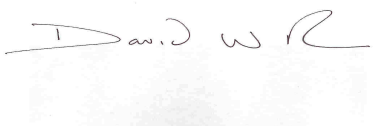
Public Document Pack

Health and Wellbeing Board

Wednesday, 13 May 2015 2.00 p.m.
Karalius Suite, Stobart Stadium, Widnes



Chief Executive

Please contact Gill Ferguson on 0151 511 8059 or e-mail gill.ferguson@halton.gov.uk for further information.
The next meeting of the Committee is on Wednesday, 8 July 2015

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

Part I

HEALTH AND WELLBEING BOARD

At a meeting of the Health and Wellbeing Board on Wednesday, 11 March 2015 at Karalius Suite, Stobart Stadium, Widnes

Present: Councillors Philbin and Polhill (Chairman) Philbin, Woolfall and P. Cook; M. Creed; B. Dutton; K. Fallon; G. Ferguson; A. Marr; A. McIntyre; E. O'Meara; D. Parr; M. Pickup; N. Rowe; M. Sedgewick; N. Sharpe; R. Strachan; D. Sweeney; L. Thompson; A. Waller; S. Wallace-Bonner and S. Yeoman

Apologies for Absence: Councillor Wright and S. Banks, D. Johnson and D. Lyon.

Absence declared on Council business: None

ITEM DEALT WITH UNDER DUTIES EXERCISABLE BY THE BOARD

Action

HWB43 MINUTES OF LAST MEETING

The Minutes of the meeting held on 14th January 2015 having been circulated were signed as a correct record.

HWB44 PRESENTATION - DELIVERING IMPROVED HEALTH AND WELLBEING THROUGH THE WIDNES VIKINGS RUGBY CLUB - JAMES RULE, WIDNES VIKINGS

The Board received a presentation from Mr James Rule, Chief Executive of the Widnes Vikings, which illustrated how the Vikings were working with the local community and schools to promote health and wellbeing. Members were shown a dvd which highlighted some of the work the Club was carrying out in the community to encourage fitness and healthy eating, involving other agencies such as Halton CCG, Halton Borough Council, schools and Halton Housing Trust and included:

- the recent world record attempt for the most number of people exercising in a fitness video;
- raising the profile of prostate cancer;
- fit for Life programme;
- launch of a new rugby shirt for Magic Weekend which will be held in Newcastle to raise money for the

Bobby Robson Foundation; and
- tackling Cyber bullying.

Mr Rule advised the Board that Widnes Vikings had received recognition for its work with the community by receiving the Super League Club of 2014 award.

Members were advised that a future initiative being explored by the Club included providing health checks at the Stadium for men aged between 40-60 years.

RESOLVED: That the presentation be noted.

HWB45 GENERAL PRACTICE STRATEGY

The Board considered a report of the Chief Officer, NHS Halton CCG, which advised that, NHS England had stated their ambition for general practice services to operate at greater scale and be at the heart of a wider system of integrated out-of-hospital care. This would require a shift of resources from acute to out-of-hospital care. These ambitions were congruent with NHS Halton CCG's 2 Year Operational Plan and 5 Year Strategy and also with the Better Care Fund delivery plan developed with Halton Borough Council.

Members' were advised that NHS Halton CCG had submitted a formal expression of interest to undertake co-commissioning arrangements for general practice services in the borough to NHS England and was awaiting a response. If approval was received, from 1st April 2015, responsibility for the commissioning of general practice services in the borough would be delegated to NHS Halton CCG. It was noted that NHS Halton had worked with general practice and other partners in the borough to develop a Co-Commissioning Strategy for General Practice Services in Halton.

In addition, it was noted that the final draft of the Strategy for General Practice Services in Halton would be presented for ratification to the NHS Halton CCG Governing Body on 5th March 2015. A copy of the strategy had been previously circulated to Members. It was anticipated that the strategy would impact on how general practice services, and/or out of hospital services in the borough, were commissioned and delivered.

The Board discussed the national shortfall of GP's and the work that was being carried out with the Royal College and locally with the Cheshire and Merseyside Local

Workforce Group to address the issue.

It was noted that a presentation entitled 'One Halton' would be brought to a future meeting of the Board. | Chief Officer NHS Halton CCG

RESOLVED: That the Board note the report and accompanying documentation.

HWB46 HEALTHY HALTON PERFORMANCE REPORT Q3 2014/15 & HEALTH AND WELLBEING PRIORITIES 2015/16

The Board considered a report of the Director of Public Health, which presented the progress of key performance indicators, milestones and targets relating to Health in Quarter 3 of 2014/15. The report also set out information relating to the Annual Review of Health and Wellbeing Strategy priorities. In 2013 the Board agreed the Health and Wellbeing Strategy for 2013-16 which outlined the following five key priority areas:

- prevention and early detection of cancer;
- improved child development;
- reduction in the number of falls in adults;
- reduction in harm from alcohol; and
- prevention and early detection of mental health conditions.

Whilst these priorities were agreed for 2013-16, the Board agreed to conduct a brief Annual Review to ensure that they were still fit for purpose. The first review took place in April 2014 as part of a public consultation event. The event concluded that the five priorities were still relevant and that work should continue under each of the five priority action plans. The Board were requested to consider if the five priorities continued to be fit for purpose for 2015/16.

RESOLVED: That

1. Quarter 3 Priority based report be received; and

2. the Health and Wellbeing Board priorities, as set out in the report, were agreed to be still relevant for 2015/16.

HWB47 BETTER CARE FUND

The Board considered a report of the Halton CCG, which sought approval on the changes to the original targeted reduction in 2015 Non-elective activity as submitted

in the Halton Better Care Fund (BCF) Plan. It was noted that one of the schemes embedded within the BCF which would have provided a significant amount of this reduction was the development of the Urgent Care Centres. However, the delays in opening the Widnes site and analysis of the initial Quarter 4 data suggested that the reduction expected in 2014/15 would not take place and non-elective activity would be similar to 2013/15.

It was noted that the impact of missing the target for 2015 had already been factored into the CCG budget for 2014/15 there was no impact on the 2015/16 budget.

In addition, the Board noted a letter from NHS England which advised that the resubmitted BCF Plan had been classified as 'Approved'.

RESOLVED: That the Board note the positive assurances of BCF (see Appendix 1) and approve the reduced planned reduction in non-elective activity to meet NHSE Governance and Timescales (see Appendix 2).

HWB48 PREGNANCY AND ALCOHOL SOCIAL MARKETING CAMPAIGN

The Board considered a report of the Director of Public Health, which sought to highlight a new social marketing campaign to educate women of the harm that drinking alcohol in pregnancy could cause, in order to reduce alcohol related harm to the unborn baby. It was reported that each year in Halton:

- around 1600 women became pregnant;
- of these women around 1300 (80%) were drinking before pregnancy; and
- of these women around 800 (60%) would give up drinking during pregnancy

Members were advised that current activity in Halton to reduce alcohol consumption during pregnancy included:

- all pregnant women were advised of safe drinking guidelines;
- Halton midwives and health visitors had been trained in the early identification and support of pregnant women who misused alcohol. This included when and how to refer to local treatment services; and
- there was the dedicated Alcohol and Substance Misuse Liaison Midwife who co-ordinated anti- natal care services for pregnant women identified as

misusing alcohol.

In addition the Halton Alcohol Strategy (2014-19) identified the need to improve general awareness and understanding of safe drinking levels during pregnancy. The Action Plan recommended developing an awareness campaign aimed at the general population to increase awareness of the danger of drinking during pregnancy. Following baseline research, the campaign was launched at the end of February, with a big bang outdoor media approach with billboards, supermarket posters at entrances, bus sides and internals.

The campaign also included social media advertising and messaging using the #boozefreebump to use on all social media communications. Further, midwives would use a new information leaflet, to provide more information to pregnant women when they book in with the midwife and at early bird and anti-natal sessions. Posters and fliers would also be distributed to all GP surgeries and in community locations across the borough.

The campaign would be evaluated by further work with the targeted audiences in July 2015; this would be compared to the previous work to establish changes in attitude/behaviour. Alongside this a sample of women would be identified at booking in stage and followed through to birth to establish attitude and behaviour change after exposure to the campaign messages.

RESOLVED: That the Board support the campaign aims:

- To bring about a change in attitude and behaviour, towards drinking alcohol in pregnancy; and

- To reduce the risk to the unborn baby due to drinking alcohol in pregnancy, and subsequently improve child development.

HWB49 HALTON BOROUGH COUNCIL AND NHS HALTON CLINICAL COMMISSIONING GROUP: REVISED JOINT WORKING AGREEMENT

The Board considered a report of the Strategic Director, Communities, which sought approval for the revised Joint Working Agreement between Halton Borough Council (HBC) and NHS Halton Clinical Commissioning Group (CCG), which now incorporated the Better Care Fund for 2015/16. During 2014, partners within Halton worked

collaboratively, within the national guidance and framework to develop Halton's Better Care Fund. It was agreed that the Better Care Fund should be incorporated into the existing pooled budget arrangements between HBC and NHS Halton CCG.

The Board had previously approved Halton's Better Care Fund Plan in January 2015. It was noted that the Joint Working Agreement had now been revised to reflect the following changes:

- the Complex Care Board was renamed the Better Care Board;

- the Executive Commissioning Board was renamed the Better Care Executive Commissioning Board; and

- the budget schedule for 2015/16 had been revised to incorporate the addition of Better Care Fund allocation for 2015/16

RESOLVED: That

1. the contents of the report be noted; and

2. the revised Joint Working Agreement attached to Appendix 1 be approved.

HWB50 MATTERS ARISING

The Board was advised that there had been recent incidents involving members of the public waiting over 50 minutes for an ambulance to arrive in an emergency. It was agreed that on behalf of the Board a letter would be sent to the Ambulance Service expressing concern at the recent delays in providing an ambulance in an emergency. Cllr Polhill

On behalf of the Board, the Chairman thanked Kate Fallon for her service and wished her well for her future retirement.

Meeting ended at 3.25 p.m.

REPORT TO: Health & Wellbeing Board

DATE: 13th May 2015

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Wellbeing

SUBJECT: The transfer of 0-5s public health commissioning responsibilities

1.0 PURPOSE OF REPORT

1.1 The purpose of this report is to provide the Board with an update on the transfer of 0-5s public health commissioning responsibilities in relation to mandation and financial arrangements.

2.0 RECOMMENDATION : That the Board note the update

3.0 SUPPORTING INFORMATION

3.1 Commissioning of 0-5 public health services

From 1 October 2015, the Government intends that local authorities will take over responsibility from NHS England for commissioning public health services for children aged 0-5. It is not a transfer of the workforce, who will continue to be employed by their current provider, Bridgewater Community Healthcare NHS Trust but rather the transfer of commissioning responsibility for 0-5 public health services which include the Health Visiting Service and the Family Nurse Partnership (FNP) - a targeted service for teenage mothers.

3.2 The transfer of commissioning responsibilities will be a “lift and shift” arrangement, where the Department of Health will transfer over what NHS England’s Area Teams are expecting to contract and spend on 0-5 services at the point of transfer. The Council has received confirmation of funding which is in line with the projected financial envelope. The financial plans have been based on a trajectory to increase the numbers of Health Visitors in line with the Governments “Call to Action”. It is expected that the contract between NHS England and the provider will be transferred and novated to the Council.

3.3 The transfer will also include a clause guaranteeing the current provider a contract for 12 months following the transfer, after which commissioners will be able to consider how best to plan for the future delivery of local services. This is to ensure that there is a minimum disruption to service delivery and to ensure the continued clinical governance and oversight of the service.

3.4 The following commissioning responsibilities will **not** transfer to local authorities:

- Child Health Information Systems
- The 6-8 week GP check (also known as child health surveillance)

3.5 **Delivering the Healthy Child Programme**

The **Healthy Child Programme** is the universal clinical and public health programmes for children and families from pregnancy to 19 years of age (and up to age 25 for young people with Special Educational Needs and Disability [SEND]). The Healthy Child Programme, led by health visitors and their teams, offers every child aged 0-5 years a schedule of health and development reviews, screening tests, immunisations, health promotion guidance and support for parents tailored to their needs, with additional support when needed at key times.

Our aim is to ensure future commissioning will support sustainable health visiting services and we will use the model of **'4, 5, and 6'**. This is the **four** tiers of health visiting service, the **five** elements of service delivery that are being mandated which will lead to **six** high impact areas.

3.5.1 The **Health Visiting Service** comprises **four tiers**, which assess and respond to children's and families' needs:

• **Community Services** - linking families and resources and building community capacity.
• **Universal Services** - primary prevention services and early intervention provided for all families with children aged 0-5 as per the Healthy Child Programme universal schedule of visits assessments and development reviews.
• **Universal Plus Services** - time limited support on specific issues offered to families with children aged 0-5 where there has been an assessed or expressed need for more targeted support.
• **Universal Partnership Plus Services** - offered to families with children aged 0-5 where there is a need for ongoing support and interagency partnership working to help families with continuing complex needs.

3.5.2 The Government has reached agreement that certain universal aspects of the 0-5 Healthy Child Programme will be mandated in regulations. In summary, the Government has now confirmed that it will mandate the **five universal checks** within the healthy child programme. These are:

1. the antenatal health promoting visits
2. new baby review
3. 6-8 week assessment
4. 1 year assessment
5. 2-2½ year review

3.5.3 This will lead to support for families in **six high impact areas**:

• transition to parenthood and the early weeks;
• maternal mental health (perinatal depression);
• breastfeeding (initiation and duration);
• healthy weight, healthy nutrition (to include physical activity);
• managing minor illness and reducing accidents (reducing hospital attendance/admissions); and
• Health, wellbeing and development of the child at age 2 – two year old review (integrated review) and support to be 'ready for school'.

3.6 In addition to the Health Visiting Service, the **Family Nurse Partnership** is a targeted, evidence-based, preventive programme for vulnerable first time young mothers. It is important to note that FNP is a licensed programme and therefore has a well-defined and detailed service model, which must be adhered to. Structured home visits, delivered by specially trained family nurses, are offered from early pregnancy until the child is two. Participation in the FNP programme is voluntary. When a mother joins the FNP programme, the HCP is delivered by the family nurse. The family nurse plays an important role in any necessary safeguarding arrangements alongside statutory and other partners to ensure children are protected.

3.7 **Finance and Contracting update**

NHS England Area Teams have worked closely with local authorities to jointly agree the finance and contracting picture. This information has informed the development of local authority baseline allocations.

Every council has had to demonstrate its capacity and capability to receive public health functions from the NHS. The indicative contract value for Halton has been agreed and is based on the anticipated number of Health Visitors who will be in post at the point of transfer in order to meet the national "call to Action" trajectory. For Halton this figure has been set at 37.29 whole time equivalent staff.

4.0 POLICY IMPLICATIONS

4.1 Children and Young People in Halton

Local Authorities are well placed to identify health needs and commission services for local people to improve health. The Government's aim is to enable local services to meet local needs. The Healthy Child programme is a critical component in giving every child in Halton 'the best start in life', and improving child development, which is a Halton priority. Improving the Health and Wellbeing of Children and Young People is a key priority in Halton and will continue to be addressed through the delivery of an effective and efficient Health Visitor Service that supports the delivery of both national and local strategies and action plans whilst at the same time meeting the needs of children and their families.

4.2 **Employment, Learning and Skills in Halton**
Employment, Learning and Skills is a key determinant of health and wellbeing and is therefore a key consideration when developing strategies to address health inequalities. An effective service will support children and their families in reducing the impact of ill health on their life chances and also encourage and support "school readiness".

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

4.4 **A Safer Halton**
Reducing the incidence of crime, improving Community Safety and reducing the fear of crime have an impact on health outcomes particularly on mental health. There are also close links between the service and on areas such as mental health, alcohol and domestic violence.

4.5 **Halton's Urban Renewal**
By providing education, information and support to children and their families the service can contribute to the wider urban renewal of Halton.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 Financial arrangements for the transfer of commissioning responsibilities are set out in 3.7 of this report with the Provisional Local Authority baselines.

6.0 **RISK ANALYSIS**

6.1 There are currently no perceived risks for the transfer of 0-5s commissioning. Should any risks be identified at a later date these will be identified and reported.

7.0 **EQUALITY & DIVERSITY ISSUES**

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

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

None within the meaning of the Act.

REPORT TO:	Health & Wellbeing Board
DATE:	13th May 2015
REPORTING OFFICER:	Michelle Creed (NHS England)
PORTFOLIO:	Health & Wellbeing
SUBJECT:	NHS England Update
WARDS:	Cheshire & Merseyside

1.0 PURPOSE OF THE REPORT

1.1 This report is an update on NHS England's Business Plan and activities to inform Board Members.

2.0 RECOMMENDATION: To note the report and seek any clarifications as required.

3.0 SUPPORTING INFORMATION

A copy of the full report is enclosed in the following pages.

4.0 POLICY IMPLICATIONS

None.

5.0 FINANCIAL IMPLICATIONS

None.

6.0 RISK ANALYSIS

None.

7.0 EQUALITY AND DIVERSITY ISSUES

None.

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

None within the meaning of the Act.

NHS ENGLAND

ACCOUNTABILITY REPORT TO HALTON HEALTH & WELL BEING BOARD

April 2015

1 CONTEXT

NHS England is the national body, tasked by Government, to improve health and care, underpinned by the NHS Outcomes framework and the NHS Constitution. The mandate given to NHS England sets out objectives and deliverables for the next two years. NHS England has established agreements for successful working alongside Public Health England, and Monitor. A concordat with the LGA recognises Health and Wellbeing Boards as system leaders comprising of membership drawn from Local Government, CCG's and NHS England.

NHS England is responsible for three main activities- system development, assurance and commissioning. NHS England undertakes some commissioning on behalf of the NHS directly, rather than through local government or CCG's. This commissioning is in five areas: Offender, Military, Public Health, Primary Care and Specialised Services.

These areas were retained by NHS England due to the scale and geography of commissioning, the expertise required and to drive England wide service standards in these areas, so they are not impacted by local variation.

2. THIS REPORT

NHS England provides a quarterly Accountability report to each Health and Wellbeing Board. This report outlines national and regional context together with specific update on priorities that the Area Teams are responsible for delivering and how these priorities are progressing.

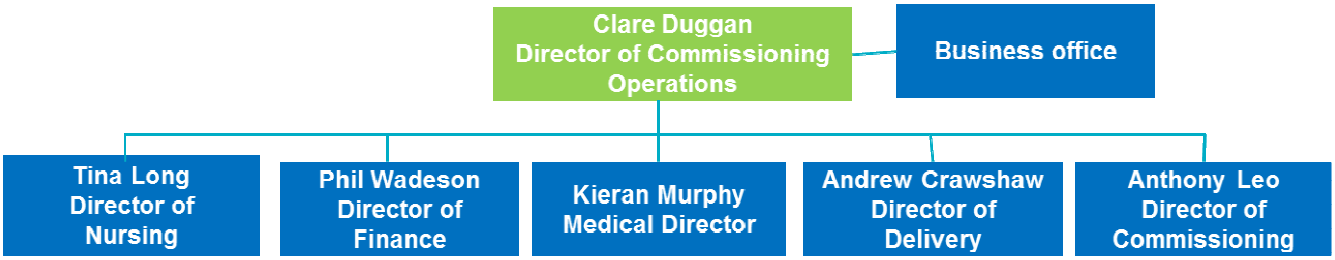
This report gives an update on NHS England, progress on the Two Year Operational Plans as well as the development of the Cheshire and Merseyside Business Plan for 2015/16.

3 NHS ENGLAND UPDATES

Organisational Alignment & Capacity Programme

You will recall from the last report that NHS England was reviewing its operational arrangements to ensure that our structures are fit for purpose and within available funding going forward. This has resulted in the merger of two area teams to form the Cheshire & Merseyside Team. Our functions will remain the same for now as there is no change envisaged currently. However we will be working closely with our CCG partners to continue to develop their leadership role and take on wider commissioning responsibilities over time specifically for Primary Care and Specialised Services.

The senior management team for the Cheshire & Merseyside Team is as follows:



As a result of the changes, we have reviewed who will be attending each of the Health and Well being Boards across the patch going forward and Michelle Creed, Deputy Director of Nursing will be attending these meetings in future.

Development of Co-Commissioning Arrangements with Local CCGs

In May 2014, NHS England invited clinical commissioning groups (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.

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 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.

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.

There has been a strong response from CCGs wishing to assume co-commissioning responsibilities and there are three models CCGs could take forward:

- Greater involvement in primary care decision making;
- Joint commissioning arrangement; or
- Delegated commissioning arrangement.

Locally we are pleased to be putting in place the following arrangements with each of the Clinical Commissioning Groups. This is subject to agreement with each of the CCG Governing Bodies by the end of March:

Delegated	Joint	Greater Involvement
NHS St Helens CCG	NHS Southport And Formby CCG	NHS Wirral CCG
NHS Liverpool CCG	NHS Eastern Cheshire CCG	NHS South Sefton CCG
NHS Knowsley CCG	NHS Warrington CCG	
NHS Halton CCG	NHS Vale Royal CCG	
	NHS South Cheshire CCG	
	NHS West Cheshire CCG	

This means that from 1 April, over 70 percent of CCGs will take on greater commissioning responsibility for GP services under the new co-commissioning arrangements.

There will be further opportunities for CCGs to assume greater joint commissioning responsibilities throughout 2015 and beyond and we will continue to support CCGs in this.

For further information, please visit: https://www.england.nhs.uk/commissioning/pc-co-comms/

Prime Ministers Challenge Fund

On 30 September 2014, the Prime Minister announced a second wave of 'Access Pilots', with further funding of £100m for 2015/16. NHS England are leading the process and overseeing the new pilots when they have been announced.

Cheshire & Merseyside Sub Regional Team have received eight bids and were asked to review and make recommendations for the national panel. The panel looked for a broad geographical spread of pilots and assessment of the breadth of the prioritised bids to ensure that there is a good spread of innovation.

We are expecting an announcement of those that have been successful in their application in the coming weeks.

New Care Models Programme - Vanguard sites

NHS England has announced the first 29 'vanguard' sites that will transform care for five million patients across England. The sites, supported by the New Care Models Programme, have been chosen from 269 applications to trail blaze new ways of providing more joined-up, personal care for patients and increase efficiency.

Groups of nurses, doctors and other health staff from across the country put forward their ideas for how they want to redesign care in their areas, and now the NHS will be backing 29 of the most innovative plans, with the aim of bringing home care, community nursing, GP services and hospitals together for the first time since 1948.

Drawing on bespoke packages of national support and a £200 million transformation fund, from April the vanguards will develop local health and care services to keep people well, reduce demand and improve productivity.

The vanguards will take the national lead on the development of game-changing care models:

- multispecialty community providers (MCPs) – moving specialist care out of hospitals into the community;
- integrated primary and acute care systems (PACS) – joining up GP, hospital, community and mental health services, and;
- models of enhanced health in care homes – offering older people better, joined up health, care and rehabilitation services.

For patients, this could mean fewer trips to hospitals as cancer and dementia specialists hold clinics local surgeries, one point of call for family doctors, community nurses, social and mental health services, or access to blood tests, dialysis or even chemotherapy closer to home.

Locally we have the following vanguard sites:

Wirral University Teaching Hospital NHS Foundation Trust

Wirral Health Partners is made up of: Wirral University Hospital NHS Foundation Trust; Cheshire and Wirral Partnership NHS Foundation Trust, Wirral Community NHS Trust; Wirral Clinical Commissioning Group; GPs on the Wirral; Wirral Metropolitan Borough Council; Cerner UK Ltd, Advocate Physician Partners ACO (USA based); and the King's Fund.

Wirral Health Partners will accelerate a new model of integrated care across primary and secondary care providers, supported by a technology enabled population health model. Integrated care teams will be expanded to reduce readmissions and support people to remain at home through primary/secondary care collaboration. Following implementation, the new model will work by identifying older people who are at potential risk of serious fracture following minor falls that result in emergency admission. With approval of the patient, care plans will be developed, home assessments carried out and aids added to reduce the probability of falls happening. With this support, patients are able to stay in her home and potentially avoid a serious fracture.

Primary Care Cheshire

A new Multispecialty Community Provider will now be developed in West Cheshire, an area in North West England with a population of 330,000. The lead partners for developing this model locally are NHS West Cheshire CCG and Primary Care Cheshire (a single entity). They are being joined by a further three participating partners: Cheshire & Wirral NHS Partnership Foundation Trust, Countess of Chester NHS Foundation Trust and Cheshire West and Chester Local Authority.

Under the plans put forward, patients can expect better and more integrated support from different local health and care services, with a particular focus on young children, managing long-term conditions and supporting elderly patients.

To this end, the new partnership will be launching 3 new programmes as part of their model: 'Starting Well' will focus on ensuring the best start in life for babies, children and young people in the local area; 'Being Well' will enable greater collaboration between local services and the several clusters of GP practices, supported by integrated

teams, to help people manage long-term conditions, and; 'Ageing Well' will focus on excellent care for the frail/complex wherever they are living (including those in care homes).

For more information, please visit: http://www.england.nhs.uk/ourwork/futurenhs/5yfv-ch3/new-care-models/

GP Infrastructure Bids

The Primary Care Infrastructure Fund is a four year £1billion investment to accelerate improvements in GP premises and infrastructure.

This is part of the additional NHS funding, announced by the Government in December last year, to enable the direction of travel set out in the Five Year Forward View.

This new funding, alongside our incremental premises programme, is designed to accelerate investment in increasing infrastructure, accelerate better use of technology. In the short term, it will be used to address immediate capacity and access issues, as well as lay the foundations for more integrated care to be delivered in community settings.

In January 2015, we invited bids for investment in 2015/16. The deadline for this wave of bids has now closed. There will now be an internal review of the bids received and an announcement of those that have been successful in due course.

4. PROGRESS ON NHS ENGLAND TWO YEAR OPERATIONAL PLANS

The 2 year operational plan represents the first 2 years of a 5 year strategic plan. The Sub Regional Team is committed to driving improvements to secure equity of access and a reduction in variation in the services all patients across Cheshire & Merseyside and the North West (for specialised services) receive.

An update is provided below for each area of direct commissioning:

Primary Care

NHS England (Cheshire & Merseyside) have carried out a successful procurement of Community Dental Services. Detailed below is a list of the new service providers from 1st April 2015. The majority of contracts tendered were awarded and will be in place for 3 years. The new contracts will allow for more detailed data to be gathered, which help to inform a health needs assessment that will be carried out during the life of these contracts. The information collected will be used to inform future commissioning of these key services, for some of the most vulnerable patients in society.

List of the successful bidders across Cheshire and Merseyside following the CDS procurement;

- Out-of-Hours Urgent Dental Care (Cheshire & Merseyside) – Revive Dental Care Ltd
- In-Hours Urgent Dental Care (Liverpool) – Atlantic Dental Practice
- Adult & Paediatric Special Care (Cheshire West & Wirral) – Wirral Community NHS Trust
- Adult & Paediatric Special Care (Cheshire East & Warrington) – East Cheshire NHS Trust
- Adult & Paediatric Special Care (Knowsley/Liverpool/Sefton) – Liverpool Community Health NHS Trust
- Adult & Paediatric Special Care (Halton/St Helens) – Bridgewater Community NHS Foundation Trust
- Paediatric Exodontia (Cheshire West & Wirral) - Wirral Community NHS Trust
- Paediatric Exodontia (Cheshire East & Warrington) – Bridgewater Community NHS Foundation Trust
- Paediatric Exodontia (Knowsley/Liverpool/Sefton) – Liverpool Community Health NHS Trust
- Paediatric Exodontia (Halton/St Helens) – Bridgewater Community NHS Foundation Trust

For those services where contracts have not been awarded; Dental Helpline / Triage Service for Cheshire and Merseyside and the In-Hours Urgent Care Dental Service across Cheshire, Warrington, Wirral, Knowsley, Sefton and Halton and St Helens, there are robust contingency plans that have been developed to ensure that these services will be provided from 1st April 2015;

- The Dental Helpline / Triage service will be provided by Revive Dental Care Ltd, who are also the new Out-of-Hours Urgent Dental Care provider.
- The In-Hours Urgent Dental service will be provided from a variety of general dental practices across the patch, which will greatly improve access for patients, who require urgent dental treatment and are not regular attenders at a general dental practice.

Public Health

Seasonal Flu 14/15 Campaign:

Previous Area Team footprint	Over 65s	All under 65s at risk	Pregnant women	2 and 3 year olds	Health Care Workers
Cheshire, Warrington and Wirral	75.2%	51.9%	50.6%	43.7%/ 48.4%	64.1%
Merseyside	76.5%	54%	47.2%	38.2%/ 37%	76%
Comments	Both ATs have exceeded the 75% target and Merseyside is the highest in England.	Both ATs performance is down on last years in % terms, but are nevertheless in the top 5 in England.	Both teams have improved uptake in pregnant women by a large portion. CWW is the highest achieving AT	This is only the second year of the childhood flu programme so lower rates are expected than with other more established age cohorts.	Mersey is currently highest performing AT for HCW vaccination

0-5 transition to Local Authorities:

All 9 Local Authorities have agreed contracting arrangements for 15/16 in advance of them assuming commissioning responsibility for 0-5 services in October 2015. We are working hard with all LAs and Providers to ensure contract sign off. The weekly 0-5 contract tracker provides the national team of progress to date. We are working with those Authorities who have issues with their proposed allocation from the Department of Health for 0-5 services and are staying close to the national team and updating them on progress. We are confident that resolution will be found by using the in-year adjustment process and are maintaining good relationships with all of our authorities in order to progress.

Health Visitor growth:

CWW is on track to meet the trajectory and Merseyside is on track to exceed the workforce trajectory. The team have worked extremely hard with local Providers to make this happen with real effort going into this work to turn performance around

Mersey trajectory 304.8 wte HVs by March 15	Position at December 2015 as per MDS submission: 310.67 wte HVs
CWW trajectory: 272.9 wte HVs by March 15	Position at December 2015: 271.85

Specialised Commissioning

There are a number of significant service issues that are currently being addressed by the Specialised Commissioning Team in partnership with key Cheshire, Warrington and Wirral colleagues. These include:

- Neurorehabilitation

The Cheshire and Merseyside Rehabilitation Network (CMRN) has been asked to consider the benefits and potential timescales associated with becoming an ODN. The CMRN and CWWAT highlighted the shortfall of CCG-commissioned level 2 services for Cheshire patients together with potential solutions to Cheshire CCGs.

Agreement was not reached on an interim or long term solution and is subject to further work at individual CCG level.

- Upper GI Cancer

Specialist upper GI cancer (oesophago-gastric) services are configured around two SMDTs, at Aintree and LHCH. Warrington patients flow to LHCH and Wirral to the Aintree SMDT. National guidance and the service specification indicate that for the volume of surgical activity being undertaken, there should be a single team providing services for the population of Merseyside.

Providers have failed to reach a collaborative solution which would bring services on to a single acute site in line with external clinical advice. LHCH has subsequently proposed that specialist surgery currently undertaken on the LHCH site is transferred to Royal Liverpool in order to meet this recommendation for the population served by this SMDT.

Strategic discussions are underway between CWW AT and CEOs which may resolve this issue and avoid the need for procurement in line with Health Liverpool strategic aims. This may involve a two stage move with integration of the LHCH SMDT on to the Royal Liverpool site and then transfer of the Aintree SMDT to Royal Liverpool, pending CEO agreement. If a procurement is required to establish a single SMDT/surgical service for Merseyside, this will be initiated in March 2015 as a single 'lot' alongside the procurement of upper GI cancer in Greater Manchester.

- Adult HIV

An implementation plan has been developed and communicated to HIV providers and public health local authority Chief Officers. The plan outlines the planned stages in developing a formal networked model of care within Cheshire & Merseyside. The paper was well received and is now in the implementation phase. Whilst the network is in development, the initial focus is on clinical governance where plans are in place to develop a service level agreement between the hub (the Royal Liverpool) and the spokes to formalise network links as per April 2015 contracting arrangements.

- Mental Health

CAMHs tier 4: Phase 1 procurement is now complete and with the opening of beds in other areas capacity within the NW is considered sufficient to meet needs. Additional case management capacity has been recruited to strengthen the management of the system across the North West. These new posts will be operational by December.

A piece of work has recently been completed looking at patients coming in and out of the North West. This has shown an increase in out of North West placements for 6 people from the North West but an increase in 144 patients from outside the North West being placed in the North West Providers. This has been raised nationally as an issue. There are significant issues relating to financial performance and case management capacity that are being addressed.

- Cancer Pathway Review for Mid Cheshire

As part of the strategic partnership Stronger Together between Mid Cheshire and UHNM, a review of cancer pathways is being undertaken commencing January 2015. A Programme Board, led by South Cheshire CCG will be established to oversee this work in conjunction with NHS England. Any change in current arrangements will need to ensure Monitor principles are satisfied and will lead to improved outcomes. A steering group including Provider CEOs is also being established.

We are currently in the process of developing our Business Plan for 2015/16 and will be sharing this with key stakeholders in due course.

Anthony Leo
Lead Director

REPORT TO: Health and Wellbeing Board

DATE: 13th May 2015

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health and Wellbeing

SUBJECT: Better Care Fund Quarter 4 report 2014/15

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To request that the Board approve the Quarter 4 report for 2014/15 for the Better Care Fund for submission to the Local Government Association and NHS England by 29th May 2015.

2.0 **RECOMMENDATION: That the Board**

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

2. **approve the Quarter 4 Better Care Fund Report, detailed in point 4.0 of the report and at the attached Appendix.**

3.0 **SUPPORTING INFORMATION**

3.1 *BCF Operationalisation Guidance and Non-elective Admissions Ambitions*

On 20th March, the BCF operationalisation guidance and non-elective admissions ambitions were published by the DH, NHS England, LGA and DCLG. The document sets out the monitoring requirements for 2015/16 for the Fund, as detailed below.

3.2 **Quarterly Reporting Template**

The national Joint BCF Taskforce (soon to be renamed Better Care Support Team) is in the process of producing a quarterly reporting template for all LAs and CCGs to use. The template covers reporting on the following areas of the BCF:

- Income and expenditure;
- Payment for Performance;
- Supporting Metrics; and
- National Conditions.

It is suggested that these reports are discussed and signed off by the Health and Wellbeing Board, given their lead role in the BCF as part of discharging their duty under s.195 of the Health and Social Care Act 2012 to encourage commissioners to provide health and

social care services in an integrated manner.

3.3 **Submission Points**

The quarterly reports are due for submission to NHS England at 5 points during the year:

- 29th May – for the period January to March 2015
- 28th August 2015 – for the period April to June 2015
- 27th November 2015 – for the period July to September 2015
- 26th February 2016 – for the period October to December 2015
- 27th May 2016 – for the period January to March 2016

Reporting commences from January 2015 due to the baseline for the quarterly Payment for Performance schedule, linked to non-elective admissions ambition, although as the BCF was not implemented until April 2015, this report does not require any financial information.

3.4 **Annual Reporting/Year-End Reporting**

NHS England and the LGA are developing Year-End reporting guidance and an annual report template which will build on the quarterly reporting. There are currently some outstanding queries around accounting and audit being worked through before these can be finalised and issued. Once finalised, they will be available on the Better Care Fund webpage.

4.0 **Quarter 4 Report**

Approval is required from the Board for the Quarter 4 report for January to March 2015, which is due for submission to NHS England by 29th May. The detail of this is attached at the Appendix, in Tabs 4, 5 and 6. A summary of the Q4 report is as follows.

Tab 4 Non-Elective Admissions:

- The target for Q4 was 4,248 non-elective admissions in to hospital, all-age per 100,000 population. The actual figure for Q4 is 4,700, therefore we have not achieved our target in this quarter. This is mainly due to the winter pressures during January/February 2015. We are expecting a recovery in Q1 (April to June 2015) with the planned implementation of schemes within the BCF, in particular the Urgent Care Centres.

Tab 5 – Supporting Metrics.

- **Residential Admissions** – The target for Q4 was 134 permanent admissions of older people to residential and nursing care homes, per 100,000. The actual figure was 131 in this area, so performance in this area has been slightly better than planned. This continues our excellent performance in this area.
- **Reablement** – The target for Q4 was 68.2% for the proportion of older people who were still at home 91 days after discharge from hospital into reablement/rehabilitation services. The actual figure was 65.6%, therefore we have not achieved the target. Analysis

of the caseload demonstrates that intermediate care in Halton operate an inclusive criteria including people who are not medically stable and also those in the last few months of their life. This metric is collated between October and December annually.

- **Falls** – The target for Q4 was 192 hospital re-admissions (within 28 days) where the original admission was due to a fall per 100,000 population. The actual figure is 159, therefore the target has been achieved.
- **Delayed Transfers Of Care** – the target for Q4 was 498 delayed transfers of care from hospital per 100,000 population. The actual figure was 920, therefore we have not achieved the target. Locally we saw significant pressures within acute mental health during the winter period which accounts for some of this increase. This issue has now been resolved, so we are on target for our planned figure in Q1.
- **Service User Survey** – Our target for Q4 was 88% for "Do care and support services help you to have a better quality of life". The actual figure was 93%. Overall levels of satisfaction with adult social care have increased from the previous period. (NB - this figure is provisional as the final figure has not yet been processed).

Tab 6 is the National Conditions showing that we are on track.

5.0 POLICY IMPLICATIONS

5.1 None identified.

6.0 FINANCIAL IMPLICATIONS

6.1 The success of the BCF is reliant on the success of the schemes within it. These schemes will be regularly monitored through the BCF ECB and Better Care Board.

7.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

7.1 Children & Young People in Halton

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

7.2 Employment, Learning & Skills in Halton

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

7.3 A Healthy Halton

Developing integration further between Halton Borough Council and

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

7.4 **A Safer Halton**

None identified.

7.5 **Halton's Urban Renewal**

None identified.

8.0 **RISK ANALYSIS**

8.1 If an area fails to meet any of the standard conditions of the BCF, including if the funds are not being spent in accordance with the plan with the result that delivery of the national conditions is jeopardised, the Better Care Support Team may make a recommendation to NHS England that they should initiate the escalation process. The process ultimately leads to the ability for NHS England to use its powers on intervention provided by the Care Act legislation, in consultation with DH and DCLG as the last resort. The quarterly reporting templates allow for any variation in spending from the plan to be explained.

9.0 **EQUALITY AND DIVERSITY ISSUES**

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

Notes for Completion

The template requires the HWB to track through the high level metrics from the HWB plan.
The template will require completion on a quarterly basis and submitted to **bettercarefund@dh.gsi.gov.uk**
The deadline for submitting the returns are as follows:
Q4 14/15 - 29/05/2015
Q1 15/16 - 28/08/2015
Q2 15/16 - 27/11/2015
Q3 15/16 - 26/02/2016
Q4 15/16 - 27/05/2016
The template return will require sign off by the HWB.
The template is based on the BCF plan template (part 2). Therefore the guidance for the part 2 template may help in completing this form.
To accompany the quarterly report we will require the HWB to submit a written narrative to explain any changes to plan and any material variances against the plan.
The template should be completed in line with relevant accounting standards. The guidance published by CIPFA and HFMA will give further details.

The template consists of four sheets:
1) Cover Sheet
2) I&E - this tracks through the funding and spend for the HWB and the expected level of benefits
3) P4P - this details the Payment for Performance calculation
4) Non Elective - tracks through the changes to non-elective activity
5) Support Metrics - details the other metrics included within the HWB plan.
6) National Conditions - checklist against the national conditions as set out in the Spending Review.

Yellow cells require input, blue cells do not.

1) Cover Sheet
On the cover sheet please enter the following information:
Health and Well Being Board
The Quarter to which this report relates to
Who has completed the report, email and contact number in case any queries arise
The cover sheet will also indicate whether the quality checks have been met and provide details of which areas need reviewing
Please detail who has signed off the report on behalf of the Health and Well Being Report.

2) I&E
The format of this sheet is combines sheets (1) and (2) from the BCF plan template.
The sheet is split into two main sections - summary of total BCF funding and summary of total BCF expenditure.
The summary of total BCF funding is split into:
Local Authority services;
CCG minimum contribution; and
additional CCG contribution.
Please select the relevant organisations from the drop down menu.
The sheet requires both the plan information and forecast information (year to date columns B and C and total columns F and G).
The total plan values should be the same as the figures submitted on the BCF template unless there has been a change agreed at the HWB.

The summary of total BCF expenditure requires details of plan and actual expenditure both year to date and forecast outturn.

Completion of both these sections will calculate the contribution less expenditure (row 52).

Four other boxes then need completing with plan and forecast information. These are:
CCG share of £1.1bn contribution to Social Care;
CCG share of £2.4m minimum contribution;
summary of NHS commissioned out of hospital services spend from minimum BCF pool
Summary of Benefits

At the end of the section the form requires 2 questions to be answered;
Has the Local Authority recived their share of the Disabled Facilites Grant (DFG)?
Have the funds been pooled via a s.76 pooled budget arrangement?

3) P4P
The majority of information feeds through from the non-elective sheet.
Input is required for the combined total of performance and ring-fenced funds. *(Note: we will see if we can pre-populate this)*
Input is required to show whether the P4P element has been paid over for the relevant quarters.
If there is a variance between the P4P element planned to be paid over and the value actually paid over please select from the drop down box. The options are:
Payment not due - for example Q2 payment would not be due if completing the Q1 report.
Non-elective admission - the P4P element will not be paid if non-elective admissions over-perform. Therefore the CCG will likely use the funding not paid over to fund the additional costs of non-elective admissions.
Other (please explain) - If for any reason the funding not paid over is not used for off-setting the additional cost of non-elective admissions please select other and explain what the funding is being spent on in the yellow box below.

4) Non Elective
The format for this sheet is the same as section 5 of the BCF template submission.
This section is split into four sections.
a) Plan - this should reflect the numbers as they appeared in your submitted plan.
b) Performance against revised plan - this should include actual and forecast performance relating to 2015/16.
c) Variance against revised plan

5) Support Metrics
This section requires information to be completed for the support metrics i.e.
Residential admissions
Regalement
Delayed transfers of Care
Patient / Service User Experience Metric
Local Metric

The data required for each section is the same as the format as the non elective sheet:
a) Plan - this should reflect the numbers as they appeared in your submitted plan.
b) Performance against revised plan - this should include actual and forecast performance relating to 2015/16.
c) Variance against revised plan

6) National Conditions
This section requires the HWB to confirm whether the six national conditions detailed in the BCF Planning Guidance is still on track for delivery.
It sets out the 6 conditions and requires the HWB to confirm 'yes' or 'no' that these are on track. If 'no' is selected please detail in the comments box what the issues are and the actions that are being taken to meet the condition.
Full details of the conditions are detailed at the end of the page.

Halton	Q1 2015/15 Report

Completed by:

Emma Sutton-Thompson

Email:

Emma.Sutton-Thompson@halton.gov.uk

Contact Number:

0151 511 7398

Quality Checks Cleared?

Signed off on behalf of the HWB:

Councillor Rob Polhill

Submission Gudiance

The template will require completion on a quarterly basis and submitted to **bettercarefund@dh.gsi.gov.uk**

The deadline for submitting the returns are as follows:

Q4 14/15 - 29/05/2015
Q1 15/16 - 28/08/2015
Q2 15/16 - 27/11/2015
Q3 15/16 - 26/02/2016
Q4 15/16 - 27/05/2016

Halton	Q1 2015/15 Report

Income and Expenditure Summary

Figures in £000

Summary of Total BCF Funding	Year to Date			Forecast Outturn		
Local Authority Social Services -Minimum Contribution	2015/16 Plan	2015/16 Forecast	2015/16 Variance	2015/16 Plan	2015/16 Forecast	2015/16 Variance
Halton	500	500	-	2,000	2,000	-
<Please select Local Authority>			-			-
<Please select Local Authority>			-			-
<Please select Local Authority>			-			-
<Please select Local Authority>			-			-
<Please select Local Authority>			-			-
<Please select Local Authority>			-			-
Total Local Authority Minimum Contribution	**500**	**500**	**-**	**2,000**	**2,000**	**-**
Additional Local Authority Contribution						
Halton	1,000	1,000	-	4,000	4,000	-
<Please select Local Authority>			-			-
<Please select Local Authority>			-			-
<Please select Local Authority>			-			-
<Please select Local Authority>			-			-
<Please select Local Authority>			-			-
<Please select Local Authority>			-			-
Total Additional Local Authority Contribution	**1,000**	**1,000**	**-**	**4,000**	**4,000**	**-**
CCG Minimum Contribution						
NHS Halton CCG	2,000	2,000	-	8,000	8,000	-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
Total Minimum CCG Contribution	**2,000**	**2,000**	**-**	**8,000**	**8,000**	**-**
Additional CCG Contribution						
NHS Halton CCG	1,000	1,000	-	4,000	4,000	-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
Total Additional CCG Contribution	**1,000**	**1,000**	**-**	**4,000**	**4,000**	**-**
Total Contribution	**4,500**	**4,500**	**-**	**18,000**	**18,000**	**-**

Summary of Total BCF Expenditure

BCF Expenditure						
Acute			-			-
Mental Health	500	500	-	2,000	2,000	-
Community Health	500	500	-	2,000	2,000	-
Continuing Care	500	500	-	2,000	2,000	-
Primary Care	1,000	1,000	-	4,000	4,000	-
Social Care	2,000	2,000	-	8,000	8,000	-
Other			-			-
Total	**4,500**	**4,500**	**-**	**18,000**	**18,000**	**-**
Contribution less Expenditure	**-**	**-**	**-**	**-**	**-**	**-**

CCG Share of £1.1bn Contribution to Social Care						
NHS Halton CCG	500	500	-	2,000	2,000	-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
Total Minimum CCG Share of £1.1bn Contribution to Social Care	**500**	**500**	**-**	**2,000**	**2,000**	**-**

CCG Share of £2.4m Minimum Contribution						
NHS Halton CCG	1,500	1,500	-	6,000	6,000	-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
Total CCG Share of Minimum £2.4bn Contribution	**1,500**	**1,500**	**-**	**6,000**	**6,000**	**-**

Summary of NHS Commissioned out of hospital services spend from MINIMUM BCF Pool						
Mental Health			-			-
Community Health	1,000	1,000	-	4,000	4,000	-
Continuing Care	500	500	-	2,000	2,000	-
Primary Care	500	500	-	2,000	2,000	-
Social Care			-			-
Other			-			-
Total	**2,000**	**2,000**	**-**	**8,000**	**8,000**	**-**

Summary of Benefits						
Reduction in permanent residential admissions			-			-
Increased effectiveness of reablement			-			-
Reduction in delayed transfers of care			-			-
Reduction in non-elective (general + acute only)	(112)	(112)	-	(447)	(447)	-
Other			-			-
Total	**(112)**	**(112)**	**-**	**(447)**	**(447)**	**-**

Has the housing authority received its DFG allocation?	
Have the funds been pooled via a s.75 pooled budget arrangement?	

Halton	

Payment for Performance

	Plan	Forecast	Variance against Revised Plan
1. Reduction in non elective activity			
Baseline of non elective activity	16,759	16,759	-
Change in non elective activity	(545)	(12,059)	(11,514)
% change in non elective activity	-3.3%	-72.0%	-68.7%
2. Calculation of performance and NHS commissioned ringfenced funds			
Financial value of non elective saving / performance fund	812,050	17,967,910	########
Combined total of performance and ringfenced funds	3,900,000	3,900,000	-
Ringfenced funds	3,087,950	#########	########
Value of NHS commissioned services	6,000,000	6,000,000	-
Shortfall of contribution to NHS commissioned services	0		-

	Q4 14/15 Revised Plan	Q1 15/16 Revised Plan	Q2 15/16 Revised Plan	Q3 15/16 Revised Plan
Cumulative quarterly baseline of non elective activity	4,242	8,462	12,595	16,759
Cumulative change in non elective activity	6	(180)	(362)	(545)
Cumulative % change in non elective activity	0.1%	-2.1%	-2.9%	-3.3%
Financial value of non elective saving / performance fund (£	205,544	204,478	200,263	201,765
Value of payment made over to BCF	148,259	-	-	-
Variance	57,285	204,478	200,263	201,765
Commentary on Variance		Payment not due	Payment not due	Payment not due

Halton	Q1 2015/15 Report

Non - Elective admissions (general and acute)

Plan

Metric		Baseline				Pay for performance period				
		Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	*Quarterly rate*	3,364	3,347	3,278	3,302	3,361	3,192	3,126	3,150	3,170
	Numerator	4,242	4,220	4,133	4,164	4,248	4,034	3,951	3,981	4,015
	Denominator	126,098	126,098	126,098	126,098	126,380	126,380	126,380	126,380	126,658

P4P annual change in admissions	*-545*		
P4P annual change in admissions (%)	*-3.3%*	Please enter the average cost of a non elective admission	£1,490
P4P annual saving	*£812,050*		

Peformance against plan

Metric		Baseline				Pay for performance period				
		Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	*Quarterly rate*	3,364	3,347	3,278	3,302	2,327				
	Numerator	4,242	4,220	4,133	4,164	4,700				
	Denominator	126,098	126,098	126,098	126,098	202,000	202,000	202,000	202,000	204,000

P4P annual change in admissions	*-12059*		
P4P annual change in admissions (%)	*-72.0%*	Please enter the average cost of a non elective admission	£1,490
P4P annual saving	*£17,967,910*		

Variance against plan

Metric		Baseline				Pay for performance period				
		Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	*Quarterly rate*	-	-	-	-	(74)	3,192	3,126	3,150	3,170
	Numerator	-	-	-	-	(94)	4,034	3,951	3,981	4,015
	Denominator	-	-	-	-					

Halton	Q1 2015/15 Report

Residential admissions

Plan

Metric		Baseline (2013/14)	Planned 14/15	Planned 15/16
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Annual rate*	664	636.6	635.1
	Numerator	125	134	138
	Denominator	19,605	21,048	21,730
	Annual change in admissions		*9*	*4*
	Annual change in admissions %		*7.2%*	*3.0%*

Performance against plan

Metric		Baseline (2013/14)	Planned 14/15	14/15 Performance
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Annual rate*	664.0	636.6	622.4
	Numerator	125	134	131
	Denominator	19,605	21,048	21,048
	Annual change in admissions		*9*	*-3*
	Annual change in admissions %		*7.2%*	*-2.2%*

Variance against plan

Metric		Baseline (2013/14) Variance	14/15 Variance	15/16 Variance
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Annual rate*	-	-	13
	Numerator	-	-	7
	Denominator	-	-	682

Reablement

Plan

Metric		Baseline (2013/14)	Planned 14/15	Planned 15/16
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Annual %*	63.6	68.2	70.0
	Numerator	65	73	77
	Denominator	100	107	110
	Annual change in admissions		*8*	*4*
	Annual change in admissions %		*12.3%*	*5.5%*

Performance against plan

Metric		Baseline (2013/14)	Planned 14/15	14/15 Performance
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Annual %*	63.6	68.2	65.6
	Numerator	65	73	86
	Denominator	100	107	131
	Annual change in admissions		*8*	*13*
	Annual change in admissions %		*12.3%*	*17.8%*

Variance against plan

Metric		Baseline (2013/14)	Planned 14/15	Planned 15/16
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Annual %*	-	-	4
	Numerator	-	-	- 9
	Denominator	-	-	- 21

Delayed transfers of Care

Metric		14/15 plans Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	15-16 plans Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	*Quarterly rate*	**701.2**	**620.6**	**507.5**	**506.1**	**568.1**	**568.1**	**568.1**	**565.4**
	Numerator	688	609	498	498	559	559	559	558
	Denominator	98,124	98,124	98,124	98,391	98,391	98,391	98,391	98,683

Performance against revised plan

Metric		14/15 plans Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	15-16 performance Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	*Quarterly rate*	**701.2**	**620.6**	**507.5**	**935.0**				
	Numerator	688	609	498	920				
	Denominator	98,124	98,124	98,124	98,391	142,593	142,593	142,593	145,357

Variance against revised plan

Metric		14/15 variance Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	15-16 variance Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	*Quarterly rate*	-	-	-	- **428.9**				
	Numerator	-	-	-	- **422.0**				
	Denominator	-	-	-	-				

Patient / Service User Experience Metric

Plan

Metric		Baseline Apr'13-Mar'14	Planned 14/15 (if available)	Planned 15/16
Do care and support services help you to have a better quality of life? (Adult Social Care survey Q 2b)	*Metric Value*	87.0%		91.0%
	Numerator	489	560	618
	Denominator	562	631	679
Improvement indicated by:	Increase			

Performance against plan

Metric		Baseline Apr'13-Mar'14	Planned 14/15 (if available)	14/15 Performance
Do care and support services help you to have a better quality of life? (Adult Social Care survey Q 2b)	*Metric Value*	87.0%	88.7%	93.2%
	Numerator	489	560	246
	Denominator	562	631	264
Improvement indicated by:	Increase			

Variance against plan

Metric		Baseline Apr'13-Mar'14	14/15 Variance	14/15 Variance
Do care and support services help you to have a better quality of life? (Adult Social Care Survey Q 2b)	*Metric Value*	-	- 1	- 0
	Numerator	-	-	372
	Denominator	-	-	415

Local Metric

Plan

Metric		Baseline Apr'12 to Mar'13	Planned 14/15 (if available)	Planned 15/16
Hospital re-admissions (within 28 days), where original admission was due to a fall (aged 65+) (directly standardised rate per 100,000 population aged 65+)	*Metric Value*	906.4	923.1	884.2
	Numerator	184	192	191
	Denominator	20,300	20,800	21,600
Improvement indicated by:	Decrease			

Performance against plan

Metric		Baseline Apr'12 to Mar'13	Planned 14/15 (if available)	14/15 Performance
Hospital re-admissions (within 28 days), where original admission was due to a fall (aged 65+) (directly standardised rate per 100,000 population aged 65+)	*Metric Value*	906.4	923.1	764.4
	Numerator	184	192	**
	Denominator	20,300	20,800	20,800
Improvement indicated by:	Decrease			

Variance against plan

Metric		Baseline Apr'12 to Mar'13	14/15 Variance	15/16 Variance
Hospital re-admissions (within 28 days), where original admission was due to a fall (aged 65+) (directly standardised rate per 100,000 population aged 65+)	*Metric Value*	-	-	- 120
	Numerator	-	-	#VALUE!
	Denominator	-	-	#VALUE!

Halton	Q1 2015/15 Report

National Conditions

The Spending Round established six national conditions for access to the Fund.
Please confirm by selecting 'yes' or 'no' against the relevant condition as to whether these are on track as per your final BCF plan.
Further details on the conditions are specified below.
If no is selected for any of the conditions please include a comment in the box below

Condition	Please Select (yes or no)	Comment
1) Have plans have been jointly agreed?	Yes	
2) Have Social Care Services (not spending) been protected?	Yes	
3) 7 day services to support patients being discharged and prevent unnecessary admission at weekends are in place and delivering?	Yes	
4) In respect of data sharing - confirm that:		
i) The NHS Number is being used as the primary identifier for health and care services	No	social care system being updated to make NHS Number mandatory field
ii) You are pursuing open APIs (i.e. systems that speak to each other);	Yes	
iii) Appropriate Information Governance controls are in place for information sharing in line with Caldicott 2	Yes	
5) A joint approach to assessments and care planning is in place and where funding is used for integrated packages of care, there will be an accountable professional?	Yes	
6) Agreement on the consequential impact of changes in the acute sector?	Yes	

National conditions - Guidance

The Spending Round established six national conditions for access to the Fund:

1) Plans to be jointly agreed
The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Round, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups.

In agreeing the plan, CCGs and councils should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.

Protection for social care services (not spending)
Local areas must include an explanation of how local adult social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013/14: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The recent national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England provided guidance on establishing effective 7-day services within existing resources.

Better data sharing between health and social care, based on the NHS number
The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.
Local areas should:
• confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to;
• confirm that they are pursuing open APIs (i.e. systems that speak to each other); and
• ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place.
NHS England has already produced guidance that relates to both of these areas. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by DH).

Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional
Local areas should identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by accountable professionals.
The Government has set out an ambition in the Mandate that GPs should be accountable for co-ordinating patient-centred care for older people and those with complex needs.

Agreement on the consequential impact of changes in the acute sector

Local areas should identify, provider-by-provider, what the impact will be in their local area, including if the impact goes beyond the acute sector. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in.
Ministers have indicated that, in line with the Mandate requirements on achieving parity of esteem for mental health, plans must not have a negative impact on the level and quality of mental health services.

REPORT TO:	Health and Wellbeing Board
DATE:	13th May 2015
REPORTING OFFICERS:	Simon Banks, NHS Halton CCG, Chief Officer Leigh Thompson, Director of Service Delivery, NHS Halton CCG
PORTFOLIO:	Health and Wellbeing
SUBJECT:	One Halton Development Session
WARDS:	Borough wide

1.0 PURPOSE OF THE REPORT

1.1 The purpose of this report is to provide a briefing for the One Halton development workshop to be held at the Health and Wellbeing Board on 13th May 2015. At the workshop, Health and Wellbeing Board members will learn more about the concept of the initiative and will work alongside one another to develop a shared vision for the programme. Attached (appendix 1) are a number of questions that members will be asked to discuss, debate and answer as part of the development workshop.

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

3.0 SUPPORTING INFORMATION

Summary of Programme

NHS Halton CCG has recently launched a new concept and initiative called One Halton. They have done this in partnership with a number of local organisations including the Local Authority, NHS providers, Voluntary sector organisations and other key local bodies and organisations. The One Halton concept was first introduced in February 2015 and a number of preliminary discussions have taken place.

3.1 The overarching concept has been discussed and an initial consideration is that the One Halton Programme is an overarching framework to deliver a collective mandate for joint action across the Borough of Halton against a jointly agreed set of strategic priorities. With a focus on primary, secondary and tertiary prevention, it creates a holistic way of working in which all local organisations – both statutory and non-statutory - co-ordinate their approach and services to managing the health and well-being needs of local people. Services will be delivered in the optimum locations for people where every resident has consistent access to care. All services will operate at a level of excellence, regardless of location.

3.2 One Halton will adopt an inclusive and collaborative approach to transforming health and care in the borough, allowing local organisations and services the opportunity to develop more integrated and joined up pathways. In turn, this will yield aligned and joined up efficiency opportunities, with risks and issues mitigated and managed on a Borough-wide basis.

3.3 The most essential criteria to deliver this programme is strong and consistent leadership from individuals, both clinically and non-clinically, within all local organisations to navigate and guide the programme and its work streams through local, regional, national and regulatory challenge and requirements.

3.4 Some ideas for schemes in the first tranche of the scheme include:

- Urgent/unscheduled care – including role of UCC (multiple)
- Frail elderly/Frailty (multiple)
- Cancer
- CVD/Hypertension (LTCs)
- Mental Health
- Children's
- Lifestyles (Drugs/Alcohol)

3.5 Benefits of the scheme include:

- Whole system approach
- Shared purpose – the power of everyone behind the same idea/concept
- Sharing expertise
- Alignment of organisational plans and priorities
- Greater opportunity for innovation – with agreed risk sharing
- Whole population approach covering all age groups

3.7 **Outcome targets**

Targets for the programme will be aligned with local organisational and partnership plans to ensure maximum benefit.

4.0 Policy Implications

4.1 By offering an integrated programme of action, the One Halton initiative will bring together a number of policy areas which in turn should contribute to the delivery of Health and Wellbeing Board priorities.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 Over time the One Halton programme should offer a number of joined-up efficiency opportunities.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children and Young People in Halton

The successful implementation of the programme should offer a range of opportunities for all age groups including children and young people.

6.2 Employment, Learning and Skills in Halton

Improving outcomes in health and social care should have an impact on this priority area which has a direct impact on health and wellbeing.

6.3 A Healthy Halton

The One Halton programme will directly contribute to improving health and wellbeing in Halton.

6.4 A Safer Halton

Improving outcomes in areas such as drugs and alcohol will directly contribute to reducing crime and improving community safety.

6.5 Halton's Urban Renewal

The environment in which we live and the physical infrastructure of our communities has a direct impact on our health and wellbeing. It should therefore be a key consideration when developing strategies to address health and wellbeing. This includes ensuring accessible services at a variety of suitable locations to meet the needs of all population groups.

7.0 RISK ANALYSIS

The One Halton programme seeks to reduce and minimise risk by fostering an integrated approach to health and social care services.

8.0 EQUALITY AND DIVERSITY ISSUES

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

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

There are no background papers within the meaning of the Act.

Appendix 1

Halton Health & Wellbeing Board Development Session 13th May 2015

Questions to be discussed

Question 1

Is *One Halton* the right thing to do?

Question 2

How do we avoid this being just another good idea?

Question 3

What is the role of the H&WBB in *One Halton*?

Question 4

What would *One Halton* look like to you as a member of the H&WBB?

Question 5

How can you accelerate change?

a) Yourself
b) In your organisation
c) In partnership

Question 6

How should the Health & Wellbeing Board through its statutory responsibilities provide oversight to *One Halton*?