return to the Governing Body on 5th February 2015. The Governing Body are invited to contribute to the development of this document as strategic decisions will need to be made following from *Five Year Forward View*, particularly in regard to new models of care.

## 5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 As stated above, *Five Year Forward View* requires action on three fronts – demand, efficiency and funding. There is no guarantee that a future government will commit additional resources to the NHS or match existing funding arrangements. It is therefore suggested that *Five Year Forward View* will need to be delivered within existing resources.

## 6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

### 6.1 Children & Young People in Halton

NHS Halton CCG will work closely with the Children's Trust to commission services for children and young people and to meet statutory responsibilities in regard to safeguarding.

### 6.2 Employment, Learning & Skills in Halton

None as a result of this report.

### 6.3 A Healthy Halton

NHS Halton CCG is a key partner in this agenda.

### 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

7.1 The greatest risk arising from *Five Year Forward View* is that the systemic, step changes that the document suggests will not be achieved. The delivery of *Five Year Forward View* needs collective and collaborative action across all sectors, organisations and communities who have links with the NHS as well as within the NHS itself.

## 8.0 EQUALITY AND DIVERSITY ISSUES

8.1 In the delivery of *Five Year Forward View* through our commissioning strategy and operational plans, NHS Halton CCG will be required to ensure that it is compliant with the duties upon public bodies under the Equality Act 2010.

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

*Five Year Forward View*, Care Quality Commission, Health Education England, Monitor, NHS England, Public Health England and Trust Development Authority, 23rd October 2014, www.england.nhs.uk/ourwork/futurenhs/.

| What the 5 Year Forward View says | What action the 5 Year Forward View suggests | What is the Halton approach? |
|---|---|---|
| **Chapter Two: What will the future look like? A new relationship with patients and communities** | | |
| ***Getting serious about prevention*** | | |
| We have not fully harnessed the renewable energy represented by patients and communities, or the potential positive health impacts of employers and national and local governments. We need a range of new approaches to improving health and wellbeing. | *Incentivising and supporting healthier behaviour*<br><br>For all major health risks – including tobacco, alcohol, junk food and excess sugar - we will actively support comprehensive, hard-hitting and broad-based national action to include clear information and labelling, targeted personal support and wider changes to distribution, marketing, pricing, and product formulation. We will also use the substantial combined purchasing power of the NHS to reinforce these measures. | Halton supports additional actions to incentivise and support healthier behaviour. There is strong collaboration across organisations and sectors within the borough on these issues. We also influence national and local policy by working with other local authority areas across Cheshire and Merseyside through CHAMPS. Our Director of Public Health also engages with counterparts across the North West England through the North West Directors of Public Health and their change manifesto.<br><br>Halton also supports Food Active (formerly Heart of Mersey) in national actions on labelling and product formulation. We are working with Drinkwise on influencing local licensing policy, Minimum Unit Pricing and with the industry locally to improve standards.<br><br>Halton has a number of co-ordinated |

| What the 5 Year Forward View says | What action the 5 Year Forward View suggests | What is the Halton approach? |
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| | | initiatives in place to make the night-time economy more vibrant, diverse and safer. These schemes include Purple Flag and Archangel.<br><br>We work closely with Tobacco Free Futures to influence across the region and develop policy.<br><br>Halton Borough Council is recruiting a new Environmental Health post which will work with local employers to address workforce health. We believe that there is more that we can do to help local employers improve the health and wellbeing of their workforce.<br><br>As the lead agency, Halton Borough Council is co-ordinating and implementing local action and activity with take away outlets to increase awareness of healthier choices.<br><br>We are developing targeted personal support around parenting programmes through our Children's Centres. We also have a number of initiatives that empower communities to act for themselves and for the population by influencing and improving health literacy. |

| What the 5 Year Forward View says | What action the 5 Year Forward View suggests | What is the Halton approach? |
|---|---|---|
| | | |
| | *Local democratic leadership on public health*<br><br>Local Health and Wellbeing Boards to drive health improvement. English mayors and local government need to be granted enhanced powers to allow local democratic decisions on public health policy that go further and faster than prevailing national law – on alcohol, fast food, tobacco and other issues that affect physical and mental health. | Halton has a strong and vibrant Health and Wellbeing Board. The Halton Health and Wellbeing Board has clear public health oriented priorities, that are shared across the participant organisations. The Halton Health and Wellbeing Board is already providing leadership, support and direction on alcohol, fast food, tobacco and other issues that affect physical and mental health.<br><br>Local democratic leadership is also being provided though the Licensing Committee through encouraging the breathalysing of individuals entering licensed premises to assist licensees in refusing service and working on the late night levy. Supplementary planning guidance is also in place to allow the Planning Committee to limit take away outlets from opening near to schools and in clusters.<br><br>Halton would welcome enhanced powers to allow local democratic decisions on public health policy to go further than prevailing national law, where appropriate. |

| What the 5 Year Forward View says | What action the 5 Year Forward View suggests | What is the Halton approach? |
|---|---|---|
| | *Targeted prevention*<br><br>Proactive primary care needs to be central to delivery of evidence-based intervention strategies. Over the next five years England will become the first country to implement at scale a national evidence-based diabetes prevention programme modelled on proven UK and international models, and linked where appropriate to the new Health Check. NHS England and Public Health England will establish a preventative services programme that will then expand evidence-based action to other conditions. | NHS Halton CCG was pivotal in the introduction of the impaired glucose regulation (IGR) programme for diabetes in Merseyside. As part of the development of this work there was correspondence with NICE who were developing their recommendations at the time. The IGR pathway is linked with the Health Check and Healthy Weight programmes. It is being systematised across all practices in the borough. An evaluation of the IGR programme will enable improvement and learning and identify opportunities to address any unwarranted variation. We would expect there is considerable alignment between the programme we have in place at the moment and the national programme.<br><br>We recognise that targeted prevention is essential. We have in place or are developing evidence-based action in regard to dementia, hypertension, cardiovascular disease (CVD), cancer and respiratory conditions. We have identified that around 40% of our population have poor health outcomes, experience significant inequalities and access support |

| What the 5 Year Forward View says | What action the 5 Year Forward View suggests | What is the Halton approach? |
|---|---|---|
| | | late in the progression of their disease or condition. We believe that there is a significant opportunity to work differently to target prevention at this cohort of our population through working the voluntary sector and other organisations such as Cheshire Fire Service. |
| | *NHS support to help people get and stay in employment*<br><br>There is emerging evidence that well targeted health support can help keep people in work thus improving their wellbeing and preserving their livelihoods – particularly in regard to mental health problems and musculoskeletal complaints. A new government-backed Fit for Work scheme starts in 2015. During the next Parliament we will seek to test a win-win opportunity of improving access to NHS services for at-risk individuals while saving 'downstream' costs at the Department for Work and Pensions, if money can be reinvested across programmes. | We agree that the NHS has a greater role to play in supporting to help people get and stay in employment. We will investigate the implications of the Fit for Work scheme to see how we can maximise opportunities to help people get and stay in employment.<br><br>We are already considering access to and maintenance of employment in a number of areas. For example, NHS Halton CCG is undertaking a redesign of MSK services, which will look to increase integration across the service and move from an activity based contract to outcomes based contract, these outcomes are expected to include a focus on maintaining and returning to work. Implementation of the Family Nurse Partnership will support young parents to |

| What the 5 Year Forward View says | What action the 5 Year Forward View suggests | What is the Halton approach? |
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| | | build confidence and return to training and/or employment. Finally, our Community Wellbeing Practices have been working on supporting people back into work alongside existing organisations in the borough. |
| | *Workplace health*<br><br>There is merit in extending incentives for employers in England who provide effective NICE recommended workplace health programmes for employees. We will also establish with NHS Employers new incentives to ensure the NHS as an employer sets a national example in the support it offers its own 1.3 million staff to stay healthy, and serve as "health ambassadors" in their local communities. | As an employer, NHS Halton CCG provides incentives and practical support to enable staff to stay healthy and maintain their wellbeing. There are also opportunities for staff to act as "health ambassadors". OTHER NHS ORGANISATIONS?<br><br>Halton Borough Council is recruiting a new Environmental Health post which will work with local employers to address workforce health. This role needs to be linked in with partners, including NHS partners, in the borough. We believe that there is more that we can do to help local employers improve the health and wellbeing of their workforce. |
| ***Empowering patients*** | | |
| Personalised care will only happen when | *Improved information* | |

| What the 5 Year Forward View says | What action the 5 Year Forward View suggests | What is the Halton approach? |
|---|---|---|
| statutory services recognise that patients' own life goals are what count; that services need to support families, carers and communities; that promoting wellbeing and independence need to be the key outcomes of care; and that patients, their families and carers are often 'experts by experience'. | Improve the information to which people have access—not only clinical advice, but also information about their condition and history. Within five years, all citizens will be able to access their medical and care records (including in social care contexts) and share them with carers or others they choose. | NHS Halton CCG and Halton Borough Council, working with provider organisations, are developing a Health and Social Care Information Management and Technology (IM&T) Strategy that will enable citizens have access to their medical and care records. |
| | *Support people to manage their own health*<br><br>Enable people to stay healthy, make informed choices of treatment, manage conditions and avoid complications. With the help of voluntary sector partners, we will invest significantly in evidence-based approaches such as group-based education for people with specific conditions and self-management educational courses, as well as encouraging independent peer-to-peer communities to emerge. | In Halton we recognise that we need to create more opportunity to support people to manage their own health, as they are often 'experts by experience'. We are supporting the re-implementation of Expert Patient to support other initiatives. For example, NHS Halton CCG already commissions a comprehensive diabetes education programme. In conjunction with the Mersey Diabetes Network a further piece of work is being undertaken to further increase the number of people who access these programmes. We have also brought together our health and wellbeing services to ensure that they |

| What the 5 Year Forward View says | What action the 5 Year Forward View suggests | What is the Halton approach? |
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| | | promote self-care and health literacy. We are also developing social marketing approaches to self-care. Finally, NHS Halton CCG already commissions a Care at the Chemist scheme to support self-care. The conditions covered by this scheme will be expanded. NHS Halton CCG is also exploring the role of community pharmacy and how pharmacies/pharmacists can support people to manage their own health.<br><br>We recognise that we need to do more to target support to the 40% of our population who have the worst health outcomes. The voluntary sector and local community networks are vital in this for it is they who can support broadening health literacy, enhancing community resilience and awareness, and moving to asset based approaches. |
| | *Increase the direct control patients have over the care that is provided to them*<br><br>Patients should have choice over where and how they receive care. We will introduce integrated personal commissioning (IPC), a new voluntary approach to blending health and social care funding for individuals with complex | Progress has already been made in Halton in regard to personalised budgets and direct payments. We would be interested in exploring the implications of IPC further and would also welcome the exploration of 'year of care' approaches. |

| What the 5 Year Forward View says | What action the 5 Year Forward View suggests | What is the Halton approach? |
|---|---|---|
| | needs. As well as care plans and voluntary sector advocacy and support, IPC will provide an integrated, "year of care" budget that will be managed by people themselves or on their behalf by councils, the NHS or a voluntary organisation. | |
| ***Engaging communities*** | | |
| We need to engage with communities and citizens in new ways, involving them directly in decisions about the future of health and care services. Programmes like NHS Citizen point the way, but we also commit to four further actions to build on the energy and compassion that exists in communities across England. | *Better support for carers*<br><br>We will find new ways to support carers, building on the new rights created by the Care Act, and especially helping the most vulnerable amongst them – young carers and the carers who are themselves aged over 85. This will include working with voluntary organisations and GP practices to identify them and provide better support. For NHS staff, we will look to introduce flexible working arrangements for those with major unpaid caring responsibilities. | |
| | *Creating new options for health-related volunteering*<br><br>Volunteers are crucial in both health and social care. The Local Government Association has made proposals that volunteers, including those who help care for the elderly, should receive a 10% | NEEDS MORE BUT:<br><br>The Expert Patients programme will be an ideal opportunity to increase the number of volunteers providing peer support and |

| What the 5 Year Forward View says | What action the 5 Year Forward View suggests | What is the Halton approach? |
|---|---|---|
| | reduction in their council tax bill, worth up to £200 a year. We support testing approaches like that, which could be extended to those who volunteer in hospitals and other parts of the NHS. The NHS can go further, accrediting volunteers and devising ways to help them become part of the extended NHS family – not as substitutes for but as partners with our skilled employed staff. For example, more than 1,000 "community first responders" have been recruited by Yorkshire Ambulance in more rural areas and trained in basic life support. New roles which have been proposed could include family and carer liaison, educating people in the management of long-term conditions and helping with vaccination programmes. We also intend to work with carers organisations to support new volunteer programmes that could provide emergency help when carers themselves face a crisis of some kind, as well as better matching volunteers to the roles where they can add most value. | training to people with long term conditions. We also have a peer support programme for breastfeeding that provides a wide range of information, advice and support. |
| | *Stronger partnerships with charitable and voluntary sector organisations*<br><br>The voluntary sector is often better able to | |

| What the 5 Year Forward View says | What action the 5 Year Forward View suggests | What is the Halton approach? |
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| | reach underserved groups, and is a source of advice for commissioners on particular needs. We will seek to reduce the time and complexity associated with securing local NHS funding by developing a short national alternative to the standard NHS contract where grant funding may be more appropriate than burdensome contracts, and by encouraging funders to commit to multiyear funding wherever possible. | |
| | *The NHS as a local employer*<br><br>The NHS is committed to making substantial progress in ensuring that the boards and leadership of NHS organisations better reflect the diversity of the local communities they serve, and that the NHS provides supportive and non-discriminatory ladders of opportunity for all its staff, including those from black and minority ethnic backgrounds. NHS employers will be expected to lead the way as progressive employers, including for example by signing up to efforts such as Time to Change which challenge mental health stigma and discrimination. NHS employers also have the opportunity to be more creative in offering supported job opportunities to 'experts by | |

| What the 5 Year Forward View says | What action the 5 Year Forward View suggests | What is the Halton approach? |
|---|---|---|
| | experience' such as people with learning disabilities who can help drive the kind of change in culture and services that the Winterbourne View scandal so graphically demonstrated is needed. | |
| ***The NHS as a social movement*** | | |
| None of these initiatives and commitments by themselves will be the difference between success and failure over the next five years. But collectively and cumulatively they and others like them will help shift power to patients and citizens, strengthen communities, improve health and wellbeing, and—as a by-product—help moderate rising demands on the NHS. | Rather than being seen as the 'nice to haves' and the 'discretionary extras', our conviction is that these sort of partnerships and initiatives are in fact precisely the sort of 'slow burn, high impact' actions that are now essential. They in turn need to be matched by equally radical action to transform the way NHS care is provided. | |
| **Chapter Three: What will the future look like? New models of care** | | |
| ***Emerging models*** | | |
| The traditional divide between primary care, community services, and hospitals is increasingly a barrier to the personalised and coordinated health services patients need. And just as GPs and hospitals tend to be rigidly demarcated, so too are social care and mental health services even though people increasingly need all three. Over the next five years and beyond the NHS will increasingly need to dissolve these traditional boundaries. Long term conditions are now a central task of the | • Increasingly we need to manage systems – networks of care – not just organisations.<br>• Out-of-hospital care needs to become a much larger part of what the NHS does. Services need to be integrated around the patient. For example a patient with cancer needs their mental health and social care coordinated around them. Patients with mental illness need their physical health | MSK?<br><br>NHS Halton CCG has been developing a Strategy for General Practice Services as well as reviewing community nursing and out-of-hospital care. |

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| NHS; caring for these needs requires a partnership with patients over the long term rather than providing single, unconnected 'episodes' of care. | addressed at the same time.<br>• We should learn much faster from the best examples, not just from within the UK but internationally.<br>• And as we introduce them, we need to evaluate new care models to establish which produce the best experience for patients and the best value for money.<br><br>We intend to support and stimulate the creation of a number of major new care models that can be deployed in different combinations locally across England. However England is too diverse – both in its population and its current health services – to pretend that a single new model of care should apply everywhere. But that doesn't mean there are an infinite number of new care models. While the answer is not one-size-fits-all, nor is it simply to let 'a thousand flowers bloom'. Our approach will be to identify the characteristics of similar health communities across England, and then jointly work with them to consider which of the new options signalled by this Forward View constitute viable ways forward for their local health and care services over the next five years and beyond. | NHS Halton CCG has expressed an interest in participating in the HOPE exchange programme to increase the sharing of best practice internationally. |

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| ***A new deal for primary care*** | | |
| General practice, with its registered list and everyone having access to a family doctor, is one of the great strengths of the NHS, but it is under severe strain. Even as demand is rising, the number of people choosing to become a GP is not keeping pace with the growth in funded training posts - in part because primary care services have been under-resourced compared to hospitals. | Over the next five years we will invest more in primary care. Steps we will take include:<br><br>• Stabilise core funding for general practice nationally over the next two years while an independent review is undertaken of how resources are fairly made available to primary care in different areas.<br>• Give GP-led Clinical Commissioning Groups (CCGs) more influence over<br>• the wider NHS budget, enabling a shift in investment from acute to primary and community services.<br>• Provide new funding through schemes such as the Challenge Fund to support new ways of working and improved access to services.<br>• Expand as fast as possible the number of GPs in training while training more community nurses and other primary care staff. Increase investment in new roles, and in returner and retention schemes and ensure that current rules are not inflexibly putting off | Suspending the PMS review is clearly a key issue if this is to be made reality for Halton.<br><br>Within the implementation of co-commissioning of primary care, NHS Halton CCG has the opportunity to support and help shape the new deal for primary care. With robust governance arrangements in place, member practices input into this will be essential and will help shape future local models.<br><br>There are clearly risks over funding and having the management capacity to do this for Halton CCG. |

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| | potential returners.<br>• Expand funding to upgrade primary care infrastructure and scope of services.<br>• Work with CCGs and others to design new incentives to encourage new<br>• GPs and practices to provide care in under-doctored areas to tackle health inequalities.<br>• Build the public's understanding that pharmacies and on-line resources can help them deal with coughs, colds and other minor ailments without the need for a GP appointment or A&E visit. | It does depend on more money being made available for primary care – as yet no formula developed to create fare share targets for pCrimary care allocations. Will Halton get any additional resources to make this a reality? |
| ***New care model – Multispecialty Community Providers*** | | |
| Primary care is entering the next stage of its evolution. The traditional model has been evolving. Primary care of the future will build on the traditional strengths of 'expert generalists', proactively targeting services at registered patients with complex ongoing needs such as the frail elderly or those with chronic conditions, and working much more intensively with these patients. Future models will expand the leadership of primary care to include nurses, therapists and other community based professionals. It could also offer | To offer this wider scope of services, and enable new ways of delivering care, we will make it possible for extended group practices to form – either as federations, networks or single organisations. These Multispecialty Community Providers (MCPs) would become the focal point for a far wider range of care needed by their registered patients.<br>• As larger group practices they could in future begin employing consultants or take them on as | NHS Halton CCG and partners are working on a strategy for general practice services and a new model for out of hospital care. There has been some initial thinking about models of care that wrap services around groups of practices. This could be the basis of a local MCP type model, although NHS Halton CCG is keen to focus on a model of Multispecialty Community Provision with existing partners as supposed to be focused on creating a Multispecialty Community Provider. |

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| some care in fundamentally different ways, making fuller use of digital technologies, new skills and roles, and offering greater convenience for patients. | partners, bringing in senior nurses, consultant physicians, geriatricians, paediatricians and psychiatrists to work alongside community nurses, therapists, pharmacists, psychologists, social workers, and other staff.<br>• These practices would shift the majority of outpatient consultations and ambulatory care out of hospital settings.<br>• They could take over the running of local community hospitals which could substantially expand their diagnostic services as well as other services such as dialysis and chemotherapy.<br>• GPs and specialists in the group could be credentialed in some cases to directly admit their patients into acute hospitals, with out-of-hours inpatient care being supervised by a new cadre of resident 'hospitalists' – something that already happens in other countries.<br>• They could in time take on delegated responsibility for managing the health service budget for their registered patients. | NHS Halton CCG has already indicated that the Urgent Care Centres could expand their offering to pick up more out-of-hospital care. There is a challenge as to whether this would increase service costs without rationalisation of acute hospital facilities.<br><br>The implementation of the Strategy for General Practice Services in Halton will include exploring further partnerships with the voluntary and community sector and community pharmacy. |

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| | Where funding is pooled with local authorities, a combined health and social care budget could be delegated to Multispecialty Community Providers.<br>• These new models would also draw on the 'renewable energy' of carers, volunteers and patients themselves, accessing hard-to-reach groups and taking new approaches to changing health behaviours.<br><br>We will work with emerging practice groups to address barriers to change, service models, access to funding, optimal use of technology, workforce and infrastructure. | |
| ***New care model – Primary and Acute Care Systems (PACS)*** | | |
| A range of contracting and organisational forms are now being used to better integrate care, including lead/prime providers and joint ventures. We will now permit a new variant of integrate care in some parts of England by allowing single organisations to provide NHS list-based GP and hospital services, together with mental health and community care services. The leadership to bring about | • In some circumstances – such as in deprived urban communities where local general practice is under strain and GP recruitment is proving hard – hospitals will be permitted to open their own GP surgeries with registered lists. This would allow the accumulated surpluses and investment powers of NHS Foundation Trusts to | It is difficult to see how, with two acute providers, a newly designated community FT and an established mental health FT this model would work in Halton. Implementation would be problematic and it is unclear what safeguards would be in place for out of hospital care, without significantly changing the current PbR contractual system. |

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| these 'vertically' integrated Primary and Acute Care Systems (PACS) may be generated from different places in different local health economies. | kickstart the expansion of new style primary care in areas with high health inequalities. Safeguards will be needed to ensure that they do this in ways that reinforce out-of-hospital care, rather than general practice simply becoming a feeder for hospitals still providing care in the traditional ways.<br>• In other circumstances, the next stage in the development of a mature Multispecialty Community Provider (see section above) could be that it takes over the running of its main district general hospital.<br>• At their most radical, PACS would take accountability for the whole health needs of a registered list of patients, under a delegated capitated budget - similar to the Accountable Care Organisations that are emerging in Spain, the United States, Singapore, and a number of other countries.<br><br>PACS models are complex. They take time and technical expertise to implement. As with any model there are also potential unintended side effects that need to be managed. We will work with a small | It is unlikely that the developing MCP model in Halton would be in a position to take over a DGH or indeed aspires to do so.<br><br>The most radical model would need to legislation - if all GPs were part of this it could be indistinguishable from the CCG and conflicts of interest may arise.<br><br>Halton's local environment does not lend itself to a PACS model. |

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| | number of areas to test these approaches with the aim of developing prototypes that work, before promoting the most promising models for adoption by the wider NHS. | |
| ***New care model – urgent and emergency care networks*** | | |
| Over the next five years, the NHS will do far better at organising and simplifying the system. | This will mean:<br>• Helping patients get the right care, at the right time, in the right place, making more appropriate use of primary care, community mental health teams, ambulance services and community pharmacies, as well as urgent care centres throughout the country. This will partly be achieved by evening and weekend access to GPs or nurses working from community bases equipped to provide a much greater range of tests and treatments; ambulance services empowered to make more decisions, treating patients and making referrals in a more flexible way; and far greater use of pharmacists.<br>• Developing networks of linked hospitals that ensure patients with the most serious needs get to | NHS Halton CCG is leading a Mid-Mersey group examining the options for stroke services, including the location of hyper- |

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| | specialist emergency centres - drawing on the success of major trauma centres, which have saved 30% more of the lives of the worst injured.<br>• Ensuring that hospital patients have access to seven day services where this makes a clinical difference to outcomes.<br>• Proper funding and integration of mental health crisis services, including liaison psychiatry.<br>• A strengthened clinical triage and advice service that links the system together and helps patients navigate it successfully.<br>• New ways of measuring the quality of the urgent and emergency services; new funding arrangements; and new responses to the workforce requirements that will make these new networks possible. | acute services at a single hospital site.<br><br>How will this be funded given very low levels of NHS growth funding? |
| ***New care model – viable smaller hospitals*** | | |
| England already has one of the more centralised hospital models amongst advanced health systems. It is right that these (smaller district general) hospitals should not be providing complex acute services where there is evidence that high | We will now take three sets of actions.<br><br>First, NHS England and Monitor will work together to consider whether any adjustments are needed to the NHS payment regime to reflect the costs of | Both our acute providers are considered to have hospitals that are “small”. Changes to the system could pose a financial risk to NHS Halton CCG. |

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| volumes are associated with high quality. Some services and buildings will inevitably and rightly need to be re-provided in other locations - just as they have done in the past and will continue to be in every other western country. In some case there may be a need to help sustain local hospital services where the best clinical solution is affordable, has the support of local commissioners and communities. | delivering safe and efficient services for smaller providers relative to larger ones.<br><br>Second, building on the earlier work of Monitor looking at the costs of running smaller hospitals, and on the Royal College of Physicians Future Hospitals initiative, we will work with those hospitals to examine new models of medical staffing and other ways of achieving sustainable cost structures.<br><br>Third, we will create new organisational models for smaller acute hospitals that enable them to gain the benefits of scale without necessarily having to centralise services. Building on the recommendations of the forthcoming Dalton Review, we intend to promote at least three new models:<br><br>• In one model, a local acute hospital might share management either of the whole institution or of their 'back office' with other similar hospitals not necessarily located in their immediate vicinity.<br>• In another new model, a smaller local hospital might have some of its services on a site provided by | |

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| | another specialised provider.<br>• And as indicated in the PACS model above, a further new option is that a local acute hospital and its local primary and community services could form an integrated provider. | |
| ***New care model - specialised care*** | | |
| In some services there is a compelling case for greater concentration of care. In these services there is a strong relationship between the number of patients and the quality of care, derived from the greater experience these more practiced clinicians have, access to costly specialised facilities and equipment, and the greater standardisation of care that tends to occur. | In services where the relationship between quality and patient volumes is strong, NHS England will now work with local partners to drive consolidation through a programme of three-year rolling reviews. We will also look to these specialised providers to develop networks of services over geography, integrating different organisations and services around patients, using innovations such as prime contracting and/or delegated capitated budgets. | |
| ***New care model – modern maternity services*** | | |
| Having a baby is the most common reason for hospital admission in England. Births are up by almost a quarter in the last decade, and are at their highest in 40 years. Recent research shows that for low risk pregnancies babies born at midwife-led units or at home did as well as babies born in obstetric units, with | To ensure maternity services develop in a safe, responsive and efficient manner, in addition to other actions underway – including increasing midwife numbers - we will:<br>• Commission a review of future models for maternity units, to report | |

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| fewer interventions. Four out of five women live within a 30 minute drive of both an obstetric unit and a midwife-led unit, but research by the Women's Institute and the National Childbirth Trust suggests that while only a quarter of women want to give birth in a hospital obstetrics unit, over 85% actually do so. | by next summer, which will make recommendations on how best to sustain and develop maternity units across the NHS.<br><br>• Ensure that tariff-based NHS funding supports the choices women make, rather than constraining them.<br><br>• As a result, make it easier for groups of midwives to set up their own NHS-funded midwifery services. | |
| ***New care model – enhanced health in care homes*** | | |
| One in six people aged 85 or over are living permanently in a care home. Yet data suggest that had more active health and rehabilitation support been available, some people discharged from hospital to care homes could have avoided permanent admission. Similarly, the Care Quality Commission and the British Geriatrics Society have shown that many people with dementia living in care homes are not getting their health needs regularly assessed and met. One consequence is avoidable admissions to hospital. | In partnership with local authority social services departments, and using the opportunity created by the establishment of the Better Care Fund, we will work with the NHS locally and the care home sector to develop new shared models of in-reach support, including medical reviews, medication reviews, and rehab services. In doing so we will build on the success of models which have been shown to improve quality of life, reduce hospital bed use by a third, and save significantly more than they cost. | |
| ***How will we support the co-design and implementation of these new care models?*** | | |

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| Some parts of the country will be able to continue commissioning and providing high quality and affordable health services using their current care models, and without any adaptation along the lines described above. However, previous versions of local 'five year plans' by provider trusts and CCGs suggest that many areas will need to consider new options if they are to square the circle between the desire to improve quality, respond to rising patient volumes, and live within the expected local funding.<br>In some places, including major conurbations, we therefore expect several of these alternative models to evolve in parallel. In other geographies it may make sense for local communities to discuss convergence of care models for the future. This will require a new perspective where leaders look beyond their individual organisations' interests and towards the future development of whole health care economies - and are rewarded for doing so. It will also require a new type of partnership between national bodies and local leaders. That is because to succeed in designing and implementing these new care models, the NHS locally will need national bodies | We will therefore now work with local communities and leaders to identify what changes are needed in how national and local organisations best work together, and will jointly develop:<br><br>• Detailed prototyping of each of the new care models described above, together with any others that may be proposed that offer the potential to deliver the necessary transformation - in each case identifying current exemplars, potential benefits, risks and transition costs.<br>• A shared method of assessing the characteristics of each health economy, to help inform local choice of preferred models, promote peer learning with similar areas, and allow joint intervention in health economies that are furthest from where they need to be.<br>• National and regional expertise and support to implement care model change rapidly and at scale. The NHS is currently spending several hundred million pounds on bodies that directly or indirectly could | |

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| jointly to exercise discretion in the application of their payment rules, regulatory approaches, staffing models and other policies, as well as possibly providing technical and transitional support. | support this work, but the way in which improvement and clinical engagement happens can be fragmented and unfocused. We will therefore create greater alignment in the work of strategic clinical networks, clinical senates, NHS IQ, the NHS Leadership Academy and the Academic Health Science Centres and Networks.<br>• National flexibilities in the current regulatory, funding and pricing regimes to assist local areas to transition to better care models.<br>• Design of a model to help pump-prime and 'fast track' a cross-section of the new care models. We will back the plans likely to have the greatest impact for patients, so that by the end of the next Parliament the benefits and costs of the new approaches are clearly demonstrable, allowing informed decisions about future investment as the economy improves. This pump-priming model could also unlock assets held by NHS Property Services, surplus NHS property and support Foundation Trusts that decide to | |

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| | use accrued savings on their balance sheets to help local service transformation. | |
| **Chapter Four: How will we get there?** | | |
| ***We will back diverse solutions and local leadership*** | | |
| Many CCGs are now harnessing clinical insight and energy to drive change in their local health systems in a way that frankly has not been achievable before now.<br><br>We will also work with ambitious local areas to define and champion a limited number of models of joint commissioning between the NHS and local government.<br><br>There is no appetite for a wholesale structural reorganisation. | NHS England intends progressively to offer CCGs more influence over the total NHS budget for their local populations, ranging from primary to specialised care.<br><br>Joint commissioning models will include Integrated Personal Commissioning as well as Better Care Fund-style pooling budgets for specific services where appropriate, and under specific circumstances possible full joint management of social and health care commissioning, perhaps under the leadership of Health and Wellbeing Boards.<br><br>Changes in local organisational configurations should arise only from local work to develop new care models or in response to clear local failure and the resulting implementation of special measures. | |
| ***We will provide aligned national NHS leadership*** | | |
| NHS England, Monitor, the NHS Trust Development Authority, the Care | We intend to develop our shared work: | |

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| Quality Commission, Health Education England, NICE and Public Health England have distinctive national duties laid on them by statute, and rightly so. However in their individual work with the local NHS there are various ways in which more action in concert would improve the impact and reduce the burden on frontline services. | • Through a combined work programme to *support the development of new local care models.*<br>• Monitor, TDA and NHS England will work together to create greater alignment between their respective *local assessment, reporting and intervention regimes* for Foundation Trusts, NHS trusts, and CCGs, complementing the work of CQC and HEE.<br>• NHS England will also develop a new risk-based CCG assurance regime that will lighten the quarterly assurance reporting burden from high performing CCGs, while setting out a new 'special measures' support regime for those that are struggling.<br>• Using existing flexibilities and discretion, we will deploy national regulatory, pricing and funding regimes to support change in specific local areas that is in the interest of patients.<br>• The key NHS oversight organisations will come together regionally and nationally to *share intelligence, agree action and* | |

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| | *monitor overall assurance on quality*. The National Quality Board provides such a forum, and we intend to reenergise it. | |
| ***We will support a modern workforce*** | | |
| We need a workforce with the right numbers, skills, values and behaviours to deliver it. That's why ensuring the NHS becomes a better employer is so important.<br><br>Since 2000, the workforce has grown by 160,000 more whole-time equivalent clinicians. These increases have not fully reflected changing patterns of demand. Hospital consultants have increased around three times faster than GPs and there has been an increasing trend towards a more specialised workforce, even though patients with multiple conditions would benefit from a more holistic clinical approach. We have yet to see a significant shift from acute to community sector based working – just a 0.6% increase in the numbers of nurses working in the community over the past ten years. | By supporting the health and wellbeing of frontline staff; providing safe, inclusive and non-discriminatory opportunities; and supporting employees to raise concerns, and ensuring managers quickly act on them.<br><br>Employers are responsible for ensuring they have sufficient staff with the right skills to care for their patients. Supported by Health Education England, we will address immediate gaps in key areas. We will put in place new measures to support employers to retain and develop their existing staff, increase productivity and reduce the waste of skills and money. We will consider the most appropriate employment arrangements to enable our current staff to work across organisational and sector boundaries. HEE will work with employers, employees and commissioners to identify the education and training needs of our current workforce, equipping them with the skills and flexibilities to deliver the new models | |

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| | of care, including the development of transitional roles. This will require a greater investment in training for existing staff, and the active engagement of clinicians and managers who are best placed to know what support they need to deliver new models of care. | |
| Since it takes time to train skilled staff (for example, up to thirteen years to train a consultant), the risk is that the NHS will lock itself into outdated models of delivery unless we radically alter the way in which we plan and train our workforce. | HEE will work with its statutory partners to commission and expand new health and care roles, ensuring we have a more flexible workforce that can provide high quality care wherever and whenever the patient needs it. This work will be taken forward through the HEE's leadership of the implementation of the Shape of Training Review for the medical profession and the Shape of Care Review for the nursing profession, so that we can 'future proof' the NHS against the challenges to come.<br><br>More generally, over the next several years, NHS employers and staff and their representatives will need to consider how working patterns and pay and terms and conditions can best evolve to fully reward high performance, support job and service redesign, and encourage recruitment and retention in parts of the country and in | |

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| | occupations where vacancies are high. | |
| ***We will exploit the information revolution*** | | |
| Progress on hospital systems has been slow following the failures of the previous 'connecting for health' initiative.<br><br>The NHS is not yet exploiting its comparative advantage as a population-focused national service.<br><br>The NHS has oscillated between two opposite approaches to information technology adoption – neither of which now makes sense - at times we have tried highly centralised national procurements and implementations. When they have failed due to lack of local engagement and lack of sensitivity to local circumstances, we have veered to the opposite extreme. The result has been systems that don't talk to each other, and a failure to harness the shared benefits that come from interoperable systems. | In future we intend to take a different approach. Nationally we will focus on the key systems that provide the 'electronic glue' which enables different parts of the health service to work together. Other systems will be for the local NHS to decide upon and procure, provided they meet nationally specified interoperability and data standards.<br><br>A National Information Board has been Established. The NIB will publish a set of 'road maps' laying out who will do what to transform digital care. Key elements will include:<br><br>• Comprehensive transparency of performance data – including the results of treatment and what patients and carers say – to help health professionals see how they are performing compared to others and improve; to help patients make informed choices; and to help CCGs and NHS England commission the best quality care.<br>• An expanding set of NHS | NHS Halton CCG and Halton Borough Council are currently developing a joint health and social care strategy which will cover all the points listed in this section. |

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| | accredited health apps that patients will be able to use to organise and manage their own health and care; and the development of partnerships with the voluntary sector and industry to support digital inclusion.<br>• Fully interoperable electronic health records so that patients' records are largely paperless. Patients will have full access to these records, and be able to write into them. They will retain the right to opt out of their record being shared electronically. The NHS number, for safety and efficiency reasons, will be used in all settings, including social care.<br>• Family doctor appointments and electronic and repeat prescribing available routinely on-line everywhere.<br>• Bringing together hospital, GP, administrative and audit data to support the quality improvement, research, and the identification of patients who most need health and social care support. Individuals will be able to opt out of their data being used in this way. | |

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| | • Technology – including smartphones - can be a great leveller and, contrary to some perceptions, many older people use the internet. However, we will take steps to ensure that we build the capacity of all citizens to access information, and train our staff so that they are able to support those who are unable or unwilling to use new technologies. | |
| ***We will accelerate useful health innovation*** | | |
| Research is vital in providing the evidence we need to transform services and improve outcomes. | We will continue to support the work of the National Institute for Health Research (NIHR) and the network of specialist clinical research facilities in the NHS. We will also develop the active collection and use of health outcomes data, offering patients the chance to participate in research; and, working with partners, ensuring use of NHS clinical assets to support research in medicine. Steps we will take to speed innovation in new treatments and diagnostics include:<br><br>• The NHS has the opportunity radically to cut the costs of conducting Randomised Controlled Trials (RCTs), not only by | |

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| | streamlining approval processes but also by harnessing clinical technology. We will support the rollout of the Clinical Practice Research Datalink, and efforts to enable its use to support observational studies and quicker lower cost RCTs embedded within routine general practice and clinical care.<br>• In some cases it will be hard to test new treatment approaches using RCTs because the populations affected are too small. NHS England already has a £15m a year programme, administered by NICE, now called "commissioning through evaluation" which examines real world clinical evidence in the absence of full trial data. At a time when NHS funding is constrained it would be difficult to justify a further major diversion of resources from proven care to treatments of unknown cost effectiveness. However, we will explore how to expand this programme and the Early Access to Medicines programme in future years. It will be easier if the costs of | |

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| | doing so can be supported by those manufacturers who would like their products evaluated in this way.<br>• A smaller proportion of new devices and equipment go through NICE's assessment process than do pharmaceuticals. We will work with NICE to expand work on devices and equipment and to support the best approach to rolling out high value innovations—for example, operational pilots to generate evidence on the real world financial and operational impact on services—while decommissioning outmoded legacy technologies and treatments to help pay for them.<br>• The Department of Health-initiated Cancer Drugs Fund has expanded access to new cancer medicines. We expect over the next year to consult on a new approach to converging its assessment and prioritisation processes with a revised approach from NICE.<br>• The average time it takes to translate a discovery into clinical practice is however often too slow. | |

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| | So as well as a commitment to research, we are committed to accelerating the quicker adoption of cost-effective innovation - both medicines and medtech. We will explore with partners—including patients and voluntary sector organisations—a number of new mechanisms for achieving this. | |
| ***Accelerating innovation in new ways of delivering care*** | | |
| We have an unexploited opportunity to *combine* different technologies and changed ways of working in order to transform care delivery. For example, equipping house-bound elderly patients who suffer from congestive heart failure with new biosensor technology that can be remotely monitored can enable community nursing teams to improve outcomes and reduce hospitalisations. But any one of these components by itself produces little or no gain, and may in fact just add cost. So instead we need what is now being termed 'combinatorial innovation'.<br><br>The NHS will become one of the best places in the world to test innovations that require staff, technology and funding all to align in a health system, | Over the next five years we intend to:<br><br>• Develop a small number of 'test bed' sites alongside our Academic Health Science Networks and Centres. They would serve as real world sites for 'combinatorial' innovations that integrate new technologies, bioinformatics, new staffing models and payment-for-outcomes. Innovators from the UK and internationally will be able to bid to have their proposed discovery or innovation deployed and tested in these sites.<br>• Working with NIHR and the Department of Health we will expand NHS operational research, RCT capability and other methods to promote more rigorous ways of | |

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| with universal coverage serving a large and diverse population. In practice, our track record has been decidedly mixed. Too often single elements have been 'piloted' without other needed components. Even where 'whole system' innovations have been tested, the design has sometimes been weak, with an absence of control groups plus inadequate and rushed implementation. As a result they have produced limited empirical insight. | answering high impact questions in health services redesign. An example of the sort of question that might be tested: how best to evolve GP out of hours and NHS 111 services so as to improve patient understanding of where and when to seek care, while improving clinical outcomes and ensuring the most appropriate use of ambulance and A&E services. Further work will also be undertaken on behavioural 'nudge' type policies in health care.<br>• We will explore the development of health and care 'new towns'. England's population is projected to increase by about 3 to 4 million by 2020. New town developments and the refurbishment of some urban areas offers the opportunity to design modern services from scratch, with fewer legacy constraints - integrating not only health and social care, but also other public services such as welfare, education and affordable housing. The health campus already planned for Watford is one example of this. | |
| ***We will drive efficiency and productive investment*** | | |

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| It has previously been calculated by Monitor, separately by NHS England, and also by independent analysts, that a combination of a) growing demand, b) no further annual efficiencies, and c) flat real terms funding could, by 2020/21, produce a mismatch between resources and patient needs of nearly £30 billion a year. So to sustain a comprehensive high-quality NHS, action will be needed on all three fronts. Less impact on any one of them will require compensating action on the other two. | *Demand*<br>On demand, this Forward View makes the case for a more activist prevention and public health agenda: greater support for patients, carers and community organisations; and new models of primary and out-of-hospital care. While the positive effects of these will take some years to show themselves in moderating the rising demands on hospitals, over the medium term the results could be substantial. Their net impact will however also partly depend on the availability of social care services over the next five years.<br><br>*Efficiency*<br>Over the long run, NHS efficiency gains have been estimated by the Office for Budget Responsibility at around 0.8% net annually. Given the pressures on the public finances and the opportunities in front of us, 0.8% a year will not be adequate, and in recent years the NHS has done more than twice as well as this. A 1.5% net efficiency increase each year over the next Parliament should be obtainable if the NHS is able to accelerate some of its current efficiency programmes, recognising that some | |

| What the 5 Year Forward View says | What action the 5 Year Forward View suggests | What is the Halton approach? |
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| | others that have contributed over the past five years will not be indefinitely repeatable. For example as the economy returns to growth, NHS pay will need to stay broadly in line with private sector wages in order to recruit and retain frontline staff. Our ambition, however, would be for the NHS to achieve 2% net efficiency gains each year for the rest of the decade – possibly increasing to 3% over time. This would represent a strong performance - compared with the NHS' own past, compared with the wider UK economy, and with other countries' health systems. It would require investment in new care models and would be achieved by a combination of "catch up" (as less efficient providers matched the performance of the best), "frontier shift" (as new and better ways of working of the sort laid out in chapters three and four are achieved by the whole sector), and moderating demand increases which would begin to be realised towards the end of the second half of the five year period (partly as described in chapter two). It would improve the quality and responsiveness of care, meaning patients getting the 'right care, at the right time, in the right setting, | |

| What the 5 Year Forward View says | What action the 5 Year Forward View suggests | What is the Halton approach? |
|---|---|---|
| | from the right caregiver'. The Nuffield Trust for example calculates that doing so could avoid the need for another 17,000 hospital beds - equivalent to opening 34 extra 500-bedded hospitals over the next five years.<br><br>*Funding*<br>NHS spending has been protected over the past five years, and this has helped sustain services. However, pressures are building. In terms of future funding scenarios, flat real terms NHS spending overall would represent a continuation of current budget protection. Flat real terms NHS spending *per person* would take account of population growth. Flat NHS spending *as a share of GDP* would differ from the long term trend in which health spending in industrialised countries tends to rise a share of national income. Depending on the combined efficiency and funding option pursued, the effect is to close the £30 billion gap by one third, one half, or all the way.<br><br>• In scenario one, the NHS budget remains flat in real terms from 2015/16 to 2020/21, and the NHS delivers its long run productivity | A key question for Halton is how the allocation formula may impact on future funding growth. Halton is likely to get a bottom range of uplift for CCGs, although the inclusion of primary care (formula still be developed) and some specialised services in CCG commissioning responsibilities may help reduce over target for Halton. |

| What the 5 Year Forward View says | What action the 5 Year Forward View suggests | What is the Halton approach? |
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| | gain of 0.8% a year. The combined effect is that the £30 billion gap in 2020/21 is cut by about a third, to £21 billion.<br>• In scenario two, the NHS budget still remains flat in real terms over the period, but the NHS delivers stronger efficiencies of 1.5% a year. The combined effect is that the £30 billion gap in 2020/21 is halved, to £16 billion.<br>• In scenario three, the NHS gets the needed infrastructure and operating investment to rapidly move to the new care models and ways of working described in this Forward View, which in turn enables demand and efficiency gains worth 2%-3% net each year. Combined with staged funding increases close to 'flat real per person' the £30 billion gap is closed by 2020/21.<br><br>Decisions on these options will inevitably need to be taken in the context of how the UK economy overall is performing, during the next Parliament. However nothing in the analysis above suggests that continuing with a comprehensive tax- | |

| What the 5 Year Forward View says | What action the 5 Year Forward View suggests | What is the Halton approach? |
|---|---|---|
| | funded NHS is intrinsically undoable – instead it suggests that there are viable options for sustaining and improving the NHS over the next five years, provided that the NHS does its part, together with the support of government. The result would be a far better future for the NHS, its patients, its staff and those who support them. | |

**REPORT TO:** Health Policy and Performance Board

**DATE:** 13th January 2015

**REPORTING OFFICER:** Simon Banks, Chief Office

**PORTFOLIO:** Health and Wellbeing

**SUBJECT:** Developing a NHS Halton CCG response to *Next steps towards primary care co-commissioning*

**WARD(S):** Borough-wide

## 1.0 PURPOSE OF REPORT

1.1 On 10th November 2014 NHS England, in partnership with NHS Clinical Commissioners, published *Next steps towards primary care co-commissioning*. The document aims to provide clarity and transparency around co-commissioning options, providing CCGs and area teams with the information and tools they need to choose and implement the right form of co-commissioning for their local health economy. NHS Halton CCG needed to decide by 9th January 2015, the level of primary care co-commissioning the organisation wishes to undertake with NHS England.

## 2.0 RECOMMENDATION: That the Health Policy and Performance Board are invited to review this paper and receive a verbal update from NHS Halton CCG.

## 3.0 SUPPORTING INFORMATION

3.1 In May 2014, NHS England invited CCGs to come forward with expressions of interest to take on an increased role in the commissioning of primary care services. The intention was to empower and enable CCGs to improve primary care services locally for the benefit of patients and local communities. There has been a strong response from CCGs wishing to assume co-commissioning responsibilities. NHS Halton CCG submitted an expression of interest in co-commissioning of primary care services in June 2014.

3.2 NHS England now wants to harness this energy and address the frustrations CCGs have expressed in the current primary care commissioning arrangements, to more effectively shape high quality local services. The purpose of *Next steps towards primary care co-commissioning* is to give CCGs an opportunity to choose afresh the co-commissioning model they wish to assume. It clarifies the opportunities and parameters of each model, including associated functions; governance arrangements; resources; and any potential

risks, with advice on how to mitigate these. The document then sets out the steps towards implementing co-commissioning arrangements, including the timeline and approvals process.

3.3 Co-commissioning is one of a series of changes set out in the NHS Five Year Forward View. The *Five Year Forward View* emphasises the need to increase the provision of out-of-hospital care and to break down barriers in how care is delivered. Co-commissioning is a key enabler in developing seamless, integrated out-of-hospital services based around the diverse needs of local populations. It will drive the development of new integrated out-of hospital models of care, such as multispecialty community providers and primary and acute care systems.

3.4 Co-commissioning will give CCGs the option of having more control of the wider NHS budget, enabling a shift in investment from acute to primary and community services. By aligning primary and secondary care commissioning, it also offers the opportunity to develop more affordable services through efficiencies gained. Co-commissioning could potentially lead to a range of benefits for the public and patients, including:

- Improved access to primary care and wider out-of-hospitals services, with more services available closer to home;
- High quality out-of-hospitals care;
- Improved health outcomes, equity of access, reduced inequalities; and
- A better patient experience through more joined up services.

3.5 Co-commissioning could also lead to greater consistency between outcome measures and incentives used in primary care services and wider out-of-hospital services. Furthermore, it will enable the development of a more collaborative approach to designing local solutions for workforce, premises and information management and technology challenges.

3.6 Primary care co-commissioning is the beginning of a longer journey towards place based commissioning – where different commissioners come together to jointly agree commissioning strategies and plans, using pooled funds, for services for a local population. From 1 April 2015 NHS England will be extending personal commissioning through The Integrated Personal Commissioning (IPC) programme. The IPC programme aims to bring health and social care together, identifying the totality of expenditure at the level of the individual, giving people more control over how this is used and enabling money to be spent in a more tailored way. Furthermore, from 2015/16 CCGs will have the opportunity to co-commission some specialised services through a

joint committee. NHS England has also been encouraging CCGs and local authorities to strengthen their partnership approach so they can jointly and effectively work to align commissioning intentions for NHS, social care and public health services.

3.7 *Next steps towards primary care co-commissioning* gives clinical commissioning groups (CCGs) the opportunity to choose afresh the co-commissioning model they wish to assume. It clarifies the opportunities and parameters of each co-commissioning model and the steps towards implementing arrangements. The document has been developed by the joint CCG and NHS England Primary Care Commissioning Programme Oversight Group in partnership with NHS Clinical Commissioners.

3.8 Primary care co-commissioning is one of a series of changes set out in the NHS Five Year Forward View. Co-commissioning is a key enabler in developing seamless, integrated out-of-hospital services based around the diverse needs of local populations. It will also drive the development of new models of care such as multispecialty community providers and primary and acute care systems.

3.9 There are three primary care co-commissioning models CCGs could take forward:

- Greater involvement in primary care decision making.
- Joint commissioning arrangements.
- Delegated commissioning arrangements.

3.10 The scope of primary care co-commissioning in 2015/16 is general practice services only. For delegated arrangements this will include contractual GP performance management, budget management and complaints management. However, co-commissioning excludes all functions relating to individual GP performance management (medical performers' lists for GPs, appraisal and revalidation). Furthermore, the terms of GMS contracts and any nationally determined elements of PMS and APMS contracts will continue to be set out in the respective regulations and directions.

3.11 Under joint and delegated arrangements, CCGs will have the opportunity to design a local incentive scheme as an alternative to the Quality and Outcomes Framework (QOF) or Directed Enhanced Services (DES). This is without prejudice to the right of GMS practices to their entitlements, which are negotiated and set nationally. In order to ensure national consistency and delivery of the democratically-set goals for the NHS outlined in the Mandate set for us by the government, NHS England will continue to set national standing rules, to be reviewed annually. NHS England will work with CCGs to agree rules for areas such as the collection of data for national data sets, equivalent of what is collected under QOF and IT intra-operability.

3.12 In joint and delegated arrangements, NHS England and/or CCGs may vary or renew existing contracts for primary care provision or award new ones, depending on local circumstances. CCGs and NHS England must comply with public procurement regulations and with statutory guidance on conflicts of interest. In delegated arrangements, where a CCG fails to secure an adequate supply of high quality primary medical care, NHS England may direct a CCG to act.

3.13 With regards to governance arrangements, draft governance frameworks and terms of reference for joint and delegated arrangements on behalf of CCGs have been developed. CCGs are encouraged to utilise these resources when establishing their governance arrangements.

3.14 A significant challenge of primary care co-commissioning is finding a way to ensure that CCGs can access the necessary resources as they take on new responsibilities. Pragmatic and flexible local arrangements for 2015/16 will need to be agreed by CCGs and area teams.

3.15 Conflicts of interest need to be carefully managed within co-commissioning. Whilst there is already conflicts of interest guidance in place for CCGs, this will be strengthened in recognition that co-commissioning is likely to increase the range and frequency of real and perceived conflicts of interest, especially for delegated arrangements. A national framework for conflicts of interest in primary care co-commissioning will be published as statutory guidance in December 2014.

3.16 The approvals process for co-commissioning arrangements will be straightforward. The aim is to support as many CCGs as possible to implement co-commissioning arrangements by 1 April 2015. Unless a CCG has serious governance issues or is in a state akin to "special measures", NHS England will support CCGs to move towards implementing co-commissioning arrangements. CCGs who wish to implement joint or delegated arrangements will be required to complete a short proforma and request a constitution amendment. The approvals process will be led by regional moderation panels with the new NHS England commissioning committee providing final sign off for delegated arrangements. The timescales for submissions are:

- Joint commissioning – 30th January 2015
- Delegated commissioning, noon, 9th January 2015

## 4.0 POLICY IMPLICATIONS

4.1 NHS Halton CCG has been required, within short timescales, to

consider the three models of co-commissioning that have been presented to the organisation. It is arguable that the first of these approaches, greater involvement in primary care co-commissioning, simply reflects where the organisation was at its inception – collaborating closely with our area team to ensure that decisions taken about healthcare services are strategically aligned across the local health economy and assisting NHS Halton CCG in fulfilling the duty to improve the quality of primary medical care. NHS Halton CCG therefore had a choice of two approaches, joint commissioning or delegated commissioning.

4.2 Joint Commissioning

4.2.1 A joint commissioning model enables one or more CCGs to assume responsibility for jointly commissioning primary medical services with their area team, either through a joint committee or "committees in common". Joint commissioning arrangements give CCGs and area teams an opportunity to more effectively plan and improve the provision of out-of hospital services for the benefit of patients and local populations. Within this model CCGs also have the option to pool funding for investment in primary care services.

4.2.2 In 2015/16, joint commissioning arrangements will be limited to general practice services. The functions joint committees could cover are:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services ("Local Enhanced Services (LES)" and "Directed Enhanced Services (DES)");
- Design of local incentive schemes as an alternative to the Quality and Outcomes Framework (QOF);
- The ability to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on 'discretionary' payments (e.g., returner/retainer schemes).

4.2.3 Joint commissioning arrangements will exclude individual GP performance management (medical performers' list for GPs, appraisal and revalidation). NHS CCGs could either form a joint committee or "committees in common" with their area team in order to jointly commission primary medical services. With regards to joint committees, due to the passing of a Legislative Reform Order (LRO) by parliament, CCGs can now form a joint committee with one or more CCGs and NHS England. NHS England's scheme of delegation is being reviewed and will be revised as appropriate to enable the formation of joint committees between NHS England and

CCGs i.e., where NHS England invites one or more CCGs to form a joint committee.

4.2.4 A model terms of reference for joint commissioning arrangements, including scheme of delegation has been developed by NHS England. This model applies to the establishment of a joint committee between the CCG (or CCGs) and NHS England. If CCGs and area teams intend to form a joint committee, they are encouraged to use this framework which could be adapted to reflect local arrangements and to ensure consistency with the CCGs' particular governance structures. The joint committee structure allows a more efficient and effective way of working together than a committees-in-common approach and so this is the recommended governance structure for joint commissioning arrangements.

4.2.5 In joint commissioning arrangements, individual CCGs and NHS England always remain accountable for meeting their own statutory duties, for instance in relation to quality, financial resources, equality, health inequalities and public participation. This means that in this arrangement, NHS England retains accountability for the discharge of its statutory duties in relation to primary care commissioning. CCGs and NHS England must ensure that any governance arrangement they put in place does not compromise their respective ability to fulfil their duties, and ensures they are able to meaningfully engage patients and the public in decision making. Arrangements should also comply with the conflicts of interest guidance.

4.2.6 The effectiveness of joint arrangements is reliant upon the development of strong local relationships and effective approaches to collaborative working. NHS England and CCGs need to ensure that any governance arrangements put in place enable them to collaborate effectively.

4.2.7 It is for area teams and CCGs to agree the full membership of their joint committees. In the interests of transparency and the mitigation of conflicts of interest, a local HealthWatch representative and a local authority representative from the local Health and Wellbeing Board will have the right to join the joint committee as non-voting attendees. HealthWatch and Health and Wellbeing Boards are under no obligation to nominate a representative, but there would be significant mutual benefits from their involvement. For example, it would support alignment in decision making across the local health and social care system.

4.2.8 CCGs will want to ensure that membership (including any non-voting attendees) enables appropriate contribution from the range of stakeholders with whom they are required to work. CCGs and area teams are encouraged to consult the Transforming Participation in Health and Care guidance when considering the membership of

their committees. It will be important to retain clinical leadership of commissioning in a joint committee arrangement to ensure the unique benefits of clinical commissioning are retained.

4.2.9 CCGs and area teams may wish to consider implementing a pooled fund arrangement under joint commissioning arrangements as per section 13V of Chapter A1 of the NHS Act 2006 (as amended by the Health and Social Care Act 2012). Establishing a pooled fund will require close working between CCG and area team finance colleagues to ensure that the arrangement establishes clear financial controls and risk management systems and has clear accountability arrangements in place.

4.2.10 The funding of core primary medical services is an NHS England statutory function. Although NHS England can create a pooled fund which a CCG can contribute to, the CCG's contribution must relate to its own functions and so could not relate to core primary medical services. However, CCGs are able to invest in a way that is calculated to facilitate or is conducive or incidental to the provision of primary medical care and provided that no other body has a statutory duty to provide that funding.

4.3 Delegated Commissioning

4.3.1 Delegated commissioning offers an opportunity for CCGs to assume full responsibility for commissioning general practice services. Legally, NHS England retains the residual liability for the performance of primary medical care commissioning. Therefore, NHS England will require robust assurance that its statutory functions are being discharged effectively. Naturally, CCGs continue to remain responsible for discharging their own statutory duties, for instance, in relation to quality, financial resources and public participation.

4.3.2 NHS England and NHS Clinical Commissioners have agreed that a standardised model of delegation would make most sense for practical reasons. CCGs have expressed a strong interest in assuming the following primary care functions which will be included in delegated arrangements:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action, such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services ("Local Enhanced Services (LES)" and "Directed Enhanced Services (DES)");
- Design of local incentive schemes as an alternative to the Quality and Outcomes Framework (QOF);

- The ability to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on 'discretionary' payments (e.g., returner/retainer schemes).

4.3.3 Delegated commissioning arrangements will exclude individual GP performance management (medical performers' list for GPs, appraisal and revalidation). NHS England will also be responsible for the administration of payments and list management. CCGs have the opportunity to discuss dental, eye health and community pharmacy commissioning with their area team and local professional networks but have no decision making role.

4.3.4 NHS England has developed a model governance framework for delegated commissioning arrangements in order to avoid the need for CCGs to develop their own model. The recommendation is that CCGs establish a primary care commissioning committee to oversee the exercise of the delegated functions. A model terms of reference for delegated commissioning arrangements including scheme of delegation has been developed. If CCGs intend to assume delegated responsibilities, they are encouraged to use this framework which could be adapted to reflect local arrangements and to ensure consistency with the CCGs' particular governance structures.

4.3.5 A formal document which records the delegation of authority by NHS England to CCGs will be issued once the approvals process is completed. In delegated commissioning arrangements, CCGs will remain accountable for meeting their own pre-existing statutory functions, for instance in relation to quality, financial resources and public participation. CCGs must ensure that any governance arrangement they put in place does not compromise their ability to fulfil their duties, and ensures they are able to meaningfully engage patients and the public in decision making.

4.3.6 It is for CCGs to agree the full membership of their primary care commissioning committee. CCGs will be required to ensure that it is chaired by a lay member and have a lay and executive majority. Furthermore, in the interest of transparency and the mitigation of conflicts of interest, a local HealthWatch representative and a local authority representative from the local Health and Wellbeing Board will have the right to join the delegated committee as non-voting attendees. HealthWatch and Health and Wellbeing Boards are under no obligation to nominate a representative, but there would be significant mutual benefits from their involvement. For example, it would support alignment in decision making across the local health and social care system.

4.3.7 CCGs will want to ensure that membership (including any non-voting attendees) enables appropriate contribution from the range of

stakeholders with whom they are required to work. CCGs and area teams are encouraged to consult the Transforming Participation in Health and Care guidance when considering the membership of their committees. Furthermore, it will be important to retain clinical involvement in a delegated committee arrangement to ensure the unique benefits of clinical commissioning are retained.

4.4 Implications for NHS Halton CCG

4.4.1 Co-commissioning is now firmly established as a direction of travel within the NHS. The guidance recognises that CCGs are at different stages of their developmental journey and are facing a variety of local challenges. Therefore it is likely that the appetite to take on further responsibilities for primary care co-commissioning will vary across the country. It is nonetheless clear that NHS England wants CCGs to enter into joint commissioning arrangements for 2015/16 before taking on delegated responsibilities for 2016/17. At the NHS Halton CCG Governing Body on 4th December 2014 it was recommended an expression of interest should be submitted for the organisation to assume delegated commissioning for 2015/16.

4.4.2 Both models, joint commissioning and delegated commissioning, involve the establishment of the appropriate governance mechanisms to support impartial decision making, engage with the local population and avoid conflicts of interest. The establishment of a set of governance arrangements for joint commissioning would be as time consuming as for delegated commissioning. Furthermore, if joint commissioning were to be pursued, another iteration of changes in governance would need to follow for delegated commissioning. It cannot be guaranteed that NHS England would have sufficient numbers of people to attend a joint committee, which could impair the ability of such an arrangement to function effectively. Joint commissioning would also involve an additional set of governance beyond the Governing Body, whereas delegated commissioning could be more easily established around existing arrangements. In terms of governance arrangements, it is therefore suggested that it would be more appropriate and efficacious to take on delegated commissioning from 2015/16.

4.4.3 A significant challenge involved in implementing primary care co-commissioning is finding a way to ensure that all CCGs can access the necessary resources as they take on new co-commissioning responsibilities. This challenge exists whatever model NHS Halton CCG decides upon.

4.4.4 Primary care commissioning is currently delivered by teams covering a large geography normally spanning several CCGs, and also covering all parts of primary care not just limited to general practice. There is no possibility of additional administrative resources being deployed on these services at this time due to running cost

constraints. It is arguable that NHS Halton CCG is already complementing and potentially supplementing these existing arrangements with our own resources, the development of the strategy for general practice services in the borough being one example. In short, NHS Halton CCG is already engaged in a *de facto* joint commissioning arrangement and it would not take a significant amount of redesign to deliver delegated commissioning.

4.4.5 Pragmatic and flexible local solutions will need to be agreed by CCGs and area teams to put in place arrangements that will work locally for 2015/16. These local agreements will need to ensure that:

- CCGs that take on delegated commissioning responsibilities have access to a fair share of the area team's primary care commissioning staff resources to deliver their responsibilities; and
- Area teams retain a fair share of existing resources to deliver all their ongoing primary care commissioning responsibilities.

4.4.6 Whether NHS Halton CCG pursues joint or delegated commissioning, a conversation will be needed with the area team regarding accessing support through their existing primary care team. Again, it would be preferable to have such a conversation once. Given the limited size of existing primary care teams, potentially only part-time capacity would be available for individual CCGs taking on delegated commissioning responsibility, so it may be that collaborative arrangements between CCGs would be desirable to achieve greater critical mass. Staffing models for these arrangements will vary across the country and will require careful discussion to ensure that the practical, legal and staff engagement issues are clearly understood. We understand that the majority of CCGs in Cheshire and Merseyside, which will be the geography served by the new Area Team, are exploring delegated commissioning and will be potentially 'fishing in the same pond' for resources. NHS Halton CCG needs to be an active participant in these discussions alongside like-minded CCGs.

4.4.7 NHS England will ensure transparency in sharing financial information on primary care with CCGs. All CCGs will have the opportunity to discuss the current financial position for all local primary care services with their area team. CCGs will be provided with an analysis of their baseline expenditure for 2014/15 broken down between GP services and other primary care services by the end of November 2014. Final decisions regarding allocations for 2015/16 will be made by the NHS England Board in December 2014.

4.4.8 NHS England recognises that it will be challenging for some CCGs to implement co-commissioning arrangements, especially delegated

arrangements, without an increase in running costs. Whilst it is not within their gift to increase running costs in 2015/16, NHS England will keep this situation under review. CCGs should discuss with area teams options for sharing administrative resource to support the commissioning of primary care services.

4.4.9 In delegated arrangements, CCGs will receive funding for known future cost pressures within current allocations e.g. net growth in list sizes. In such circumstances, there may be a linked efficiency requirement which will need to be delivered in order for budgets to balance. Furthermore, if supported by clear strategies, CCGs would also have greater flexibility to "top up" their primary care allocation with funds from their main CCG allocation. Delegation would therefore give NHS Halton CCG greater control than joint commissioning in terms of resource allocation, which would enable the delivery of any aspirations for revised care models that emerge from our *Strategy for General Practice Services in Halton* or in response to *Five Year Forward View*.

4.4.10 NHS England is taking steps to move towards a fair distribution of resources for primary care, based on the needs of diverse populations. The GMS Minimum Practice Income Guarantee (MPIG) will be phased out by April 2020, and a review of local PMS agreements is underway as set out in the Framework for Personal Medical Services (PMS) Contracts Review. Area teams should ensure that any decisions relating to future use of PMS funding are agreed with CCGs. We envisage that CCG and primary care allocations will continue to move towards a fair distribution of resources and reflect inequalities, as in the current CCG formula. As part of any delegation of primary care commissioning responsibilities, area teams will provide details of any differential funding levels across localities. Again, it is arguable that a delegated model would give NHS Halton CCG more influence over the future use of PMS funding.

4.5 <u>Decision Making</u>

4.5.1 At the time of writing, NHS Halton CCG is preparing to make a firm decision as to which of the three co-commissioning options the organisation should pursue. It will be recommended to the CCG's Governing Body on 4th December 2014 that a submission for delegated commissioning should be developed, rather than a submission for joint commissioning. This document needs to be completed and submitted by noon on 9th January 2014.

4.5.2 The guidance states that, as membership organisations, CCGs should fully engage with their members when considering co-commissioning options. It also suggests that it would be of benefit it the CCG and local stakeholders such as patients, local authorities, Health and Wellbeing Boards and HealthWatch had an open and

inclusive conversation about options and possible arrangements.

4.5.3 Unfortunately the time frame within which NHS Halton CCG Governing Body needs to make a decision is not conducive to meaningful engagement with member practices or other partners. The paper that went to the NHS Halton CCG Governing Body on 4th December 2014 therefore proposed that a draft submission supporting delegated commissioning is drawn up and comments invited from member practices and other key partners by 19th December 2014. The submission would also be discussed at the NHS Halton CCG Service Development Committee on 10th December 2014 with clinical and practice leads and at the Governing Body Development Session on 18th December 2014. The final submission would be ratified by the Governing Body on 8th January 2015.

4.5.4 The Health Policy and Performance Board will be given a verbal update on the outcomes of this work.

## 5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 Co-commissioning will need to be delivered within existing programme and running cost allowance budgets. There may be opportunities for pooled or delegated budgets and other resources depending on the model followed.

## 6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

### 6.1 Children & Young People in Halton

None as a result of this report.

### 6.2 Employment, Learning & Skills in Halton

None as a result of this report.

### 6.3 A Healthy Halton

None as a result of this report.

### 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

7.1 The greatest risk arising from co-commissioning is the ability of NHS

Halton CCG to deliver additional commissioning responsibilities with existing resources.

## 8.0 EQUALITY AND DIVERSITY ISSUES

8.1 NHS Halton CCG will be required to ensure that it is compliant with the duties upon public bodies under the Equality Act 2010 as co-commissioning develops.

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

*Five Year Forward View*, Care Quality Commission, Health Education England, Monitor, NHS England, Public Health England and Trust Development Authority, 23rd October 2014, www.england.nhs.uk/ourwork/futurenhs/.

NHS England and NHS Clinical Commissioners, *Next steps towards primary care co-commissioning*, NHS England, Gateway Reference 02501, 10th November 2014, www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2014/11/nxt-steps-pc-cocomms.pdf.

**REPORT TO:** Health Policy and Performance Board

**DATE:** 13th January 2015

**REPORTING OFFICER:** Simon Banks, Chief Officer CCG

**PORTFOLIO:** Health and Wellbeing

**SUBJECT:** Maternity Services

**WARD(S):** Borough-wide

1.0 **PURPOSE OF REPORT**

1.1 To inform the Health Policy and Performance Board of work that is progressing to across Cheshire and Merseyside to sustain and develop maternity services.

2.0 **RECOMMENDATION: That the Health Policy and Performance Board are asked to note the report.**

3.0 **SUPPORTING INFORMATION**

3.1 Having a baby is the most common reason for hospital admission in England. Births are up by almost a quarter in the last decade and are at their highest in 40 years.

3.2 Whilst the majority of women have low risk pregnancies, have a positive experience of birth and deliver healthy babies, this is not always the case. There has been an increase in the complexity of births and there is variation in the outcomes and experience of women and babies.

3.3 Cheshire and Merseyside Clinical Commissioning Groups (CCGs) have agreed to undertake a review of maternity services across the sub-region. This review is being undertaken with the support of provider organisations and the Cheshire and Merseyside Strategic Clinical Network (SCN). The involvement of the SCN is crucial as this ensures that clinicians are engaged in and leading this work.

3.4 Through this review, the NHS in Cheshire and Merseyside will explore how it can improve outcomes, reduce variation, deliver high quality services and sustain and develop maternity provision across the area. From this work, which will stay close to the national agenda as set out in the NHS *Five Year Forward View*, future options for sustainable maternity services will be explored with the intention that the NHS is able to offer better choice, improved

outcomes and a model of care with mothers, babies and families at the heart of it.

3.5 Work is currently underway to develop a baseline understanding of the nature and shape of maternity services in Cheshire and Merseyside. Using all available data this is specifically looking at:

- clinical outcomes
- patient experience and choice
- education and training of the current and future workforce
- co-dependencies with other services including neonatal intensive care, co-surgical support, critical care, A&E and other specialist services
- safeguarding
- capacity and size of current provision
- current and future demographics and geographical access
- epidemiology of the population
- current commissioning and financial arrangements

3.6 UPDA

## 4.0 POLICY IMPLICATIONS

4.1 The work on maternity services in Cheshire and Merseyside needs to be linked to the NHS *Five Year Forward View*. The *Five Year Forward View* states that, in addition to increasing midwife numbers, the NHS will:

- Commission a review of future models for maternity units, to report by next summer, which will make recommendations on how best to sustain and develop maternity units across the NHS.

- Ensure that tariff-based NHS funding supports the choices women make, rather than constraining them.

- Make it easier for groups of midwives to set up their own NHS-funded midwifery services.

## 5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 The review will take into account the funding of NHS maternity services, which are resourced through a nationally agreed tariff.

## 6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

### 6.1 Children & Young People in Halton

The Children's Trust will need to stay close to this review.

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

None as a result of this report.

6.3 **A Healthy Halton**

None as a result of this report.

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**

7.1 A lack of engagement in and awareness of the review is a significant risk. This risk will be mitigated as the review progresses with an engagement plan.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 The review will be undertaken in a way that ensures that it is compliant with the duties upon public bodies under the Equality Act 2010.

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

*Five Year Forward View*, Care Quality Commission, Health Education England, Monitor, NHS England, Public Health England and Trust Development Authority, 23rd October 2014, www.england.nhs.uk/ourwork/futurenhs/.