Public Document Pack

Health and Wellbeing Board

Wednesday, 8 July 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, 16 September 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, 13 May 2015 at Karalius Suite, Stobart Stadium, Widnes

Present: Councillors Philbin, Polhill and Woolfall and S. Banks, P. Cook, B. Dutton, R. Foster, D. Lyon, A. Marr, A. McIntyre, E. O'Meara, D. Parr, N. Rowe, A. Scales, R. Strachan, L. Thompson, S. Wallace Bonner, A. Waller and S. Yeoman

Apologies for Absence: M. Creed, N. Sharpe and Councillor Wright

Absence declared on Council business: None

ITEM DEALT WITH UNDER DUTIES EXERCISABLE BY THE BOARD

Action

HWB51 MINUTES OF LAST MEETING

The Minutes of the meeting held on 11th March 2015 having been circulated were signed as a correct record.

HWB52 THE TRANSFER OF 0-5'S PUBLIC HEALTH COMMISSIONING RESPONSIBILITIES

The Board considered a report of the Director of Public Health, which provided an update on the transfer of 0-5s public health commissioning responsibilities in relation to mandation and financial arrangements. From 1st 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. The workforce would continue to be employed by their current provider, Bridgewater Community Healthcare NHS Trust, whilst the commissioning responsibilities for 0-5 public health services, which included the Health Visiting Service and the Family Nurse Partnership (FNP), would transfer across to the Council.

It was reported that the Government had reached agreement that the following universal aspects of the 0-5 Healthy Child Programme would be mandated in regulations:

1. The antenatal health promoting visits;
2. New baby review;
3. 6-8 week assessments;
4. 1 year assessment; and
5. 2-2½ year review.

With regard to finance and contracting, NHS England had worked closely with local authorities to jointly agree the finance and contracting picture. The indicative contract value for Halton had been agreed and was based on the anticipated number of Health Visitors who would be in post at the point of transfer.

RESOLVED: That the update be noted.

HWB53 NHS ENGLAND UPDATE

The Board received a quarterly Accountability report submitted by NHS England. The report outlined national and regional context together with specific updates on priorities that the Area Teams were responsible for delivering and how these priorities were progressing. In addition, the report gave 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.

RESOLVED: That the update report be noted and requests for further information be forwarded to Michelle Creed at NHS England.

HWB54 BETTER CARE FUND QUARTERLY MONITORING REPORT (Q1) - UPDATE

The Board was advised that the Better Care Fund operationalisation guidance and non-elective admissions ambitions had been published and the document set out the monitoring requirements for 2015/16 for the Fund which included:

- Quarterly reporting template;
- Submission points; and
- Annual reporting/year-end reporting.

It was noted that approval was sought for the Quarter 4 report from January to March 2015 which was due for submission to NHS England by 29th May 2015. Details of the submission, including a summary which covered non elective admissions and supporting metrics, were outlined in the report.

Arising from the discussion it was agreed that a training session on the Better Care Fund would be arranged for Board Members. Strategic Director Communities

RESOLVED: 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.

HWB55 'ONE HALTON' DEVELOPMENT SESSION

The Board received a presentation from Leigh Thompson, Director of Commissioning & Service Delivery, Halton CCG, which advised that NHS Halton CCG had recently launched a new concept and initiative called *One Halton*. This had been done 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* Programme was an overarching framework to deliver a collective mandate for joint action across 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 organisation – both statutory and non-statutory – co-ordinate their approach and services to managing the health and well-being needs of local people. Services would be delivered in the optimum locations for people where every resident had consistent access to care. Benefits of the scheme included:

- 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; and
- Whole population approach covering all age groups.

As part of the consultation on *One Halton* the Board divided into three groups to discuss six questions around:

Is *One Halton* the right thing to do?

How do we avoid this being just another good idea?

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

What would *One Halton* look like to you as a member of the

H&WBB?

How can you accelerate change?

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

Each group presented their findings and commented on each question. Leigh Thompson agreed to circulate a discussion document following the consultation workshop and the collective responses to the above set of questions.

It was agreed that progress of the *One Halton* programme would be presented at the next meeting.

RESOLVED: That the report be noted.

Meeting ended at 4.05 pm

REPORT TO: Health and Wellbeing Board

DATE: 8th July 2015

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Wellbeing

SUBJECT: Healthy Living Pharmacies

WARDS: Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To provide members of the Board with a briefing on the Healthy Living Pharmacies (HLP) proposal including health benefits for the local population and opportunities for joint working between pharmacies and other health and wellbeing organisations.

2.0 RECOMMENDATION: That

1. **Healthy Living Pharmacies are introduced throughout the Borough via a phased roll out.**

2. **The introduction of Healthy Living Pharmacies will be a partnership approach led by Halton Council and NHS Halton Clinical Commissioning Group (CCG), supported and facilitated by the Local Pharmaceutical Committee (LPC).**

3. **The accountability for Healthy Living Pharmacies will be through Halton Council's Senior Public Health Team and NHS Halton CCG Medicines Management Working Group which will report jointly by exception to the Health and Wellbeing Board.**

3.0 SUPPORTING INFORMATION

3.1 Background to Healthy Living Pharmacies

The Healthy Living Pharmacy is a nationally agreed accreditation or 'kite mark' for community pharmacies which deliver proactive health and wellbeing advice as part of their day to day role. It is a tiered commissioning framework aimed at achieving consistent delivery of a broad range of high quality services through community pharmacies to meet local need, improving the health and wellbeing of the local population and helping to reduce health inequalities.

The Healthy Living Pharmacy concept was developed by NHS Portsmouth. It recognised the significant role community pharmacies could play in helping

reduce health inequalities by delivering consistent and high quality health and wellbeing services, promoting health and providing proactive health advice and interventions.

In 2011/2012 The Healthy Living Pharmacy (HLP) programme was rolled out across a number of other areas as part of an HLP pathfinder programme supported by the Department of Health.

Key findings from the evaluation of the HLP pathfinder sites in April 2013[1,2,3]:

- Results from Portsmouth can be replicated in other areas of the country as the benefits are not dependent on levels of local health need and deprivation;
- increased service delivery and improved quality measures and outcomes;
- 60% of peopled surveyed would have otherwise gone to a GP;
- Public feedback was positive with 99% comfortable to receive the service in the pharmacy;
- More people successfully quit smoking in HLPs than non-HLPs.
- More sexual health advice given than in non-HLPs;
- Potential for contribution to alcohol harm reduction service;
- HLPs were effective at delivering increased support for people taking medicines for long term conditions, through both Medicines Use Reviews and the New Medicine Service.
- Pharmacies were also positive about the scheme; with 70% of the contractors surveyed saying it had been worthwhile for their business.
- Health promotion zones within pharmacies play a vital part in supporting the public health role of the pharmacy

3.2 What is a Healthy Living Pharmacy[4]

A Healthy Living Pharmacy should:

- consistently delivers a range of health and wellbeing services to a high quality:
- Has achieved defined quality criteria requirements and meets productivity targets linked to local health needs e.g. number of stop smoking quits at 4 weeks; number of targeted Medicines Use Reviews (MURs) completed
- Has a team ethos that proactively promotes health and wellbeing and proactively offers brief advice on a range of health issues such as smoking, activity, sexual health, healthy eating and alcohol
- Has at least one Healthy Living Champion trained to level 2 qualification in 'Understanding Health Improvement' accredited by the Royal Society of Public Health.
- Should be recognisable by the public and other healthcare professionals
- The services provided as part of HLP are tailored to local health needs with the aim of reducing health inequalities by improving health and wellbeing outcomes in their communities
- An HLP builds on all existing core pharmacy services (Essential and Advanced) with a series of locally commissioned services.

The delivery of services is supported by three enablers:

1. workforce development, a skilled team to pro-actively support and promote behaviour change,
2. the pharmacy environment
3. pro-active engagement with the local community, other health professionals (especially GPs), social care and public health professionals.
4. provision of robust, up to date health information

3.3 What is a Healthy Living Champion (HLC)?

Within a Health Living Pharmacy, HLCs are members of the pharmacy team who are trained and accredited to provide customers with health and wellbeing advice. The key role of a HLC is to provide customers with information about improving their health and signpost them to other community services that will help them to adopt healthier lifestyles and access the support they need to do so. A HLC would be responsible for ensuring that health promotion materials are displayed in an appropriate way, overseeing training of staff and developing and maintaining a 'health zone' within the pharmacy. The HLC will also be responsible for developing the service in line with local need and providing regular feedback to the commissioner.

3.4 Pharmacy services

All pharmacies must deliver **Essential services** as detailed in the current contractual framework: Dispensing, Repeat Dispensing, Supply of Appliances, Waste Management, Support of Public Health (including 6 health promotion campaigns dictated by NHS England but based on local need each year), Signposting to additional health support and advice, Support for self-care, Clinical Governance.

Advanced services are part of the national community pharmacy contract and are delivered in most pharmacies by pharmacists who are appropriately accredited.

Medicines Use Reviews (MURs) can help identify medication not taken as prescribed, preventing unmet treatment goals, unplanned and unnecessary hospital admissions and wasted resources. Pharmacies on the Isle of Wight demonstrated the benefits to patients of effectively targeted and delivered MURs to respiratory patients, giving improved treatment outcomes and reduced hospital admissions.

New medicines Service provides support for people with certain long-term conditions newly prescribed a medicine during the first month of taking the medicine;

- Aims to improve patient adherence which will generally lead to better health outcomes
- Aims to increase patient engagement with their condition and medicines, supporting them in making decisions about their treatment and self-

management
- Reduces the risk of hospital admissions due to adverse events from medicines
- Reduces medicines waste

Pharmacies also provide **enhanced services** commissioned by NHS England, and other services commissioned locally by Clinical Commissioning Groups (CCGs) and local authority Public Health teams.

Healthy Living Pharmacies will not just deliver all these services, but will use each and every opportunity to offer other relevant services and to deliver public health awareness messages, making every contact count in improving health and wellbeing of the people using their services.

Increased training and staff development will enable the pharmacy team to qualify and deliver, more health and wellbeing services such as level 2 smoking cessation, alcohol brief intervention and to support self-care e.g. inhaler technique checks and support for people with long term conditions.

3.5 The Healthy Living Pharmacy Quality Mark

Healthy living pharmacies will have a healthy living pharmacy logo that is easily identified by members of the public, healthcare professionals and commissioners. This will require marketing and publicity to ensure that people recognise what this means. A national logo exists but a local variant could be agreed if this is thought more locally acceptable. See appendix 1 for national logo.

3.6 Community Pharmacies

Nationally 99% of the population can get to a pharmacy within 20 minutes by car; 96% by walking or using public transport. 84% of adults visit a pharmacy at least once a year, 78% for health-related reasons, and the majority (>75%) use the same pharmacy all the time.

Pharmacies are located in the community, are a non-clinical environment, offer anonymity and privacy and are accessible without appointment, not just during the day but often at evenings and weekends as well. A qualified pharmacist is on duty and available virtually all of the opening hours.

People with regular health needs, especially long term conditions know their pharmacies and pharmacy staff well, as they often need regular medication and value the support and advice that is also provided.

Community pharmacies offer convenient and equitable access to healthcare. The vast majority of households in England, and especially those in the most deprived areas, have access to a community pharmacy within 20 min walk: a positive pharmacy care law[5]. Halton has good access to community pharmacy compared many parts of the country.

There are 31 community pharmacies within Halton eligible to become healthy living pharmacies, some are open late at night, early morning and at weekends, giving good access to services.

Many community pharmacies within Halton provide additional services commissioned by NHS Halton CCG or by Halton Local Authority Public Health:

Services commissioned by NHS Halton CCG:
Care at the Chemist Minor Ailments Service (CATC) This service improves access to advice for minor ailments within primary care, it aims to also reduce the need for GP and walk in centre appointments, and to avoid unnecessary A and E attendances.

On Demand Access to Palliative Care Drugs – a few pharmacies are commissioned to keep a dedicated list of palliative care drugs to ensure access to this vital medication is available when it is needed.. This reduces undue distress for family members and ensures they can spend as much time as possible with their loved ones.

Services commissioned by Local Authority Public Health team:
Smoking Cessation – Some pharmacies dispense vouchers issued by stop smoking services and counsel the quitter on their use and also offer a level 2 stop smoking service where the pharmacy provides the motivational support as well as issuing and dispensing nicotine replacement vouchers. From 1st April 2015 some pharmacies will also be able to issue Varenicline (champix) under PGD to support quit attempts.

Substance Misuse – Some pharmacies supervise methadone consumption and provide needle exchange, these services support the work of the commissioned drug and alcohol service.

Sexual health – accredited pharmacists supply emergency hormonal contraception (EHC) under patient group direction (PGD), at the same time providing advice on sexually transmitted diseases, signposting to testing if appropriate, future contraception, and issuing condoms if needed.

3.7 Benefits of HLP in Halton

Clients

'Healthy' people are also regular users of pharmacies, and there will be opportunities to support them to improve their health.

Halton residents are already used to seeking advice from their community pharmacies this scheme will increase the opportunity for a brief intervention relevant to the minor ailment or an opportunity for the client to access health promotion information.

Pharmacies can support families and carers through what can be a difficult time when dealing with long term or life threatening conditions and signpost to

additional support services for family members as well as patients

Primary Care
HLPs will divert some of the wellbeing consultations currently being held within GP appointment time and as such will improve access within primary care. It will support the self-care agenda and promote healthy living enabling people to lead healthier lives and so reduce the risks of developing long term health conditions.

It will help patients with existing long term health conditions to manage their condition more effectively and so avoiding complications, this will again improve access to primary care and free up GP appointments.

Commissioners
The introduction of healthy pharmacies will maximise the benefits of existing commissioning, and future commissioning of population based health services from pharmacies.

HLPs will support improved access within primary agenda and will reduce the number of people developing chronic health conditions and the associated pressures within the health economy as a result of this.

HLPs support the national drive to optimise the skill base within community pharmacy to improve health and wellbeing.

Community Pharmacies
Becoming a HLP will mean the pharmacy is awarded a quality kite mark that can be displayed, this will be identify the pharmacy as taking part in the scheme and will demonstrate a commitment to delivering high quality services and to health improvement. Participation in the scheme is likely to have a positive impact on their business as was demonstrated by the pathfinder evaluation, 70% of the contractors surveyed said it had been worthwhile for their business.

Overarching benefits for all stakeholders
There are a number of organisations working to improve the health and wellbeing in Halton. HLPs will develop close working relationships with the local Health Improvement Team and Wellbeing Service, supporting and complementing their work as well as developing their own initiatives.

Reduced duplication within the system to maximise access to health and wellbeing service.

3.8 Opportunities for future commissioning

These could include

- Chlamydia screening
- Blood pressure checks
- Dementia screening

- Healthy weight advice.
- Alcohol harm reduction advice.
- Support for people with long term conditions.
- Support for clients with respiratory conditions.
- Minor ailment clinics

3.9 Commissioning arrangements

Commissioning of HLPs would utilise existing arrangements for current CCG and Public Health pharmacy contracts.

In Halton we would be looking at initially developing accreditation criteria for level 0-1 of the healthy living pharmacy framework which support the priorities of the Health and Wellbeing Board, the Council, and the Clinical Commissioning Group. It will involve a phased approach with pharmacies required to demonstrate that they are achieving a basic minimum standard in the delivery of all essential and advanced services and that they do this to a consistently high quality. This ensures the accreditation is appropriate and creates the gateway by which the pharmacies achieve additional levels of accreditation. See table 1.

Table 1: Quality Criteria needed to demonstrate that a pharmacy is either working towards Healthy Living Pharmacy status or actually achieving this quality mark. Once progressed to the next level the pharmacy must ensure that the standards of the previous level are maintained

	HLP Level 0 (Pre-accreditation)	**HLP Level 1 (Accreditation)**	**HLP Level 2 (Advanced)**
Pharmacy environment			
Staff and Leadership	All staffs are immediately identifiable with name badges. Pharmacy has identified at least 2 members of staff to be Healthy Living Champions (HLC).	The pharmacy team is led by an effective leader to achieve the agreed vision and ethos of a Healthy Living Pharmacy. There is a 'can do' attitude within the pharmacy team and this is driven through effective leadership. Named HLC/s have completed accredited training within the last 2 years. Certificate to be	TBC

		recorded in Portfolio.	
Appearance	The pharmacy premises and merchandise / merchandising reflect a professional healthcare and healthy living environment.	The pharmacy premises and merchandise / merchandising reflect a professional healthcare and healthy living environment. Health Living logo displayed prominently	TBC
Pharmacist availability	The pharmacist is visible and accessible to the public for health advice.		
Consultation Room	The pharmacy has available consultation room/s that are fit for purpose and reflect a professional environment. Rooms need to allow for privacy		
Proactive engagement			
Engagement with GP practice	The pharmacy team identify ways to engage with local GP practice(s) Records are made of interventions and queries	The pharmacy team engages with the local GP practices to ensure there are formalised referral pathways for health improvement and wellbeing services. Where the local GP practice is reluctant to engage, the pharmacy can demonstrate the processes and the proposals put forward to the practice. Discussions should also take place with the CCG medicines management team regarding how the CCG can encourage engagement.	The pharmacy team regularly meets with their local GP practice(s) and/or attends practice meetings periodically to discuss potential collaboration to deliver enhanced patient care Where there are multiple pharmacies in one geographical area the pharmacy team will demonstrate a collaborative approach with other local pharmacies to improve GP engagement

Other providers	The pharmacy team links into other services and groups on an ad hoc basis	The pharmacy team is aware of and actively links into other groups to promote health & wellbeing activity e.g. Health Trainers, Healthwatch, Wellbeing Service, Community/ Village agents, local support groups.	The pharmacy team regularly meets with other groups to plan health promotion and wellbeing activities
Public Health priorities	The team leader has an awareness of the local public health needs outlined in the Joint Strategic Needs Assessment (JSNA) and Pharmaceutical Needs Assessment (PNA)	All staff have an awareness of the local public health needs outlined in the JSNA, the Director of Public Health Annual Report and PNA. All staff are trained to proactively advise the public on basic health and wellbeing. Public health interventions are regularly being recorded - Any supporting evidence or case study examples are kept in Portfolio.	A minimum of 20 public health related interventions have been recorded - Supporting evidence and case studies are kept in the Portfolio.
Information Provision			
Healthy Living Zone	Health promotion materials, e.g., books, DVDs, leaflets, promotional displays, etc., are available in an area but this	There is a dedicated health promotion zone clearly marked and accessible to the public, which displays current Health Topic and is linked to	Development of Information Technology to deliver health promotion messages e.g. use of apps.

	is not clearly identified for the public.	campaigns & priorities. This area may include a local health and wellbeing notice board, plasma screen and access to touchscreen displays by the public. There is a good display of up to date and relevant health and wellbeing resources appealing to the majority of local public and ethnicity. It is accommodated where appropriate. Resources are checked every month	
Information Environment	Pharmacy has internet access (use of NHS Mail is desirable) with a working, professional email address.	Procedures are in place for informing and accessing emails regularly. Relevant staff can access emails at agreed frequency and reply as required. Internet access is allowed for information retrieval on locally and nationally recognised websites.	Procedures are in place for informing and accessing emails regularly. Relevant staff can access emails at agreed frequency and reply as required. Internet access is allowed for information retrieval on locally and nationally recognised websites.
Service Delivery			
Enhanced Services Delivery	Pharmacy is committed to delivering all locally	Pharmacy can demonstrate a committed and consistent	n/a

	commissioned enhanced services that they are given the opportunity to. They will fulfil all requirements of the SLA and will ensure availability of the service in line with that stipulated in the service specification	provision of services - there is a rolling programme of training and service activity that has increased from last year (where relevant) The pharmacy will provide evidence of high quality interventions and service delivery in line with that stipulated in the service specification	
Medicines Use Review (MURs)	Pharmacy is actively engaged in MURs, and provides clear evidence to NHS England Area Team that 70% of MURs have been completed on patients in nationally agreed target groups during previous year.		To be developed
New Medicines Service	The pharmacy has declared to NHS England Area Team that it offers NMS from the branch and that pharmacists have self-declared that they are competent to do so.	The pharmacy has set up a system for actively recruiting patients for the NMS. The pharmacy actively delivers high quality NMS to patients.	To be developed
Repeat Dispensing	Pharmacy dispenses repeat dispensing prescriptions according to national requirements of the essential service	Pharmacy dispenses repeat dispensing prescriptions according to national requirements of the essential service There is a system for	To be developed

		proactively identifying and informing patients who may benefit from this service	
Example criteria for areas for future Development			
Targeted MURs	The pharmacy delivers MURs on respiratory patients and feeds back any actions to the patient's GP according to national requirements for the advanced service	The pharmacy delivers MURs on respiratory patients and feeds back any actions to the patient's GP according to national requirements for the advanced service. Staff have been trained to understand how to coach patients to use their inhalers effectively.	An Advanced Inhaler Technique trained pharmacist/technician is available to test inhaler technique and measure symptom control (ACT or CAT score) for respiratory targeted/recruited MUR patients..

4.0 POLICY IMPLICATIONS

Halton Health and Wellbeing Strategy 2012 – 2015 will be used as the principle focus for developing HLP within Halton. Additional factors that will be included will be drawn from existing evidence that suggests that HLPs can make a difference. Sources that will provide evidence of need include NHS Halton CCG and Halton public health strategies; JSNA, PNA, NHS Halton CCG commissioning plan and the Primary care strategy.

5.0 FINANCIAL IMPLICATIONS

The full cost for setting up the scheme is £12,000. An annual running fee of £2,000 to £3,000 covers renewal of marketing materials.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children and Young People in Halton

Improving the Health of Children and Young People is a key priority in Halton and this will be reflected in healthy living pharmacies with service provision that is appropriate to this age group, including information appropriate to their needs and prominently displayed reassurance that

all consultations will be in confidence. Young people often feel more comfortable using community pharmacies and children visit pharmacies regularly, when growing up, as part of a family group and get to know and trust the pharmacy staff.

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

Staff working in Halton Community Pharmacies, often live within the Borough and as a result of this initiative will receive additional training and gain new qualifications. Experience in other areas has shown this training and new responsibilities has increased the job satisfaction of community pharmacy staff.

6.3 **A Healthy Halton**

All issues outlined in this report focus directly on a Healthy Halton. With regard to the Health and Wellbeing Boards priorities relevant pharmacy services are listed under each priority.

Prevention and early detection of cancer

- Safe sun advice and health promotion materials
- Support and information to encourage residents to take up all screening opportunities.
- Stop smoking services.

Improved Child development

- Health promotion information and posters designed to appeal to children and young people.
- Good health promotion information for families on healthy eating, 'fit for life', childhood immunisation
- Sexual Health promotion and sexual health services in pharmacies such as Emergency Hormonal contraception and chlamydia testing will help reduce teenage pregnancies and improve the sexual health of young people

Reduction in the number of falls in adults

- Pharmacies may often be the first port of call when someone has a fall, often for first aid provisions. This places pharmacies in an ideal place to help identify the reason for the fall and with permission refer on to other services.
- A pilot enhanced service in Wigan pharmacies enabled pharmacies to undertake a medication review on all patients taking 4 or more medicines to look for the possibility that either one medicine or a number of medicines might increase their risk of falls. (Four or more medicines report[6]).
- It would also be an opportunity for a brief intervention and advice if the fall was the result of overenthusiastic alcohol consumption.
- Local training events for pharmacists will be needed to support this

Reduction in harm from alcohol

- Brief intervention service could be commissioned from pharmacies

- Support for local and national health promotion campaigns on alcohol
- Health promotion materials and posters

Prevention and early detection of mental health conditions

- Dementia identification
- Depression identification
- Health promotion materials and posters, with information on where to go for support
- Advice and proactive signposting into services
- Staff trained as dementia champions
- Some local pharmacies will sign up with Halton Dementia Action Alliance and develop their own action plan.

Respiratory Disease

- NMS for patients newly prescribed a medicine for respiratory disease
- Targeted MURs could improve patients ability to use their inhalers properly
- Support and advice to get maximum benefit from medicines adherence which would all improve management of their condition and reduce hospital admissions and improve their health.

Hypertension

- BP checks
- Advice on understanding BP measurements such as 'Know your numbers'
- Signposting to primary care and lifestyle services
- Raising awareness of importance of BP checks
- Medication advice including MURs and NMS

6.4 A Safer Halton

Any improvement made to the drugs and alcohol services achieved as a result of healthy living pharmacies could impact on the number of crimes perpetrated as a result of drugs and alcohol misuse.

6.5 Halton's Urban Renewal

Pharmacies are an integral part of local communities and provide a vital primary health care service to residents across the borough. They know and are known by the communities they serve, they already offer open access to trained health professionals and are aware of the health needs of both the individuals and the community as a whole

6.6 Corporate effectiveness and business efficiency

Evidence shows that Healthy Living Pharmacy is an effective service

7.0 RISK ANALYSIS

Failure to introduce Healthy Living Pharmacies in Halton will miss an opportunity to supplement the excellent work already being done to improve the health and wellbeing of Halton residents.

8.0 EQUALITY AND DIVERSITY ISSUES

Healthy Living Pharmacies will improve access to services for a range of vulnerable groups and will offer services and information relevant to all groups of the population they serve.

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

Document	Place of Inspection	Contact Officer
		Dr Ifeoma Onyia

Report Prepared by:
Lucy Reid Lead Pharmacist NHS Halton CCG
Dr Claire Forde Clinical Lead for Medicines Management NHS Halton CCG
Dr Ifeoma Onyia Public Health Consultant Halton Borough Council
Bertha Brown, Chief Officer, Halton, St Helens and Knowsley LPC

References:

1. HLP Pathfinder Work Programme Report Executive Summary April 2013
   http://psnc.org.uk/wp-content/uploads/2013/08/HLP-evaluation.pdf
   http://www.instituteofhealthequity.org/projects/evaluation-of-the-healthy-living-pharmacy-pathfinder-work-programme-2011-2012
2. Evaluation of the Tees healthy living pharmacy project
   https://www.npa.co.uk/Documents/HLP/Healthy-Living-Pharmacy-Evaluation-Tees.pdf
3. NPA Health Living Pharmacies
   http://www.npa.co.uk/Business-Management/Service-Development-Opportunities/Healthy-Living-Pharmacy/
4. Healthy living champions
   http://www.npa.co.uk/Documents/HLP/Healthy_Living_Champion_FAQs_12.11.pdf

REPORT TO: Health and Wellbeing Board

DATE: 8 July 2015

REPORTING OFFICER: Director of Public Health.

PORTFOLIO: Health and Wellbeing

SUBJECT: Joint Strategic Needs Assessment Summary update

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

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

2.0 RECOMMENDATION: That the report be noted.

3.0 SUPPORTING INFORMATION

3.1 Background to the JSNA summary document

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

In 2012 the first executive summary of the JSNA mapped across the life course (the approach advocated by the Marmot Review on tackle health inequalities) was presented.

This approach has continued to receive good feedback from various partnerships and stakeholders. As a consequence the revised annual summary has used broadly the same approach, updating data and information since the previous version.

3.2 Local development of the JSNA

The JSNA continues to be hosted on the Halton Borough Council website.

The JSNA is developed as a series of chapters, on a rolling

programme, with an annual dataset, annual summary and local health profiles, keeping the data updated.

The JSNA summary document outlines the data across five key life stages:

- Pregnancy and infancy (under 1 year)
- Children (1-15)
- Young adulthood (16- 24)
- Healthy adulthood (25-64)
- Older People (65 and over)

It also includes a set of data on wider determinants of health:

- Economic
- Community safety
- Housing
- Transport
- Social care & vulnerable people

This summary document is attached as Appendix 1.

3.3 **In depth assessments during 2014/15**

Updating a core dataset only gives a brief overview of the main health and social outcomes of the borough. To aid commissioning decisions it is sometimes necessary to explore an issue in more depth. The summary document presents the key findings of the detailed JSNA chapters and in depth health needs assessments developed during 2014/15, including health needs assessments that have been commissioned by the CCG (adult offenders in the community and ex-armed forces personnel) and collaboratively across the Liverpool City Region/ Cheshire & Merseyside.

These are:

- Adult offenders living in the community
- Health needs of ex-armed forces personnel
- Children's JSNA
- Pharmaceutical Needs Assessment
- Series of chapters on long term conditions
- Health needs of homeless people
- Fixed odds betting
- Dental Health Needs Assessment

3.4 **Key changes since the previous summary**

Despite the continuing challenges the borough faces many of the health indicators show year on year improvements. So whilst the borough's health continues to be, generally, worse than the England average, these improvements show that we are moving in the right

direction – we are doing the right things for the right people, who are then able to engage with services, making the most of them to bring about positive changes for themselves, their families and their communities.

Some highlights include:

- Average life expectancy for both men and women has improved
- Reduced levels of child obesity amongst Year 6 children (now similar to England levels)
- Improved levels of children achieving a good level of development by age 5. However, Halton figures remain some of the lowest in England
- Child immunisations and flu vaccination uptake continue to perform well
- Educational attainment continues to be good with the borough now performing above the England average
- Teenage pregnancy rates continue to fall
- Increased case finding of people with long-term conditions has reduced the gap between estimated prevalence and diagnosed levels of disease
- Hospital admissions due to alcohol during 2010-13, both all age and under-18s, have fallen compared to the previous period
- Unemployment rates have fallen although they remain at significant levels for some parts of the borough.
- Halton has good outcomes for Children in Care compared to England and its comparator boroughs.
- Rates of statutory homeless and households in temporary accommodation continue to be lower than England. The number of households which are prevented from becoming homeless has increased
- There have seen a fall in the percentage of households in fuel poverty, with rates in Halton below the England and North West averages
- The number of mortgage possession claims and orders has fallen.
- Clients and carers receiving self-directed support as percentage of all receiving community based support is higher than England and the North West
- The rate of all persons and children killed or seriously injured on the roads (2011-13) is statistically significantly lower than the England rate and the percentage reduction is greater.

However, some areas do remain difficult to improve and others have worsened since the previous reporting period:

- Internal differences in life expectancy for women have widened and remain significant for men also
- Smoking at time of delivery has improved but remains higher

than the Merseyside and England rate

- Hospital admissions due to accidental injury for children and older people remain high
- Hospital admissions due to self harm, ages 10 to 24 years, have increased since on the previous year. They are also significantly higher than England
- Smoking levels amongst routine & manual workers remain high although they have fallen. This means the gap between prevalence amongst this group and the overall population prevalence remains
- Premature mortality (death rates) have improved but remain some of the poorest in the country. However, compared to local authorities in the same socio-economic grouping as Halton, borough death rates are about average (apart from cancers were the borough performs worst)

3.5 **Findings for the JSNA long term conditions (LTC) chapters**

Halton has a higher proportion of its population stating that they have a limiting long term illness (LLTI) that affects their ability to carry out daily tasks than England. As with the England pattern, rates with LLTI in Halton increase with age and by social class amongst all age groups.

Halton also has a higher proportion of its population with three or more long term conditions. It has high rates of Disability Living Allowance claimants, including significant ward level variation.

People diagnosed with LTC, irrespective of their age, are offered an annual influenza vaccination (all those over age 65 are offered it). Uptake rates vary amongst those with different conditions, with rates being highest amongst diabetics and lowest amongst those with chronic liver disease. There is a World Health Organisation recommended target of 75% eligible population being vaccinated. This is not reached for any of the eligible groups. There are also practice level variations for each condition. Comparing uptake with this target it is possible to calculated that an additional 3,461 immunisations are needed to reach the target of 75% for at risk under 65 year olds.

Flu uptake amongst under 65s by condition, 2013/14, Halton CCG

	No vaccinated	% uptake	Extra required to meet 75% target
Chronic Heart Disease	1504	52.8	633
Respiratory Disease	3532	51.5	1612
Chronic Kidney Disease	488	59.7	126
Chronic Liver Disease	194	46	123
Diabetes	2314	63.5	420
Immunosuppression	494	55.2	178
Chronic Neurological Disease (including Stroke/TIA, Cerebral Palsy or MS)	788	51.1	369

Source: IMMFORM, PHE 2014

Diagnoses rates can be calculated for several LTCs, where there are modelling tools to estimate the total number of people in a given population likely to have a particular condition. These estimates can then be compared to the numbers on GP disease registers. Overall Halton does well for the level of disease it has diagnosed and the gap between estimated and diagnosed has been closing, following concerted efforts to case find these 'missing numbers'

LONG TERM CONDITION	MODELLED		OBSERVED	
	Number	Prevalence (%)	Number	Prevalence (%)
CHD	6971	6.01	5563	4.31
HYPERTENSION	32303	25.12	19332	14.99
STROKE	2883	2.24	2390	1.85
DIABETES	7549	7.34	10250	9.96
CKD	8267	8.16	4397	4.34
COPD	3664	2.84	3284	2.55

It is estimated that there are 8,933 men and 12,365 women with musculoskeletal conditions, with pain levels for at least half of these being severe enough to be disabling. It is also estimated that there are between 5,374-5,783 people with long-term nuerological conditions (excluding headache and migraine).

This places a substantial pressure on health and social care. For example, unplanned hospitalisation for chronic ambulatory care sensitive conditions measures how many people with specific long-term conditions, which should not normally require hospitalisation, are admitted to hospital as an emergency. Analysis shows rates are higher in Halton than for Merseyside and England. Emergency admissions for long-term nuerological conditions are higher in Halton than the national average whilst the rate for planned admissions is lower. Total costs per 1,000 population are higher, especially when considering those for emergency admissions.

People with long term conditions also have increased risk of complications and even death. For example, diabetics in Halton have a greater risk than diabetics across England for angina, heart failure, myocardial infarction and minor amputations. Mortality rates

for diabetes are higher in Halton than in the North West and England. For deaths under 75s it was nearly twice as high as England. People living in the most deprived quintile in Halton are three times more likely to die from diabetes as those living in the least deprived quintile

3.6 **Developments for the JSNA during 2015/16**

It is important to recognise that the JSNA is an on-going, continuous process, refreshing data to ensure its timeliness, and producing 'deep dive' needs assessments to assist commissioning decisions.

The final elements of the summary document detail plans for major refresh elements of the JSNA during 2015/16:

Completion of a number of chapters started late 2014/15:

- Lifestyles – sexual health; tobacco; healthy weight (including healthy eating and physical activity)
- physical and sensory disability amongst adults
- Completion of Respiratory chapter (part of long term conditions work)
- Completion of an in depth needs assessment jointly commissioned across Halton, Warrington and Cheshire West and Chester to look at the health needs of young offenders in the community
- Accidental injuries across the lifecourse

- Start the Older People JSNA (commenced June 2015). To include:
  - Analysis of results of older people's health & wellbeing survey (carried out by Liverpool John Moores University)
  - Mental health and emotional wellbeing, including loneliness
  - Care homes
  - Dementia
  - Falls

- Refresh of the detailed needs assessment for Learning Disabilities and Autism, September 2013.
- Air Quality
- Adult Carers
- Adult Safeguarding
- Mental Health, including community resilience
- Transport (including development of common framework across the Liverpool City Region to support implementation of the overarching Transport Plan for Growth)

4.0 POLICY IMPLICATIONS

4.1 The health needs identified in the JSNA have been used to develop the Health & Wellbeing Strategy.

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

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 None identified at this time.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**
Improving the Health of Children and Young People is a key priority in Halton and this is reflected in the JSNA, taking into account existing strategies and action plans so as to ensure a joined-up approach and avoid duplication.

6.2 **Employment, Learning & Skills in Halton**
The above priority is a key determinant of health. Therefore improving outcomes in this area will have an impact on improving the health of Halton residents and is reflected in the JSNA.

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

6.4 **A Safer Halton**
Reducing the incidence of crime, improving community safety and reducing the fear of crime have an impact on health outcomes, particularly on mental health. Community safety is part of the JSNA.

6.5 **Halton's Urban Renewal**
The environment in which we live and the physical infrastructure of our communities has a direct impact on our health and wellbeing and will therefore need to be addressed within the JSNA and Health and Wellbeing Strategy. Health Impact Assessments of the Local Development Plan, the Local Transport Plan and the HBC Field development as part of 3MG have taken place. Evidence reviews on the health impacts of housing and ways of addressing these have been undertaken and an assessment of the health and healthcare costs of fuel poverty presented to the housing partnership.

7.0 RISK ANALYSIS

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

8.0 EQUALITY AND DIVERSITY ISSUES

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

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

None within the meaning of the Act.

Appendix 1

JSNA summary document

HALTON JOINT STRATEGIC NEEDS ASSESSMENT (JSNA)

PURPOSE:
This document is an annual summary - a supplementary document to support the updating of the JSNA. It reflects work undertaken during 2014/15 and developments that are due to take place during 2015/16.

Updating the JSNA:
This document is the third to use the '*Life course'* approach to summarise data and priorities from the suite of JSNA documents.

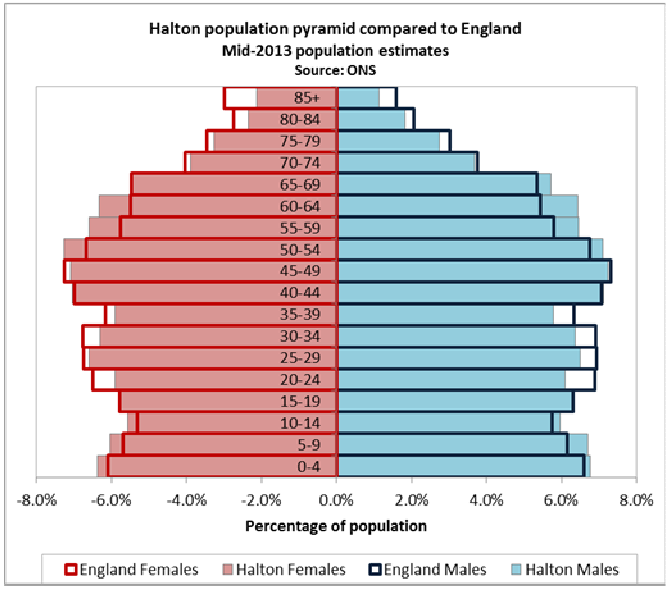
The Health & Wellbeing Board first Health & Wellbeing Strategy, 2013-2016, is entering its final year. Much work has been undertaken across all 5 priorities, with separate strategies and action plans developed and implemented for each one.

The health issues and social determinants identified in each round of the JSNA continue to present challenges locally, although there has been much progress.

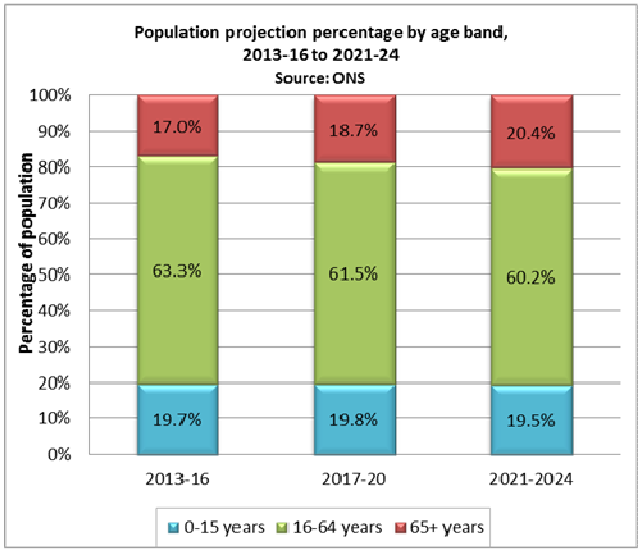
The full JSNA, together with the annual data updates spread sheet, can be found on Halton Borough Council's website at http://www3.halton.gov.uk/Pages/health/JSNA.aspx

If you require any further information about the Halton JSNA please contact Sharon McAteer at: sharon.mcateer@halton.gov.uk or a member of the Public Health Evidence & Intelligence Team at: health.intelligence@halton.gov.uk

Produced by Public Health Evidence & Intelligence Team, Halton Borough Council, April 2015



- As at the 2011 Census, Halton's population was 125,970
- 48.8% male to 51.2% female
- Population projections based on the 2011 census suggest the younger age band will remain fairly static, with the working age population to shrink and older age band will increase as a proportion of total population
- Population registered with Halton GPs is 129,582 (January 2015).



Just a few success stories from across the borough

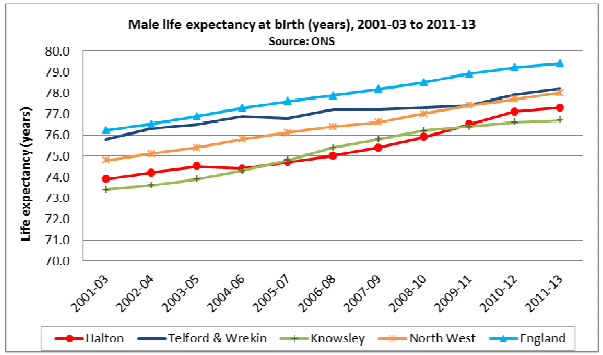
- Unemployment rates as at December 2014 (2.6%) were lower than those seen in December 2013 (4.0%).
- The number of young people not engaged in education and training (NEET) has decreased from 8.9% in 2012 to 8.4% in 2013.
- Attainment of 5 or more A*-C including English and Maths was higher for Halton (57.2%) than the England average (53.4%). Overall, 64.9% of pupils in Halton achieved 5 A*-C's, which was also higher than the England average (63.8%).
- The level of excess winter deaths is lower than England average.
- The infant mortality rate has fallen and is now below the national average.
- The percentage of Year 6 children with excess weight decreased in 2013/14, and is now similar to the England average.
- Under 18 hospital admissions for alcohol-specific conditions continues to decrease.
- The rate of statutory homelessness is lower than England average. There has been an increase in the number of households prevented from becoming homeless
- Child immunisation rates are higher the England average.
- By the end of March 2014, a higher percentage of children in care were up-to-date with their immunisations (95.2%) compared to the England average (87.1%).
- The under 75 mortality rates from cancer and circulatory disease continue to decrease

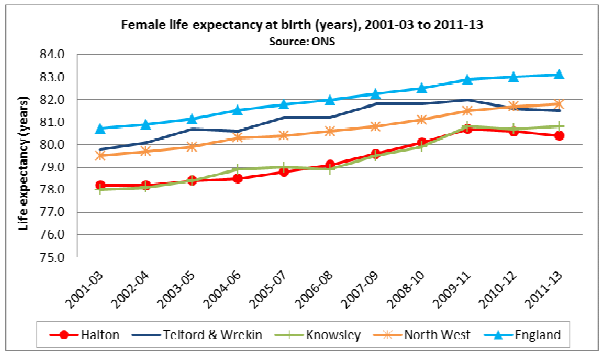
…… and lots of others.

But significant challenges remain

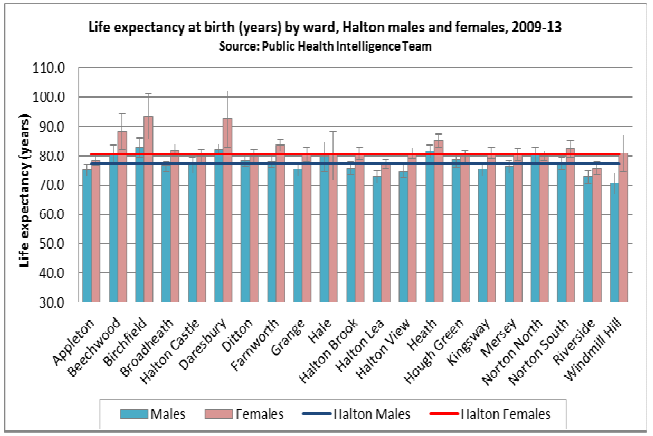
- Inequalities still exist between Halton and its comparators and within the borough
- Smoking at time of delivery and breastfeeding rates remain worse than the England averages
- There has been an increase in the number of emergency hospital admissions
- Child poverty and child development remain significant issues for the borough
- Excess weight at reception year has increased
- Hospital admissions due to self harm amongst 10-24 year olds is significantly higher than England
- It is estimated that the number of older people with dementia will continue to rise. Halton has a good diagnosis to expected prevalence ratio
- Cancer screening coverage and influenza vaccination uptake amongst 65+ have fallen slightly
- The proportion of working age adults with no qualifications is higher than England, and average weekly earnings are lower
- The rate of Disability Living Allowance claimants remains higher than England

Life expectancy

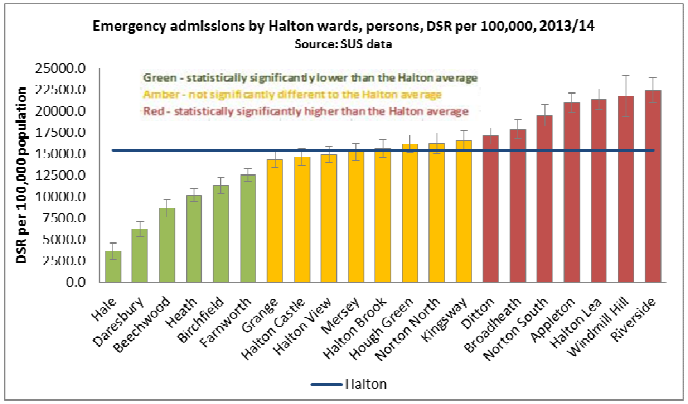




- Life expectancy has risen steadily over time, however, it has decreased slightly for females in Halton since 2009-11.
- In 2011-13 average life expectancy in the borough was 77.3 years for men and 80.4 years for women. However, the borough is consistently lower than the England average.
- Internal differences in life expectancy range from 70.7 years for males in Windmill Hill to 82.9 years in Birchfield. For females, the differences range from 75.8 years in Riverside to 93.4 years in Birchfield ward. A difference of 12.2 years for males and 17.6 years for females.
- This is a widening of internal inequalities for men from 10.4 years and also a widening for women from 13.3 years during the previous reporting period 2008-12.

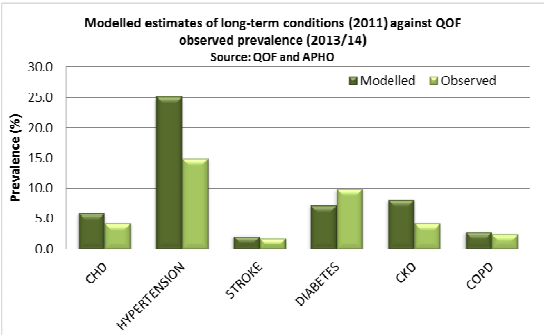


Emergency admissions to hospital



- There were 17,881 emergency admissions, an increase on the previous years figure of 16,487.
- Injuries accounted for 13.9%, respiratory for 12.4%, circulatory 9.1% and digestive 8.3%.
- Compared to 2012/13, Riverside ward remains the ward with the highest admissions rate and Hale remains the lowest.
- There have been year on year improvements in the number of people identified with long term conditions (except for CHD and CKD which saw a slight decrease between 2012/13 and 2013/14).
- Out of the six diseases, COPD has the smallest difference between modelled and observed prevalence.

Disease prevalence: expected against observed rates



LONG TERM CONDITION	MODELLED		OBSERVED	
	Number	Prevalence (%)	Number	Prevalence (%)
CHD	6971	6.01	5563	4.31
HYPERTENSION	32303	25.12	19332	14.99
STROKE	2883	2.24	2390	1.85
DIABETES	7549	7.34	10250	9.96
CKD	8267	8.16	4397	4.34
COPD	3664	2.84	3284	2.55

HALTON JSNA: DATA ON HEALTH & WELLBEING ACROSS THE LIFECOURSE -4-

Pregnancy & 1st year of life

1603 live births (1% pop)

- Smoking at time of delivery ***19.0%*** *(2013/14),* higher than the Merseyside (17.6%) and England (12.0%) averages
- % Low birth weight has decreased. Now ***6.8%*** *(2012),* slightly lower than England rate (7.3%)
- Breastfeeding initiation ***51.6%*** and breastfeeding at 6-8 weeks ***21.8%*** *(2013/14).* Similar to the previous year but remaining lower than comparators
- Access to antenatal care within 12 weeks of pregnancy ***86.0%*** *(Q1-Q2 2014/15)*
- Infant mortality ***3.3 per 1,000 live births*** (2011-13) which is lower than the England (4.1) and North West (4.4) averages

Childhood (1-15)

23,500 children (19% pop)

- Child Poverty **25.7%** *(2012)*
- Hospital admissions due to asthma (0-18 years), crude rate ***296.1 per 100,000 population*** *(2012/13)*
- Hospital admissions caused by injury *(2012/13)* ***1306.0 per 100,000 population.*** Higher than England average (1038.0)
- Children in Need ***1146*** (as at 31 March 2014) (higher rate than NW and England)
- Looked After Children ***210*** (as at 31 March 2014)
- Excess weight: ***Reception 29.5%,*** an increase on previous year
- Excess weight ***Year 6 33.7%,*** a reduction on previous year. Now similar to England
- Immunisation : MMR 1st & 2nd dose by 5years **93.0%** (2013/14). Significantly higher than England average
- Children achieving a good level of development at the end of Reception, ***46%.*** This is an improvement on the previous year but remains lower than comparators and one of the lowest in the country.

Young adulthood (16-24)

13,700 people (11% pop)

- NEETs 2013 **370** people aged 16-18 (8.4%). A decrease on the 2012 figures, but remains higher than comparators
- Teenage pregnancy: ***33.3 per 1,000 females aged 15-17*** (2013), a reduction on the 2012 rate
- Hospital admissions due to alcohol: ***73.5 per 100,000 population*** (2010-13), a reduction on previous period
- Reduction in sexually transmitted infections 2013/14: ***Chlamydia 454 cases; Genital warts 181 cases***
- Chlamydia screening (2013/14) ***29.7%*** 15-24 year population tested (England 24.9%)
- Hospital admissions due to self harm, ages 10 to 24 years, ***636.4 per 100,000*** (crude rate, 2010-13), an increase on the previous year. Significantly higher than England (346.3)

Healthy adulthood (25-64)

66,900 people (53% pop)

Lifestyle choices:
- Smoking prevalence ***18.4%***; manual & routine workers ***21.9%***
- Binge drinking ***22.7%***
- Obese ***35.2%***

Number of people with long term conditions (all ages) (QOF 2013/14):
- Hypertension ***19,332*** (15%)
- CHD ***5,563*** (4.3%)
- Diabetes (ages 17+) ***7,549*** (7.3%)
- COPD ***3,284*** (2.6%)
- Stroke ***2,390*** (1.9%)
- Depression ***7,342*** (7.3% GP pop aged 18+)

Coverage/uptake of cancer screening (average for CCG, range across GP practices):
- Breast: average ***69.8%***, range ***57.6% to 78.5%***
- Cervical average: ***75.8%***, range ***71.7% to 82.8%***
- Bowel: average ***48.8%***, range ***39.0% to 56.0%***

Hospital admissions (all ages, rate per 100,000 population, 2013/14):
- Emergency admissions ***15,365***
- Alcohol specific ***948***
- Alcohol related ***2,741***
- Cancers ***1,406***
- Heart Disease ***790***
- Stroke ***285***
- Digestive ***4835***

Older people (65+)

20,300 people (16% pop)

Life expectancy (2011-13)
- Males ***77.3*** (England 79.4)
- Females ***80.4*** (England 83.1)

Life expectancy at 65 (2011-13)
- Males ***17.1*** (England 18.7)
- Females ***18.8*** (England 21.1)

Inequalities in life expectancy (by ward 2009-13)
- Males ***12.2 years*** (70.7 in Windmill Hill, Birchfield 82.9) (an increase in inequality)
- Females ***17.6 years*** (Riverside 75.8, Birchfield 93.4) (an increase in inequality)

All age all cause mortality (DSR per 100,000 population) 2010-12:
- Males ***1,378*** (England 1,151)
- Females ***1,083*** (England 846)

- Hospital admissions (2012/13) injuries due to falls , aged 65+, ***3,293 per 100,000 population*** (England 2,011)

- Dementia: estimated ***1,287 people*** aged 65+: QOF register (2013/14) **761** people diagnosed (better diagnosed to expected ratio than North & England)

- Flu vaccination uptake 65+ CCG average ***73.8%*** (2014/15), ***range 67.2%-79.4%.*** 7 out of 17 achieved 75% target. (England 72.8%)

Populations all based on mid-2013 population estimates rounded to the nearest 100 (ONS 2014) except live births which is actual numbers for 2013.
Population percentages rounded to nearest whole number (based on population of 125,970)

HALTON JSNA: DATA ON WIDER DETERMINANTS OF HEALTH

Economic

- Unemployment (Job Seekers Allowance) rates falling: *2.6% = 2061* adults (December 2014)
- Highest unemployment rate (Job Seekers Allowance) in Windmill Hill *5.2%*
- Working age adults claiming out of work benefits fallen: *12,040* (May 2014) or *14.9%*
- Windmill Hill *31.9%* working age adults claiming out of work benefits (May 2014) is the highest in the borough (lowest 3.4% in Birchfield)
- Youth unemployment rate (18-24 years) *4.9% = 520* people (December 2014)
- Business survival rate (after 1 year) higher than England average at *94.1%* (Eng 86.6%)
- Average weekly earnings for full-time workers *£485* (lower than England £521)
- Gap between Halton adult qualifications & GCSEs compared to England has narrowed since 2010 across all levels.
- Proportion of working-aged adults with no qualifications higher than England average, *10.9%* (Jan 2013-Dec 2013). England 9.1%
- *74.5%* working aged adults economically active (Oct 2013-Sept 2014) (NW 74.7%, Eng 78.0%)

Community Safety

- Anti-social behaviour incidents have fallen: *57.6 per 1,000* residents
- Hate crimes *0.5 per 1,000* residents
- Domestic incidents increased rate: *125 per 1,000* residents
- Rate of domestic violence fallen: *30 per 1,000* residents
- Levels of crime were seen as important indicators for making an area a good place to live (2011 Residents survey)
- Overall crime rate has increased from 2011. Now *61.5 per 1,000* residents

(all data is for 2013)

Housing

- At 31st March 2013 there were *54,833* dwellings in Halton
- *25%* housing in Halton is social rented accommodation (higher than the England level of 10%)
- There were *50* Statutory Homeless Households and *16* households in temporary accommodation (2013/14). This means rates per 1,000 households are much lower in Halton than in England
- Homelessness was prevented for a further *744* households during the year, an increase in previous period
- In 2012 *9.2%* of households were in fuel poverty. This is a fall on the previous year (9.6% 2011). The Halton percentage is lower than England (10.4%) and North West (11.3%)
- During 2014 *126* mortgage possession claims were issued, of which *44* resulted in possessions, a reduction on 2012/13 figures
- Over the same period there was an increase in Landlord Possession claims issued to *560* . However, there was a fall in possession orders, to *98*

Transport

- The number of cars licensed in Halton between 2004 and 2013 increased by *6.3%*
- Since 2001, Halton has experienced an *increase in traffic growth*. This increase is greater than the increase experienced by Great Britain as a whole
- *27%* of households are without private transport (no car/van), compared to 25.8% across England (Census 2011)
- *40.4%* use their car/van to get to work, *5.6%* travel on foot, *1.3%* use a bicycle, *4.1%* bus, *4.3%* car passenger (Census 2011)
- The rate of all persons and children killed or seriously injured on the roads (2011-13) is *31.8 per 100,000* (120 people). This is significantly lower than the England rate (39.4)
- A further *1,026* people were slightly injured (2011-13)
- In 2013 the number of children killed or seriously injured has decreased by *65%* from the 2005-09 average. England average is 34%.

Social care & vulnerable people

- Proportion older people (65+) discharged from hospital to intermediate care/ rehabilitation/ re-ablement who are still living 'at home' 91 days after discharge: *63.6%*. This is a decrease on previous figures and lower than NW and England. Higher for females (65.1%) than males (61.1%) and for those aged 75-84 (77.8%) than total 65+ population
- Clients and carers receiving self directed support as percentage of all receiving community based support *82.5% = 4,310* out of total of 5225. Higher than North West (67.5%) and England (61.9%)
- Adults with learning disabilities in settled accommodation *76.0%,* higher than England (68.9%)
- Proportion of adults on CPA who were followed up within 7 days after discharge from psychiatric inpatient care *97.0%* (2013/14). England 97.3%
- Rate of Disability Living Allowance claimants *8.4%* (England 5%) (Feb 2014)

HALTON JSNA: AREA FORUM (AF) HEALTH & WELLBEING PRIORITIES

AF1
Broadheath
Ditton
Hale
Hough Green

Similar to the Halton averages across all academic, environmental and crime indicators.

Similar to the Halton figures for unemployment – however this is still worse than the England figures.

Overall, Broadheath, Ditton and Hough Green similar to the Halton average for the majority of the health indicators.

However, Hale tends to have better health than the Halton and England average.

Alcohol-specific hospital admissions for males are significantly higher than the Halton average for Broadheath and Hough Green.

Smoking quitter rates are significantly higher for Broadheath and Hough Green, but are significantly lower for Hale.

AF2
Appleton
Kingsway
Riverside

Higher than average levels of 16-18's Not in Education, Employment or Training (NEET) and higher than average levels of children claiming free school meals.

High levels of anti-social behaviour, burglary, criminal damage to dwellings and deliberate fires.

Higher rates of unemployment, people on out-of-work benefits and youth unemployment than the Halton average. The area also has low average house prices.

Generally worse than the Halton average for the majority of the health indicators, particularly in terms of alcohol hospital admissions and life expectancy.

Smoking quitter rates significantly better for all wards in the Area Forum compared to the borough average.

AF3
Birchfield
Farnworth
Halton View

Lower than average levels of children claiming free school meals.

Crime is comparatively low.

Relatively low levels of unemployment, worklessness, youth unemployment and 16-18's Not in Education, Employment or Training (NEET). High levels of GCSE attainment (5+ A*-C inc. English and Maths).

Health generally better than the borough average.

Levels of overweight and obese children are around the same or lower than the Halton and England averages.

Admissions to hospital due to alcohol-related and alcohol-specific conditions are lower than the borough average.

Smoking quitters rate significantly worse than the borough average.

AF4
Grange
Halton Brook
Heath
Mersey

Has the largest population out of the 7 area forums in Halton.

Quite poorly performing economy (when compared with Halton's average) and quite poor crime rates.

However, Heath ward is an exception, as this area generally performs better than the Halton average across most indicators.

Grange, Halton Brook and Mersey generally perform similar to or below the borough average for the health indicators. However, Heath tends to perform better.

The percentage of overweight or obese children in Reception and Year 6 is higher than the Halton average, (except for Year 6 in Halton Brook).

Percentage of low birth weight babies is higher than the borough average.

AF5
Halton Castle
Norton North
Norton South
Windmill Hill

Higher than average levels of NEET and lower GCSE pass rates than borough average.

Contains some of the most deprived areas in Halton. Norton North is an exception to this.

Very high levels of unemployment, youth unemployment and worklessness. Very low average house prices.

Deaths under 75 years of age due to cancer higher than the Halton and England averages (except Norton North).

Alcohol-attributable and specific hospital admissions are higher than the Halton and England averages (except Norton North).

The percentage of overweight or obese children in Reception is higher than the borough average.

Smoking quitter rate is higher than the borough average, except for Halton Castle which is slightly lower

AF6
Beechwood
Halton Lea

Consists of two differing areas, the ward of Beechwood is one of the most affluent in Halton, with low levels of unemployment and crime.

Halton Lea is quite deprived, with high levels of unemployment and worklessness and low house prices.

Crime also remains an issue in Halton Lea But is lower than Halton average in Beechwood.

Beechwood better than the borough average for all but two of the health indicators (cancer incidence is slightly higher and the smoking quitter rate is lower).

Halton Lea worse than the Halton and England averages for the majority of health indicators.

AF7
Daresbury

Has the smallest population out of the 7 area forums in Halton .

NEETs: lower than borough average.

All crime indicators are better than borough average.

Area one of the most affluent in Halton, with low levels of unemployment, and higher than average house prices.

Better than the borough average for the majority of health indicators.

Highest male life expectancy in Halton.

The percentage of overweight and obese children in Reception and Year 6 is slightly higher than the England and Halton averages.

Children's JSNA

- High levels of risk factors for development of emotional health & wellbeing problems and mental ill health
- High level of A&E attendance and hospital admissions due to accidental injuries
- High levels of hospital admissions overall compared to England and North West. In addition to accidents the admission rates for asthma, diabetes and epilepsy are comparatively high
- Concerns expressed about continued ability to maintain good results for many of the indictors where progress has been made and being able to continue driving them in the right direction
- Some issues remain significant and resistant to change. These include breastfeeding and smoking during pregnancy. Small improvements have been made but levels remain low compared to the national and regional averages
- Even for issues that have improved e.g. education attainment, there remain inequalities across the borough that need to be addressed
- Significant time of change: new services and payment tariffs, organisational change and financial pressures against a back-drop of welfare reforms and continuing economic hardship
- Risk taking behaviour is a key issue detailed in the school-age children chapter

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

The Safeguarding and Children in Care chapters were presented to the Halton Safeguarding Children Board & Executive Board in June and July 2014. They were used to support the recent Ofsted inspection.

Child Speech, Language and Communication Needs (SLCN) Assessment

❖High level of risk factors that are associated with development of SLCN. There is a strong association between SLCN and deprivation

❖Estimated 1,131 – 2,306 children aged under 5 and 225 -459 aged 5 have transient SLCN

❖Estimated 1,355 (aged 0-7); 1,788 (aged 8-19); 941 (aged 20-25) have persistent, long-term SLCN

❖Estimated 813 (aged 0-7); 1,083 (aged 8-19); 565 (aged 20-25) have specific primary SLCN

❖Much lower numbers accessing SLCN services than estimated numbers

❖Highest rates of children accessing SLCN were in more deprived wards. However, correlation between access and deprivation at Lower Super Output Area was weak

❖Percentage of children with behavioural and social difficulties higher in Halton than regionally and nationally

Adult offenders in the community

❖There are clear links between the wider determinants of health and factors affecting reoffending (such as sustainable housing or employment), which can create a vicious circle

❖Local issues relate to:

- ❖ Underlying alcohol and drug misuse issues
- ❖ Being able to effectively manage offenders with complex needs, particularly when offenders present with a mix of personality disorders and other interconnected drug misuse characteristics
- ❖ Mental health, personality disorders and learning disabilities
- ❖ Access to healthcare and the role of GPs and dentists in particular

Health needs assessment for ex-Armed Forces 'Veteran' personnel

❖Nationally, Veterans may have health and help seeking behaviours that are influenced by their experience in the Armed Forces. Consultation rates while serving are about twice the non-military average, partly due to a greater rate of musculoskeletal injuries and partly because in the Armed Forces they are not able to self certify sick leave

❖The diverse range of support options , especially third sector support, reflects the diverse range of people who are in the Veteran community (for example, needs vary according to age, gender, socio-economic classification, rank, combat history, etc) and can be seen as a positive feature – as long as the overarching service 'offer' in Halton is co-ordinated and clearly understood

❖There are an estimated 6,412 Veterans living in Halton, with 3,406 of these aged under 65. There is a lack of local data on population numbers and amongst local services on the needs of Veterans

❖Veterans face a unique set of circumstances that lead to some facing mental health problems. Service responses need to be sensitive to these

❖It is important to work with local Veteran support groups, to target alcohol awareness campaigns, and ensure training in veteran-sensitive practice is available to health professionals

❖Clarify the 'support offer' from support groups

Pharmaceutical Needs Assessment (PNA)

❖Overall access in terms of community pharmacy locations, opening hours and services, is considered to be adequate

❖The PNA did not identify a current need for new NHS pharmaceutical service providers in Halton

❖Any decision to extend existing locally commissioned services or introduce new ones should initially be done by discussion with existing providers

❖There is adequate provision for smoking cessation services, substance misuse (needle & syringe exchange and supervised administration services) and emergency hormonal contraception across the borough. Pharmacies are a key component of this provision, with easy access, and this should be maintained

❖Community pharmacies are well placed to take part in local and national campaigns around alcohol misuse, cancer prevention and awareness, mental health and other issues. Under the essential services contract pharmacies should support six health education campaigns per year

❖There is generally good access to both New Medicines Reviews and Medicine Use Reviews across the borough

❖There is currently partially adequate access to Care at the Chemist, including 100-hour evening and weekend provision. This is being addressed

❖Pharmacies are well placed to detect the early signs of mental health problems and could refer people in to the single point of access to mental health services and to participate in awareness raising campaigns

❖There is currently no evidence to suggest that more provision of palliative care services is required. Geographical spread and formulary has been reviewed during 2014/15

KEY FINDINGS FROM 2014/15 LONG-TERM CONDITIONS CHAPTERS

Long Term Conditions Overall

❖According to the 2011 Census, 11.58% of Halton residents reported that they had a long-term health problem that limited their day to day activities a lot. There is an association with social class across all age groups

❖Analysis of the GP survey showed that Halton has a higher percentage of its population with 3 or more long-term conditions than nationally, just under 15% in Halton compared to just over 10% for England

❖The percentage of patients saying they feel supported to manage their long term condition was similar to England

❖Halton has statistically higher rates of unplanned hospitalisation for chronic ambulatory care sensitive conditions than England

❖Halton has a higher percentage of Disability Living Allowance claimants than nationally

Long Term Neurological Conditions (LTNC)

❖Apart from epilepsy there is no routinely collected local data on LTNC.

❖The overall percentage of eligible patients receiving interventions is lower across Halton CCG than its comparators. Added to this there are wide practice-level variations

❖Emergency admissions for LTNCs are higher in Halton than the national average whilst the rate for planned admissions is lower. Total costs per 1,000 population are higher, especially when considering those for emergency admissions

❖Half of Halton GP practices had emergency admission rates above expected levels and all have outpatient rates below the North West and England averages

Musculoskeletal Conditions (MSK)

❖It is estimated that 8,933 men and 12,365 women in Halton have MSK. For about half, the level of pain experienced due to MSK are severe enough to cause disablement

❖Lifestyle factors can contribute significantly to the prevalence of musculoskeletal conditions

❖There are just over 1,000 people on QOF GP disease registers due to arthritis but the estimates suggest as many as 3,000 people may have the condition. The prevalence of arthritis is slightly higher than comparators but the percentage receiving interventions is lower than Merseyside (but higher than England)

Cardiovascular Disease (CVD)

❖Local lifestyle services demonstrate that they are able to support people to make lifestyle changes such as loosing weight and stopping smoking

❖There is a clear deprivation gradient in CVD mortality with rates highest in the most deprived quintile and lowest in the least deprive

❖The estimates levels of CVD in Halton are similar to England and lower than in the North West. Diagnosis rates for CHD, stroke and hypertension are 73%, 72% and 48% respectively

❖There is significant variation in admission rates for CVD across the borough. Deprivation probably accounts for about half of the relationship

❖Halton is currently on par or slightly better at managing patients with CVD than its comparators. However, there is practice-level variation with several practices with 20% or more of patients newly diagnosed with hypertension not having had a CVD risk assessment

Diabetes

❖Need to be able to routinely monitor adult obesity levels and to assess outcomes of adult Specialist Weight Management Service against levels of need

❖Halton CCG diagnosis rate 2013/14 was 73.6%, ranging from 41.6% to 91.2% at practice level. This means there may be up to 2,700 people in Halton with undiagnosed diabetes

❖Overall 2013/14 QOF performance across diabetes care processes was lower than Merseyside, North and England as a whole

❖However, for 2012/13 the National Diabetes Audit showed that Halton CCG had a higher proportion of patients receiving the NICE recommended 8 care processes was higher than the England

❖There is significant variation across electoral wards with a correlation between emergency admissions and deprivation

❖Diabetics in Halton have a greater risk than diabetics across England for angina, heart failure, myocardial infarction and minor amputations.

❖Mortality rates for diabetes are higher in Halton than in the North West and England. For deaths under 74 it was nearly twice as high as England

❖Inpatient mortality was higher than the England rates

❖People living in the most deprived quintile in Halton are 3 times more likely to die from diabetes as those living in the least deprived quintile

Health Needs of Homeless People

❖Analysis of 2012/13 data showed the most common reason for statutory homelessness in Halton was the 'loss of rented or tied accommodation' (25%). The next most common reason was 'violent relationship breakdown with partner' (18%)

❖In 2012/13, 18% of all housing assistance applications were eligible, homeless, but not in priority need (i.e. mainly single homeless). This is the same as the Liverpool City Region (LCR) rate and lower than the England rate of 20%

❖There were 280 single homeless people moving on from Supporting People services in 2012/13 (primary client group):

- ❖ (22%) had physical health needs (compared to 32% in LCR) and 90% had these needs met (87% LCR)
- ❖ (20%) had mental health needs (28% LCR) and 82% had these needs met (78%LCR)
- ❖ (35%) had substance misuse issues (37% LCR) and 61% had these needs met (53% LCR)

❖During a 9 month period (1/4/13 to 31/12/13), there were 44 alcohol clients and 62 drug clients who were homeless. Halton has the highest proportions of homeless drug and alcohol clients, at more than 1 in 4 of all clients (22% of alcohol clients and 27% of drug clients) – compared to around 1 in 7 across LCR

❖There is no dedicated GP lead or nursing team for the homelessness population in Halton. There are weekly sexual health screening drop-in sessions at the hostel and various health and well-being block sessions

❖*Hospital Outreach Work:* A recent pilot at Whiston Hospital involved the outreach worker ensuring that on discharge, homeless patients can be found accommodation and offered GP and drug and alcohol services if needed. Readmission statistics need to be analysed to evaluate whether the project is helping to prevent unnecessary hospital admissions amongst homeless people

Fixed Odds betting

❖National surveys show that 68% of men and 61% of women aged 16 and over gamble. However, only 0.8% of men and 0.2% of women are estimated to be problem gamblers. However, obtaining local data on gambling in Licensed Betting Offices is problematic

❖There are an estimated 378 men in Halton who are problem gamblers and 101 women

❖There are around 27 betting shops per 100,000 population in Halton, lower than Liverpool, Knowsley and Sefton but slightly higher than the Wirral or St Helens

❖National research shows that Licensed Betting Offices are far more likely to be in areas of high socio-economic deprivation

❖Respondents to a survey across the LCR reported a wide range of impacts from problem gambling, including impact on family life, relationships and employment, as well as financial impacts. Problem gambling can lead to problems with sleep, due to anxiety, and has a 'ripple' effect

❖Some respondents felt that there was a lack of services for problem gamblers, compared to services for those with drug and alcohol problems

Dental Health

❖Health in Halton is generally worse compared with the average health of the population in England. Research has shown that dental disease correlates closely with social and economic deprivation, meaning that usually, dental need is greater in areas of deprivation

❖The common risk factors to poor oral & dental health include unhealthy diet, smoking and harmful alcohol use. Halton compares worse than the national average for most of these risk factors

❖Around 1 in 3 (33.6%) children aged 5 have decayed, missing or filled teeth. (England average of 27.9%, North West average 34.8%)

❖Child dental access rates in Halton are better than the England average for all ages. Adult access rates are 58.1%, also higher than the England average

❖The majority of the Halton area has dental practices within a 8.4 minute drive. However, for those without a care, there are significant densely population areas that lie outside a 15 or 30 minute walk time distance

Full needs assessments detailed can be found at http://www.liv.ac.uk/PublicHealth/obs/publications/report/obs_report.htm

It is not the intension of JSNA to update every element on an annual basis. The full refresh will fall in line with the Health & Wellbeing Strategy timeline i.e. it will be a three-year rolling programme of work. In addition to in-depth chapters, the core dataset for the overall JSNA and various local profiles will be updated on an annual basis.

The following information details key developments for 2015/16.

For completion:

- Lifestyles
  - Sexual health
  - Tobacco
  - Healthy Weight, including healthy eating and physical activity
- Physical & Sensory Disability (Adults)
- Accidental Injury
- Health and wellbeing needs of Young Offenders living in the community (collaboration with Warrington and Cheshire West & Chester)
- Respiratory Health (part of long term conditions work)

Focus on: older people

When the findings of the Children's JSNA were presented to the Health & Wellbeing Board in the summer 2014, the Board requested the next round of JSNA updates included a focus on older people. This is being scoped and is likely to include:

- Results of Older People's Health & Wellbeing Survey
- Falls
- Care Homes
- Dementia
- Emotional Health and Wellbeing

Focus on: Air Quality

The JSNA currently does not include any reference to environmental health issues. Given the history of and continuing concern about air quality, work has begun on a new chapter detailing the level of air pollutants, causes, best practice and current action to monitor and address it. This can then be used for onward planning of preventative and remedial activity needed. It will link closely to the Local Development Plan and Transport Plan.

Focus on: Learning Disabilities and Autism

For 2014/15 JSNA it was decided to split physical & sensory disabilities from Learning Disabilities and Autism. During summer/autumn 2013 Halton led on work across Merseyside and North Cheshire on an in-depth health needs assessment. This now needs updating to support a refresh of the local strategy. A scope is being agreed with both local authority and CCG commissioners.

Other priorities:

During discussions with commissioners and policy leads from both the local authority and CCG a number of other areas for consideration within the JSNA have been identified:

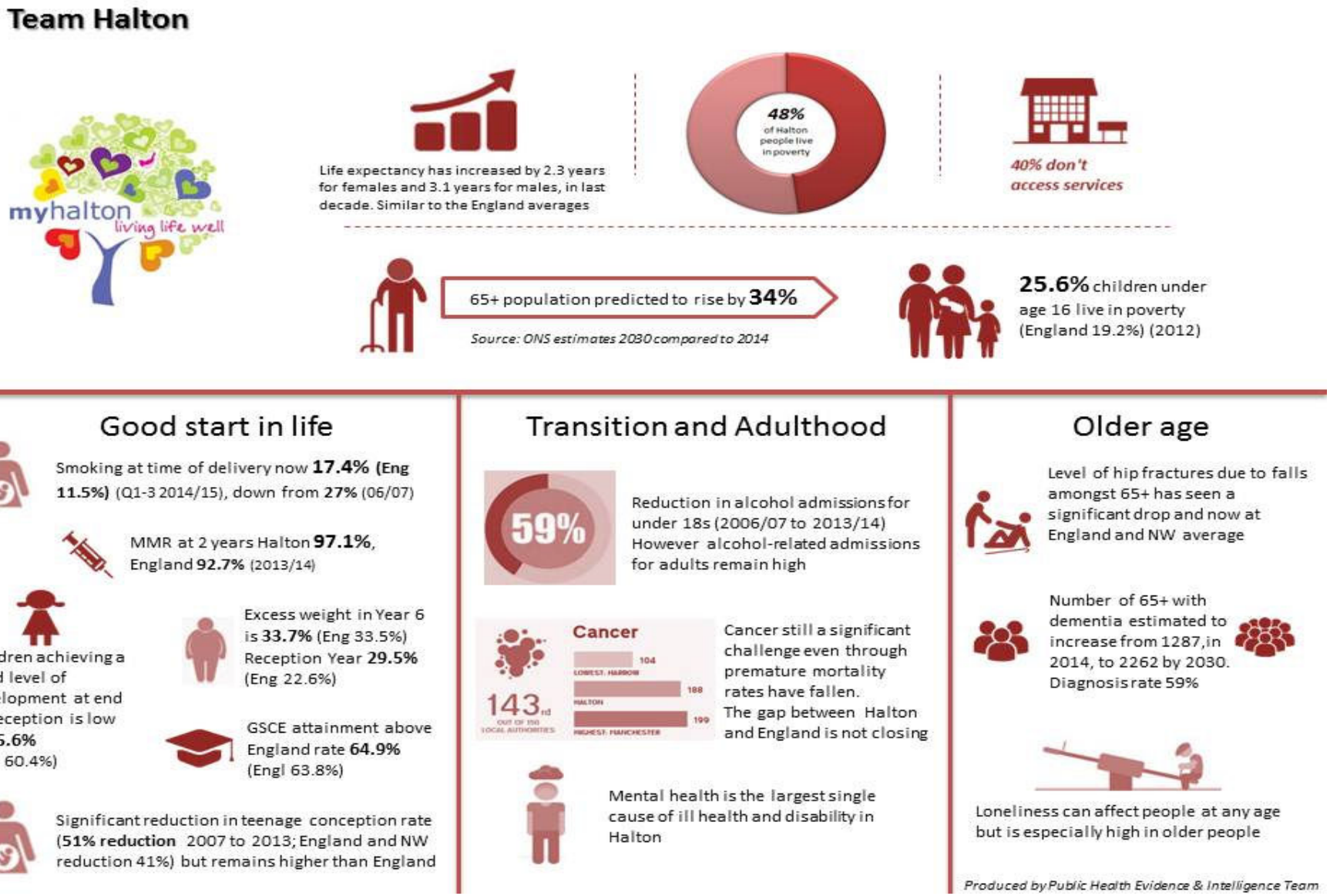
- Adult Safeguarding
- Carers (Adults)
- Transport
- Mental Health, including community resilience

Collaborative working to assess need

It is important to continue to work on a bigger footprint where this delivers economies of scale and enables scarce skills to be utilised locally.

- The new Cheshire & Merseyside Public Health Intelligence collaborative research & intelligence service will go live by summer 2015
- Continue to work with the Trauma & Injury Intelligence Group (TIIG) on bespoke analysis of accidents and other injuries being presented at A&E departments

Below is an example of an 'infographic' recently developed to provide a brief snapshot of JSNA issues across the lifecourse. We aim to produce one for each JSNA chapter from this year onwards. Bespoke pieces can also be done. Contact sharon.mcateer@halton.gov.uk to discuss.



REPORT TO: Health and Wellbeing Board

DATE: 8th July 2015

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Wellbeing

SUBJECT: Health and Wellbeing Strategy Action Plan update 2015

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 The purpose of this report is to provide the Health and Wellbeing Board with an update on progress with the Health and Wellbeing Strategy action plans.

2.0 RECOMMENDATION: That the Board note the contents of Appendix 1 and provide feedback as appropriate.

3.0 SUPPORTING INFORMATION

3.1 Halton's Health and Wellbeing Strategy has now been in place for just over two years. The strategy is accompanied by a set of action plans for each of the five priorities which are linked to relevant targets and outcomes.

3.2 Appendix 1 provides an update for each of the action plans including RAG ratings. During 2015/16 a review of action plans will take place to ensure they are still fit for purpose.

4.0 POLICY IMPLICATIONS

4.1 The Health and Wellbeing Strategy and associated action plans provide the focus for the health priority in Halton. Action in each of the five priority areas should therefore contribute towards improving outcomes in this area.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 There are no direct financial implications as a result of this report

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**
The Health and Wellbeing Strategy identifies improving child development as a key local priority. Action in this area should contribute to improving the

health and wellbeing of children and young people.

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

Employment, Learning and Skills is a key determinant of health and wellbeing and is therefore a key consideration when developing strategies to improve health. Action in areas such as alcohol harm reduction and improving mental health can all have a positive effect on improving outcomes in this area.

6.3 **A Healthy Halton**

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

6.4 **A Safer Halton**

Excessive alcohol consumption is associated with higher levels of crime and disorder, anti-social behaviour and domestic violence. Therefore, action taken to reduce the harm from alcohol can also have an impact in this priority area.

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. Therefore, improving outcomes in this area will also have an impact on issues such as alcohol associated anti-social behaviour and mental health.

7.0 RISK ANALYSIS

7.1 Implementation of health and wellbeing action plans should reduce risk and improve outcomes.

8.0 EQUALITY AND DIVERSITY ISSUES

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

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

None within the meaning of the Act.

Health and Well Being Priority Area Action Plans

Halton Health and Well Being Board

Action plans for the Health and Well Being Priority Areas

(VER 5 28/03/14) UPDATE JULY 2015

Eileen O'Meara Director of Public Health

July 2015

Contents

Overall Target - Increase of 1% in self-reported wellbeing (Feeling Worthwhile)
(Baseline 2012 – 17.6%)

Name of Priority: Prevention and Early Detection of Cancer

Overall Target - 1% Reduction in under 75 mortality rate from cancer (Baseline 2010 – 147.96/100,000)

Pregnancy & Early Years						
Outcomes	**Targets**		**Actions**	**Timescales**	**Rag Rate**	**Lead**
Reduction in incidence of skin cancer.	100% of nurseries and Children's centres provided with sun awareness training in year 1	C1	Health Improvement Team to run sun awareness training for all nurseries and Children's centres in Halton in 2013/14 (this is to be part of Halton Healthy Early Years Standard accreditation).	2013-14		Health Improvement Team
Reduction in incidence of skin cancer	**Local Policy/guidance on sun protection** To develop sun protection policy during 2013/14	C2	HBC Policy developed, to be reviewed 2015	2015/16		Health Improvement Team Public Health CYP Team
Children to reach a good level of physical development and make healthy choices.			Detail included in child development action plan			
School Age School age						
Outcomes	**Targets**		**Actions**	**Timescales**		**Lead**

Reduction in obesity rates for school age children.	Ensure Fit for Life is available in 70% of primary schools in year 1. 100% in year 2 Year 1- Run Fit for Life as a pilot in 20% of secondary schools	C3	Health improvement team to extend Fit for Life programme across Halton.	2013-16		Health Improvement Team
Reduction in sunbed use amongst children under 16 years.	Educational events across all secondary schools in Halton in year 1.	C4	Liaise with school head-teachers to organise collaborative educational events run by HIT & school nurses.	2013-16		Health Improvement Team
Reduced incidence in skin cancer. **All children protected against sunburn**	Development of sun protection guidance for schools by 2014. Educational awareness raising in PHSE lessons in all schools by 2015	C5	Public Health/ Health Improvement Team to work with local head teachers to develop simple policy/guidelines with clear messages on sun risks and how to prevent them. Attended head teachers meeting – building engagement and support	2013-15		Public Health to develop policy. Health Improvement Team to deliver implementation.
Maintain HPV vaccine uptake and herd immunity.	Maintenance of 95% compliance	C6	Regular communication with Halton schools to provide information on benefits of vaccination including information events for lowest performing schools. Included in School Nursing Specification. Home Schooled children are offered the vaccine at home..	2013-16		NHS Commissioning Board / Public Health commission service, School Nursing to deliver service with Health Improvement Team to support promotion.
Reduced number of children starting to smoke. **Reduced number of children using counterfeit and illegal tobacco.**	Smoking prevention and illegal and counterfeit tobacco training for all teachers and school nurses. Raised awareness of the dangers of smoking for all children	C7 C8	HIT to deliver smoking prevention training to teachers & school nurses. On going. Teachers & school nurses to raise awareness with all children.	2013-16		Health Improvement Team Schools School Nurses

Reduced prevalence of smoking in school children.	33% staff trained year 1 33% staff trained year 2 33% staff trained year 3					Health Improvement Team
Young Adulthood (16-24)/ Healthy Adulthood (25-64) Older People (65+)						
Outcomes	**Targets**		**Actions**	**Timescales**		**Lead**
Improved healthy lifestyles for young people & adults.	Meet NICE guidelines of 5% reduction in obesity after completion of the active phase of the healthy weight programme Reduce smoking by 0.5% year on year to 2016. (baseline 24% based on Halton Health Profile 2012)	C9 C10	HIT implement and extend weight management programmes. HIT implement training & stop smoking services.	2013-16 2013 - 16		Health Improvement Team Health Improvement Team
Reduction in incidence of skin cancer.	**Increased awareness of Sun and UV Risks** Halton Council endorsed information displayed in 50% of sunbed shops in Halton Year 1, 100% in Year 2	C11	Trading standards contact local sunbed shops to agree standard information to be displayed informing of the risks of UV and sunbed use so that customers can make informed choices. Support regional and national initiatives to combat the use of sunbeds and raise awareness of the link with skin cancer.	2013-14		Halton Borough Council
Increased awareness of resources available for early detection and prevention of cancer for service providers and the public.	Information workshop to be carried out in **ALL** GP practices on role of Merseyside and Cheshire Cancer Network and support they can offer.	C12	CCG to liaise with MCCN to establish dates for all practices in Year 1. Continue to commission use of the iVan based on GP profile data in 13/14, targeting areas where uptake is lower with support from local voluntary groups. iVan is to be decomissined in 2015 as a result of transfer of provision and associated increased costs.	2013		Merseyside & Cheshire Cancer Network Health and Wellbeing Service Steering Group CHaMPs.
Increase uptake of national cancer screening programmes.	**Increased uptake of Screening Services:** **-Breast** **-Bowel** **-Cervical** 100% of all Halton GP	C13	CCG lead in collaboration with cancer lead and MCCN to visit practices and discuss cancer profile to establish priorities. All practices should have established an achievable screening target by Year 1 and met their specific target by year 3.	2013-16		NHS Commissioning Board Local Area Team Health

	practices to agree practice specific target in Year 1 and to maintain all other screening levels Improved screening uptake of vulnerable and hard to reach groups. GP training to improve early detection.		Development of user friendly materials for vulnerable and hard to reach groups especially men (CCG lead to investigate potential for incentive schemes where target is not part of contractual obligations)			Improvement Team
Improved detection of cancer.	**Increased uptake of Primary Care Cancer Audit** 100% of GP practices to take part in annual primary care cancer audit.	C14	CCG to distribute communication on Primary Care Audit All practices to audit on an annual basis The Audit has been completed and assessed and a final report/action plan completed to be circulated/implemented from Jul 2015	2013-16		CCG Lead, GP Practices
Improved detection of cancer.	GP Practice Staff training programmes on Cancer Awareness All low performing GP Practices to receive staff training.	C15	Extension of staff training programme (Health Improvement Team) to **all** GP practices below CCG average for breast, cervical, lung or bowel screening with input from Cancer Support Group Health trainers are attached to each practice	2013-16		Health Improvement Team
Access to staging data	Routine monthly staging data to be reported to Halton Action on Cancer Board (HACB) in Year 1	C16	Develop requirement (or potential CQUIN) for staging data to be sent to HACB as routine monthly information Staging data is proving difficult to get. Secondary care representative to be established to attend HACB meetings Merseyside and Cheshire Support to Unit to require staging data from Acute Trusts	2013		CCG/Secondary care provider
Rise cancer awareness	Utilisation of iVAN: Targeted use of iVan in **9** GP Practices that have significantly lower screening	C17	The ivan has been reviewed and it has been agreed that with the appointment of extra staff in house to deliver this service it is no longer required.	2013		Public Health

	rates than CCG average for either breast, cervical, lung or bowel screening.					
Improved early detection	Maintenance or improvement of 2 week wait referrals	C18	Utilising GP practice profiles identify practice specific targets based on referral rates. CCG lead and GP lead to establish targets and action plans with GP practices.	2013-16		CCG Lead/Clinical Lead
Improved early detection	Reduce cancer related A&E admission rates	C19	• Target the 6 GP practices that have above national average emergency presentations • Work with Wellbeing Areas to promote symptoms of cancer in these areas and encouraging populations to visit GP sooner.	2013-16		Wellbeing Areas / Health Improvement Team
Link to Alcohol strategy outcomes			Detail included in alcohol action plan			

Name of Priority: Improved Child Development

Overall Target – 2% year on year increase in children achieving a good level of development at age 5 (Baseline 2011 – 49.9%)

Antenatal

Outcomes	Targets		Actions	Comment on progress May 15	Timescale	Lead	RAG
Improved parenting skills	100% of expectant parents will have access to a session on parenting	CD1	Review current provision of existing programmes Delivery of innovative antenatal / parent education session on expectations of parenting / attachment	Preparation for birth and beyond pilot underway Further work required to identify overlap in programmes Available for all, and targets high risk groups	Completed Completed Ongoing	Health visiting Health visiting/Midwifery Service	
Improved ante-natal health	90% women have seen a midwife by 12 weeks and 6 days of pregnancy	CD2	Design targeted/specific antenatal classes, to attract vulnerable families Timely GP referral to community midwifes to ensure early booking	Universal offer for antenatal class, and early bird session. Vulnerable women are targeted and get a home visit Early booking rates are on target 87% q1-3 2013/14	Monitor quarterly Ongoing	Midwifery Service CCG	

Outcomes	Targets		Actions	Comment on progress May 15	Timescale	Lead	RAG
Improved early detection and treatment of maternal depression	100% of women screened for mental health issues at booking appointment 100% of women offered screening at home antenatally, targeting uptake in high risk women	CD3 CD4	Determine if current pathway is in line with national evidence and guidelines for detecting depression, including ensuring women who book in late are screened Monitor screening rates	100% of women are screened at booking, 100% offered a home visit, and vulnerable groups are targeted Pathway has been reviewed by midwifery and is in line with evidence base. Bridgewater policy on maternal/perinatal mental health and action plan for Halton in development. Future work to look at outcomes of women screened Recruitment of Bridgewater wide specialist health visitor for perinatal and infant mental health	September 2013 Ongoing August 2015	Midwifery Service Health visiting Health visiting	
To reduce risks associated with vulnerable socially excluded women.	Establish a targeted programme to support vulnerable women.	CD5	Midwives produce Individual care plans for vulnerable women to reduce risk and minimize harm. Explore the Commissioning of Family Nurse Partnership, a targeted programme to support young mothers Explore Evidence for families needing additional support but who are not eligible for family nurse partnership	There are specialised midwives for drugs and alcohol, teenage pregnancy and domestic violence who produce care plans FNP became operational in Halton in November 2014 Health visitors are developing 'universal partnership plus' package for those families who need additional support, Identified antenatally. Currently focusing on care	Completed Completed March 2014	Midwifery Service Public Health NHS England Health Visiting	

Outcomes	Targets		Actions	Comment on progress May 15	Timescale	Lead	RAG
			Midwives link with Speech and language therapy to implement “talk to bump”	leavers, offering more home visits and more antenatal appointments Talk to bump leaflet distributed – SLT training workforce, but needs more work. A needs assessment on SLT has been completed	ongoing	Midwifery Service	
Increased opportunities for antenatal access to health visitors available to assess risk and improve outcomes	100% parents to be offered antenatal contact from health visiting from March 2015 (staged increase)	CD6	Universal antenatal contact from Health visitors All staff to be trained in motivational interviewing.	Staggered implementation at 19% Completed Dec 2013 Health visitors trained again June 2015	Year on year increase to March 2015 March 2014	Health Visiting	
Reduce smoking in pregnancy to improve maternal and child health, and reduce infant hospital admissions.	Reduce number of women Smoking at the time of delivery by 2% per annum 100% of women and their partner who smoke are offered smoking cessation	CD7 CD8	Continue Antenatal incentive scheme Follow the smoking and pregnancy pathway	This is still available, All women are CO monitored at every midwifery contact Funding has been secured to train all midwives in the Baby clear package. Baby clear offers pregnant women an enhanced smoking cessation pathway.	Ongoing Ongoing March 2015 onwards	Midwifery Service Midwifery and Health Improvement Team	

Birth and postnatal care

Outcomes	Targets		Actions		Timescales	Lead Officer	RAG
Improved infant-mother bonding	100% health visitors trained	CD9	Training for staff to promote responsive parenting with new parents.	All health visitors and trained in Solihull approach.	Completed	Health Visiting	

Outcomes	Targets		Actions		Timescales	Lead Officer	RAG
	100% new parents receive new birth visit	CD10	New Birth visit offered to all families	All Family Work Service staff in Children's Centres trained in Family Links Nurturing Programme	Completed	CYP services	
				Family Work Service based in Children's Centres is offering Family Links Nurturing Programme	Completed	CYP Services	
				100% of families receive the new birth visit from health visitors at 10-14 days	Quarterly monitoring	Health Visiting	
				Reviewed, additional support through FNP	Ongoing	FNP Advisory board	
				Health visitors trained in Brazelton technique.	Ongoing	Health visiting	
			Review of services to support attachment disorder	Bridgewater to implement perinatal mental health policy.	Ongoing	Health visiting	
Improved breastfeeding support, initiation and bonding	Achieve Baby Friendly Initiative stage 2 by March 2014	CD11	Put in place all actions to achieve UNICEF Baby friendly initiative stage 2, and subsequently stage 3	BFI Stage 2 assessment achieved, inspection for stage 3 imminent	July 2015 (stage 3)	Health visitors/midwives and infant feeding coordinator	
	Increase breastfeeding initiation and at 6-8 weeks by 2% year on year	CD12	GPs complete online breastfeeding training	GPs are offered online training, but it is not being accessed, ongoing work to increase GP awareness	Available from Sept 2013, Ongoing	CCG	
Earlier detection and management of Post Natal Depression to	90% of women screened at 6-8 weeks	CD13	Measure the number of women screened and supported, and patient outcomes	This is a KPI for bridgewater 72% of women screened for postnatal depression at 6-8 weeks	On going	Health Visiting	

Outcomes	Targets		Actions		Timescales	Lead Officer	RAG
improve attachment			Review pathway against NICE guidelines	Updated pathway awaiting ratification	completed	Health Visiting/ Public Health	

Early years and Preschool years

Outcomes	Targets		Actions	Comment on progress Nov 13	Timescales	Lead Officer	RAG

Early detection and support to improve physical and emotional health and wellbeing	All eligible staff have access to training in 'Every contact counts' and Healthy child programme	CD14	Training for staff in every contact counts for children's services	Training received by health visitors, health improvements and available in children's centres	Ongoing	Health Improvement Team / Health Visiting	
			Promotion of healthy child programme across child and family workforce in Halton to improve signposting	Health child programme had a promotion event, performance review day, and GPs have requested training, health and Wellbeing board had a paper	completed	Health Improvement Team / Health Visiting	
	95% of participating settings gain Healthy early years (HHEYS) accreditation	CD15	Terrific Two's and Positive Play available in all Children's Centre. From 2015 delivering new groups for 2 year olds developed to improve on the weaker areas of Halton's EYFS results e.g. Mini Markers, Making Your Mark.	Terrific 2's and positive play available for vulnerable groups	Ongoing	CYP Services /	
			Continue and improve consistency in Halton Healthy early years status (HHEYS)accreditation and target new settings	HHEYs self-assessment being launched	Completed	Health Improvement Team	
			Provide training on introduction to solid foods to staff and information and support to parents	Universally families signposted to "weaning parties "held by health improvement team. Health visiting team one to one support or home visits available for more vulnerable families	Ongoing	Health Visitors	
Improved child development and preparation for school	100% children receiving 2-2 ½ year review	CD16	Child development training for child and family workforce across Halton (including early years settings)	Staff trained, 86% of children reaching 2 years 6 months had received 2-21/2 review	Completed	CYP Services / Health Visitors	

			Ages and stages to be introduced as an assessment tool for 1 year and 2 year review	Staff trained	Quarterly monitoring	Health visiting	
	Health professionals collocated in children's centres	CD17	Co-location in 2 children's centres Development plan for further centres	Warrington road and Kingsway are co-located. Borough level integrated early intervention work in progress	completed	Health visiting/CYP Services	
	Increase number of 2 year placements in line with national requirement	CD18	Increased number of vulnerable 2 year old early years places Children's Centres carrying out home visits to eligible families to improve take up.	The number of early year's places for vulnerable 2 year olds has increased from between approx. Current DFE target list for Halton is to place 762, children, currently hitting 63% of target	Ongoing		
	Rolling programme of Speech and Language training available to Early Years Workforce	CD19	Speech and Language training to early years workforce	Following a JSNA of SALT, a new SALT specification has been commissioned and will come into effect from 1.7.15. SLT are delivering 'you make the difference' to families universal and targeted.	Ongoing Sept 2015	SLT Service SLT service	
	Pilot Integrated reviews in 4 settings	CD20	Health visitor and Early years providers share outcomes from review and conduct the child's 2/2 ½ year review together where practicable	A pilot is underway supporting an integrated process. Information sharing event for practitioners planned for 16.7.15.	Quarterly monitoring	CYP Services / Health Visitors	
	100% early years staff competently track child's development	CD21	Provide training, and support to settings to track child's development	All voluntary, private and independent settings have access to an early years consultant teacher. Training and support		CYP Services	

				provided. Most EY settings are tracking progress and identifying children at risk of delay in order to plan interventions and support needed			
Improved school readiness	Children achieving a good level of development at age 5 improve by 3% points from 2012 baseline of 55%	CD22	Commission universal SEAL (Social and emotional aspects of learning programme) Deliver Letters and Sounds; mark making and engaging boys training	No funding available to commission SEAL. Tier 2 CAMHS service commissioned, to include training teachers, early years staff, mobilisation July 2015 Letters and sounds is currently being delivered. Engaging boys is not currently delivered Child development measure has changed, due to a new curriculum and new assessment process so can't be compared with previous EYFS assessment. 46% of children in Halton reached a good level of development in 2014 (nationally 60%). This Good level of development indicator (GLD), measured at the end of reception year remains a key priority. The current EYFS statutory profile arrangements and EYFS statutory assessment will cease in summer 2016. Although a Baseline Assessment tool is being	Ongoing	Children's Trust CYP Services	

				introduced at the beginning of the reception year, this will only give a scaled score to measure progress against Reading, Writing and maths at the end of Key Stage 2 ie the pilot assessment arrangements undertaken in September 2015 will be used to measure a child's progress in 2022, it is not a measure of school readiness.			
Increase in MMR immunisation rates	95% of children received 1 dose of MMR by 24 months	CD23	Ensure Department of Health childhood immunisation targets are met.	Immunisation rates reaching target for all childhood immunisations for children under 2 years 2013/14 97% children have received 1 dose of MMR by 24 months	Ongoing	NHS Commissioning Board / Public Health	

Name of Priority: Reduction in the number of falls in Adults

Overall Target – 5% annual reduction in hospital admissions as a result of falls (Baseline 2011/12 – 2,962/100,000)

Adulthood (25-64) Older People (65+)							
Outcomes	**Targets**		**Actions**	**Comment on progress Mar 2014**	**Timescales**	**Lead Officer**	**RAG**
Reduction in hospital admissions due to falls	5% annual reduction in hospital admissions as a result of falls (Baseline 2011/12) 10% increase in the number of people accessing falls services (2011/12 baseline) Decrease the number of repeat fallers by 5% on discharge from the falls service	F1 F2 F3	Increase the number of people who access the Falls service by 5% Increase the number of people discharged from the falls service who access low level prevention services by 10%. Increase number of people accessing community services on discharge from hospital by a minimum of 10%	There has continued to be a slight reduction in hospital admissions due to a fall. The figures for each year since the baseline of 2011/12 are as follows: • 2011/12 – 944 admissions • 2012/13 – 885 admissions (6.25% reduction on baseline) • 2013/14 – 868 admissions(8.1% reduction on baseline) • 2014/15 – 847 admissions (10.3% reduction on baseline) There has been a 26.6% increase in referrals to the falls service during the first three quarters of the year (baseline 365 – 2013-14 figure 462) There has been a 2.5%	By 1st April 2015	Falls Steering Group	

				reduction in the number of repeat fallers compared to the baseline			
Reduction in the number of readmissions to hospital due to falls	5% annual reduction in hospital readmissions due to falls. (Baseline 2011/12)	F4	Increase the number of people who have been admitted to hospital as a result of a fall who are subsequently referred to the falls service by 10%	The figures for readmissions have fluctuated, however overall they have seen a 2.6% reduction compared to the baseline: • 2011/12 – 162 readmissions • 2012/13 – 128 readmissions (21% reduction on baseline) • 2013/14 – 184 readmissions (13.5% increase on baseline) • 2014/15 – 158 readmissions (2.6%reduction on baseline)	By 1st April 2015	Falls Steering Group	
Reduction in the risk of falls at home amongst older people	5% annual increase in the numbers of people, at risk of falls, accessing prevention services (Baseline 2011/12) 10% annual increase in falls screening completed (Baseline 2011/12) 20% increase in	F5 F6 F7	Increase the number of people who access the Falls prevention service from 93 per year to 200 per year Provide falls awareness sessions twice yearly for --- number of Older People Introduce whole system screening for people at risk of falls Targeted approach to those	There has been an increase in the number of community services now using the FRAT including Red Cross, Health Improvement Team and work is commencing with Housing Providers. The increased usuage of the FRAT tool has seen an increase of over 26% in referrals to the falls service.	By 1st April 2015	Falls Steering Group	

	the number of providers using the Falls Risk Assessment Tool (FRAT)		GP practices with higher incidences of falls. Specific training developed relating to the Falls Risk Assessment Tool (FRAT)				
Improved access to falls services	Redesign and implement the new service by 2013/14	F7	Develop a falls strategy for Halton. Review the falls pathway for people who have fallen Review the falls pathway for people at risk of falls. Implement performance management system, across all falls services. Review access and range of falls prevention services Review age criteria for access to the falls service Develop a business case for additional resources for falls prevention services.	The falls strategy is complete with agreed pathways and performance measures. The falls service has been redesigned to ensure the training is delivered through a wider network of staff. This has allowed the falls specialist to increase the level of falls assessments (up by 26.6%)	Ongoing	Falls Steering Group	
Reduction in the number of people in care homes who experience a fall	5% annual reduction in recorded falls	F8	Develop robust data collection methods Carry out provider forum awareness raising Identify specific training for providers to support their individual needs.	The figure has remained static since the baseline (2011 – 911 falls – 2014/15 – 920 falls) Further work has begun to establish improved processes, training and best practice in homes.	October 2015	Falls Steering Group	
Reduction in the severity of fall related injuries	5% annual reduction in number of fractured neck of femur's. (current baseline 499 per 100,000 people)	F9	Increase in the number of Exercise / balance programmes to six per year Develop and implement specific training programmes around the needs of different providers	Number of fractured neck of Femur for 2013/14 was 113 this reduced to 11 in 2014/15.	April 2015 April 2015	Falls Steering Group	

Increase in the number of frontline staff who receive specialist falls training	Provide initial training to 20 frontline staff	F10	ROSPA accredited training for 20 frontline staff Increase provider training sessions to raise awareness of the risk of falling from 2 sessions to 5 sessions per year. Train 50 frontline staff in identifying the risk of falling	ROSPA training was delivered to 32 frontline staff. 283 staff have now gone through the falls training programme delivered through the Health Improvement Team.		Completed Falls Steering Group	

Name of Priority: Reduction in the harm from Alcohol

Overall objective – 2% reduction in rate of increase of admission episodes for alcohol-attributable conditions (Baseline - (2011/12) – 2836.7/100,000)

Pregnancy & Early Years							
Outcomes	**Targets**		**Actions**	**Timescales**	**Lead**	**Comments**	**RAG**
Increase awareness of effects of alcohol on children, families and the unborn child.	The provision of a concentrated campaign aimed at new and prospective parents.	A1	Develop series of messages for new parents, prospective parents and pregnant women to include: • Alcohol consumption and pregnancy • Alcohol and safety – accidents, co-sleeping, etc. • Alcohol and domestic violence • Foetal Alcohol Spectrum Disorder (FASD)	By End March 2014	Health Improvement Team	Completed Public FASD social marketing campaign launched.	
Reduction in the numbers of people drinking to harmful levels	All Midwives (20-30), Health Visitors (20), (Early Years Intervention workers, front line Children's Centre Staff to be identified) provided with information and training/update training on alcohol IBA.	A2	Midwives / Health Visitors to be trained in identification and brief advice (IBA) for alcohol including when and how to refer to local support.	By End March 2014	Health Improvement Team	Completed	
		A3	Appropriate Early Years Intervention Workers and Children's Centre Staff to be trained in identification and brief advice (IBA) for alcohol including when and how to refer to local support.	By End March 2015	Health Improvement Team	Completed	

School Age							
Reduction in the number of people drinking to harmful levels	The provision of a concentrated campaign aimed at education staff, school age children and their families.	A4	Explore opportunities through the curriculum and creative social networking. Areas of particular relevance to include: - Raise profile of national campaigns e.g. “talk to Frank”. - Proactive Campaign on School Help Advice Reporting Page (SHARP). - Delivery/expansion of ‘’Healthitude’ programme - Expand ‘Teen Drop Ins’ in Schools and outreach sessions including VRMZ outreach bus across Halton. - Develop work to target alcohol education work at those most at risk(e.g. NEETs, PRUs, etc.)	By End March 2014	Health Improvement Team, Young Addaction, School Nursing Service, CYP Team	Completed	
	All frontline School Nurses (~30), (Youth Workers, Youth Offending staff to be identified) are offered information and training/update training on alcohol IBA. (70% uptake)	A5	People who work with children will be trained to: recognise when children exhibit signs of either personal or parental alcohol misuse; deliver holistic screening; provide alcohol IBA; signpost appropriately.	School Nurses/ YOT by end March 2014, Other staff by end March 2015	Health Improvement Team	Completed	
	20 Police Community Support Officers and 20 Special Constables trained in alcohol IBA.	A6		By End March 2014	Health Improvement Team	Completed	

			Expand the training programme for the Police to include all Community Safety Team staff in Halton to deliver holistic screening and alcohol IBAs and the development of an appropriate monitoring system.				
Reduction in the rate of alcohol-related admissions	20% Increase in the number of IWST referrals from Adult Treatment Service. Develop data collection for local A&E and/or Alcohol liaison service data to include repeat admissions/attendance Increase in range of agencies referring and using screening protocols from universal, targeted and specialist youth services as a measure of increased awareness of systems.	A7 A8 A9	Further develop access to and the impact of specialist treatment by utilising IWST process and ensure multi-agency action planning for all young people in specialist service affected by their own or parental alcohol misuse. Review, improve and develop system to monitor pathways into community services for young people attending A&E and Acute Wards in hospital with alcohol related harm. Further embed referral and screening protocols across universal, targeted and specialist treatment services, within the framework of Integrated/Targeted Youth Support. - Provision of updated information and protocols to all relevant organisations. - Monitor awareness of systems and protocols	By End March 2014 By End March 2015 By end March 2014	Integrated CYP Commissioners Integrated CYP Commissioners Integrated CYP Commissioners	Completed "Hidden harm" report regularly reported to childrens safeguarding board. Pathway review underway – due to report December 2015 Pathway review underway – due to report December 2015	

			via number of referrals, range of services etc				
Reduction in the level of social disruption and harm due to alcohol consumption	Maintain current test sales protocols and related enforcement / educational activity and expand to include 'test sales' against Challenge 25 campaign. Development and implementation of monitoring tool to	A10 A11	Maintain Trading Standard activity around alcohol Test Sale purchases and appropriate vendor education and enforcement activity as required. Incorporate additional 'test sale' purchases to test current adoption and application of Challenge 25 campaign.	By End March 2015 By End March 2014 and on-going	Trading Standards (TS) A&C, CST, CYP, PH MA, DG, JB	Challenge 25 being rolled out across licensed venues. Test purchasing exercises being conducted. Operation Staysafe operating	

	measure Operation Staysafe activity and outcomes. Evidence of a robust Halton response to the National Alcohol Consultations and other key Government policies and initiatives.	 A12	Operation Staysafe will continue to operate, identifying, offering advice and removing vulnerable school age children to a place of safety and referring to appropriate agencies. A tool will be developed to monitor activity and follow up outcomes against individual referrals. Work with partners to influence the Government and other key decision makers in relation to issues such as cheap alcohol and irresponsible promotions and advertising.	 On-going	 Public Health	supported by multi agency partnership group Completed	

Young Adulthood (16-24)							
Reduction in the number of people drinking to harmful levels	The provision of a concentrated campaign aimed at young adults between the ages of 16 and 24. An increase in the local awareness of young adults on how they can access support and information.	A13 A14	Develop a series of age specific messages and campaigns to address alcohol harm and other risk taking behaviours. Monitor local services activity and contact as a proxy for measuring increased awareness amongst the young adult population.	End September 2013 By End March 2015	Health Improvement Team Integrated CYP Commissioners	Completed Community outreach work undertaken to increase awareness of local support services.	

	All frontline Children's Social Care (~60) provided with information and training/update training on alcohol IBA	A15	Children's Care Social Workers to be trained in identification, holistic screening and alcohol IBA. - Identify appropriate Looked after children Staff and college pastoral care staff and extend training to these staff groups.	Looked After Young People Staff by end March 2014, other staff By End march 2015	Health Improvement Team	Completed	
Reduction in the rate of alcohol-related hospital admissions	Develop data collection for local A&E and/or Alcohol liaison service data to include repeat admissions/ attendance (create baseline to measure future reduction)	A8	Review, improve and develop system to monitor pathways into community services for young people attending A&E and Acute Wards in hospital with alcohol related harm.	By end March 2015	Integrated CYP Commissioners	Pathway review underway – due to report December 2015	
Reduction in the level of social disruption and harm due to alcohol consumption	Reduction in alcohol related crime/ASB in Night Time Economy Hotspots Adoption of the Purple Flag Principles.	A16 A17	Define appropriate methodology for measuring alcohol related crime and pathways for reporting in order to assess activity and set reduction target Work with local business and key stakeholders to continue to develop local action plans to reduce alcohol related harm within Halton's Town Centre and the local Night Time Economy. - Ensure that all street pastors who work in the night time	End March 2014 By End March 2015	Community Safety Team Adults and Communities & Public Health Community Safety Team Adults and Communities, Health Improvement Team & Public Health	Alcohol-related crime reported to Safer Halton Partnership Benchmarking against Purple flag standrads undertaken as part of night time scrutiny review. Street pastors trained in IBA	

		A18	economy are adequately trained to give brief alcohol advice and signposting information to wider alcohol services. Development of a multi-agency working group to support the adoption of the Purple Flag Principles.	By End March 2015	Community Safety Team Adults and Communities, Health Improvement Team & Public Health	Benchmarking against Purple flag standrads undertaken as part of night time scrutiny review.	

Healthy Adulthood (25-64)							
Reduction in the number of people drinking to harmful levels	Reduction of proportion of adults drinking to harmful levels by 0.44% from baseline (2009 synthetic estimate 6.44%) Reduction in proportion of adults who binge drink by 1.4% baseline (2007/08 synthetic estimate 22.7%)	A19 A20	Develop a series of messages and campaigns for adults and ensure that they are disseminated through the most appropriate mediums Develop dedicated activities to support the promotion of Alcohol Awareness Week. *National synthetic data update available*	By End March 2014 March 2014 *August 2014*	Health Improvement Team Health Improvement Team	Completed – multi agency alcohol communication plan being developed.	
Reduction in the rate of alcohol-related hospital admissions	100% of GP Practices in Halton to be provided with updated information and Training alcohol IBA	A21	All 17 GP practices (to include GHPs, Practice Nurses, Health Care Assistants and co-located allied health professionals) are to be trained in alcohol IBA.	All GP Practices by end March 2014	Health Improvement Team	Ongoing	

	Liver Disease Pathway is in place across primary and secondary care & specialist treatment services Development of a full family support strategy (to support A7 activity). Phase 2 of Whiston A&E Alcohol Liaison Nursing Scheme implementation to manage repeat attendees (contributes to a 33% reduction in the number of admissions from the Frequent Attendee	A22 A23 A24	Ensure that the community treatment service (CRI) is successfully embedded within pathways and meets local needs and that prevention strategies are in place for alcohol related liver disease. Embed a 'whole family approach' into CRI services: • Delivering/facilitating access to interventions to improve relationship and parenting skills • The identification of young carers • Develop local integrated treatment provision for families who need help to address alcohol related challenges and break the cycles of harm. This includes families identified as part of the Inspiring Families Project. • Review inpatient treatment services for people with intense need. (The Windsor Clinic - Mersey care). Robust pathway in place and effective demand management.	By End March 2014 By End March 2014 By End March 2015	Adults and Communities & Public Health CCG, Adults and Communities & Public Health CCG & Public Health	Pathway review underway – due to report December 2015 All new treatment journeys to Halton Integrated Recovery service are checked with IWST (Integrated Working Support Team)to highlight current or previous Health and Social Care Involvement. Inspiring families project has alcohol as a key priority. In patient treatment services reviewed and pathway in place.	Page 70

	cohort).		Support the full implementation of the A&E Alcohol Liaison Nursing Scheme to include identification and management of regular attendees to hospital for alcohol related harm.			Completed – alcohol liaison nurse service commissioned to support Halton residents in Whiston and Warrington Hospitals	
Reduction in the level of social disruption and harm due to alcohol consumption	Reduction in the harm caused by alcohol to individuals and others by using repeat Section 27 (S27) notices and Police IBA interventions. - 100% of S27 notices will be followed up with an appropriate health intervention. Reduction in alcohol related crime/ASB in Night Time Economy Hotspots (cross ref A16)	A25 A26	Offers of support to parents under pressure or families with additional needs (including families who have come to the attention of the criminal justice system, through issues for example domestic violence) will also encompass alcohol treatment within that support if appropriate. Maximise forthcoming changes in licensing law to address problem premises and exploring processes for informing licensing decisions. - Roll out Arc Angel accreditation to premises running business in a well-managed way. - Maximise opportunities that arise	By End March 2015 By End March 2015	Community Safety Team Adults and Communities, Health Improvement Team & Public Health	All new treatment journeys to Halton Integrated Recovery service are checked with IWST (Integrated Working Support Team)to highlight current or previous Health and Social Care Involvement. Statement of Licensing Policy refreshed to reflect national best practice Increase in number of licensed	

			from information sharing with local A&E departments.			premises with Arc Angel accreditation. A+E data being collated to inform local licensing decisions	

Older People (65+)							
Reduction in the number of people drinking to harmful levels	The provision of a concentrated campaign aimed at adults over the age of 65.	A27	Develop a series messages and campaigns for older adults and ensure that they are disseminated through the most appropriate mediums. Areas of particular relevance to include: • Alcohol and Falls • Alcohol and Mental Health	By End March 2014	Health Improvement Team	Multi agency alcohol communication plan being developed to include campaign aimed at older adults – April 2016 Falls prevention service staff trainined in alcohol IBA	
Reduction in the rate of alcohol-related hospital admissions	All appropriate Home Care Staff are provided with updated information and access to training on signposting and brief interventions.	A28	Appropriate front-line Home Care professionals to be identified and offered training in screening and alcohol brief advice (IBA).	By End March 2015	Health Improvement Team	Completed.	

Name of Priority: Prevention and early detection of mental health conditions

Overall Target - Increase of 1% in self-reported wellbeing (Feeling Worthwhile) (Baseline 2012 – 17.6%)

Pregnancy and early years							
Outcomes	**Targets**		**Actions**	**Comment on progress 2014**	**Timescales**	**Lead Officer**	**RAG**
Detection and treatment of maternal	100% of women screened at home	M1	Determine if current pathway is in line with national evidence and guidelines for detecting depression	Pathway has been reviewed by midwifery and is in line with evidence base.	September 2013	Midwifery Service	

depression	antenatally at 36 weeks		Monitor screening rates	Bridgewater policy on maternal/perinatal mental health and action plan for Halton in development.	Ongoing	Midwifery Service	
Detection and management of Post Natal Depression to improve attachment	90% of eligible women screened at 6-8 weeks	M2	Measure the number of women screened and supported, and patient outcomes Review pathway against NICE guidelines	This is a KPI for bridgewater Pathway was compliant with Nice guidelines. Working to update with recent ammendments	On going March 2014	Health Visitors Health Visitors / Public Health	
Improved support for families in dealing positively with toddlers	Borough-wide availability of specific programmes and activities in Children's Centres Training for staff in Nurturing-based approaches to support parenting skills and confidence in achieving positive behaviour management and emotionally healthy relationships	M3 M4	Terrific Two's and Positive Play available in all Children's Centres Getting it Right with Families training delivered to first cohort of 16 practitioners	Terrific 2's and positive play available for vulnerable groups	By Sept 2014 By March 2014	CYP Services CYP Services	
School age children							
Outcomes	**Targets**		**Actions**	**Comment on progress Mar 2014**	**Timescales**	**Lead Officer**	
Improved	Early	M5	Train 10 school nurses in how to	School nurses have	September	Primary Care	

mental wellbeing of school-aged children	identification and support for children who are potentially more vulnerable to developing mental health problems Reduce levels of sexual exploitation and improve self-esteem and confidence Reduce levels of cyber bullying Improve healthy eating and reduce levels of obesity Emotional wellbeing of looked after children (PHOF, Placeholder) Increased promotion and use of materials within schools about the importance of emotional health and well being		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	received STORM training, on suicide prevention	2013	Mental Health Team	
		M6	Run four workshops per annum to train teaching staff in how to communicate with children on social and emotional issues using evidence based interventions, e.g. SEAL	New service has been commissioned for Tier 2 services which will deliver this, comensing activity June 2015	September 2013	Primary Care Mental Health Team	
		M7	Develop resources and packs for teachers on gender, identity, confidence and aspirations	To be completed.	January 2014	CAMHS team	
		M8	4 sessions per annum on anti-cyber bullying training and materials for front line staff, teachers and school nurses.	Widnes Vikings commissioned to deliver sessions.	September 2013	Health Improvement Team	
		M9	Enrol all schools on Healthitude programme which covers healthy eating, drinking, tobacco and drugs.	Completed. All Schools offered programme.	June 2014	Health Improvement Team	
		M10	Review school nurse provision and develop new school nurse specification to include social and emotional health outcomes.	School Nurse Service has been procured	June 2014	Public Health	
		M11	Develop information packs and resources on the impact of change on social and emotional health of children for front line staff	To be developed	September 2013	Health Improvement Team	
		M12	Refresh CAYP EWB Strategy and Implementation plan	CAMHS reviewed as part of Tier 2 development.	December 2013	Integrated CYP Commissioners	
		M13	Implement recommendation of HNA of	CAMHS reviewed as part of	March 2014		

			children & young people's emotional wellbeing	Tier 2 development.			
		M14	Agree final recommendations from the Looked After Children's needs assessment and implement.	Ongoing implementation.	September 2013	Integrated CYP Commissioners	
		M15	Support for children living with parents/carers who have mental health, alcohol or drug problems.	Better working relationship between CRI and Young Addaction to identify CYP. Still low numbers of referrals.	Ongoing	All	
		M16	Expansion of Healthitude Programme in schools which includes: • Drug and alcohol • Relationships • Peer Pressure • Sexual Health • Exam Stress	Ongoing. Widnes Vikings element on bullying added to offer, and multi agency group established.	September 2013	Health Improvement Team	
Improved support for children and young people experiencing mental health problems	CAMHS needs assessment refreshed And CAHMS Strategy developed	M17	Refresh the CAMHS health needs assessment to reflect current Halton data (needs to feed strategy review detailed above)	Complete	July 2013	Public Health	
		M18	Develop new CAHMS Strategy & Action Plans Review Tier 2 CAMHS provision	Mental health action plan completed, and underway New Tier 2 service procured.	2013	Integrated CYP Commissioners	
		M19	Ensure staff are able to meet the needs of Children and Young People	Ongoing	Within 2013-14	Integrated CYP Commissioners	

			with both a mental health and learning disability need.				
Few people suffer avoidable harm	A&E attendance Reduction in hospital admissions due to self-harm <18 years of age	M20	Ensure self-harm referrals to commissioned 'Hear4u' Service are prioritised and audited, with revised assessment process in place to deliver most appropriate response for individual children and young people Two Training Sessions per year for GP, A & E nurses, social workers and teachers on how to communicate and treat self harming children and young people using evidence based material and programmes	Ongoing Completed	June 2013 June 2013	Integrated CYP Commissioners Health Improvement Team	
Adulthood (16-64)							
Outcomes	**Targets**			**Actions**	**Timescales**	**Lead Officer**	
More people will have & maintain good mental health Improve the social and other determinants of mental ill health across all ages, and reduce the inequalities that can both cause and be the result of mental health problems	Reduce number of first time entrants into the Youth Justice System (PHOF) Baseline: Increase in self-reported wellbeing (PHOF) Reduce unemployment, including youth unemployment and long-term unemployment	M21 M22 M23 M24	Implement recommendations from the health needs assessment of young offenders Implement recommendations from the HNA on adult mental health and wellbeing Implement recommendations of the Health impact of the economic downturn report from Liverpool Public Health Observatory	Establishment of a health sub group of the YOT service to take forward recommendations. New Mental Health Strategy developed – action plans in development to meet recommendations. Ongoing	2013 2014 2014	Integrated CYP Commissioners Public Health / CCG / Adults & Com Adults and Communities	

including, for example, social isolation.	Increase access to green space Reduction in admissions due to alcohol and drugs, including reduced inequalities	M25					
Improved information and support available to help young people maintain positive mental health	Develop a series of messages for young adults and ensure that they are disseminated through variety of mediums. Mental health and wellbeing issues will be considered alongside other issues important to young people	M26	Insight work carried out. Messages developed and disseminated. Measure use as much as possible e.g. website visits Information distributed throughout the borough	Development of the "Like Minds" campaign	September 2013 December 2013	Health Improvement Team	
Early identification of for those with mild to moderate mental health problems. Improved range and use of self-help and other	GP Practices support patients to access local services and facilities, use self-help tools, access training and participate in the local community	M27 M28	Rollout of the Community Wellbeing Practice Initiative. GPs and primary care staff will be encouraged to use non-medical initiatives where appropriate for those with mild mental health issues eg. social prescribing Expansion of social prescribing services e.g. access to CAB, books on prescription, access to self-help website.	Completed Ongoing	Rollout from April 2013 Commissioner will performance manage provider at	Halton CCG/ Wellbeing Initiative/ evaluation support from Public Health Health Improvement Team	

non-medical interventions to improve levels of self-reported wellbeing.	50% of practice staff participating in the initiative will undertake brief intervention training re: wellbeing Increased referral of 20% into community based services An agreed % of the practice population of those practices involved will report improved wellbeing levels using SWEMWBS before and after interventions	M29	Training for GP Primary Care staff on how to recognise mental health conditions and early non-medical treatment.	Ongoing	quarterly contract meetings against agreed KPIs September 2013		
Improved access and availability of psychological therapies.	IAPT Programme: Services provided to at least 15% of disorder prevalence Recovery rate of at least 50% in fully established services. Improved access for BME	M30 M31	Redesign current IAPT service to improve access to psychological therapies as part of the commitment to full rollout by 2014/15. Promote increased access of services by black and minority ethnic groups and by older people, and increased availability of psychological therapies for people with severe mental illness and long term health problems.	New IAPT service procured. Ongoing	Tender timetable to be developed in 13/14 and timescales then set Monthly contractual reporting of current contract will happen in	CCG IAPT Service	

More people will recover	and older people Increased availability of psychological therapies for people with severe mental illness and long-term health problems Pre and post treatment outcome data (PHQ9 & GAD7)on over 90% of all patients who start treatment.				tandem with tender exercise		
Few people suffer avoidable harm *(this relates to all adults)*	Self harm: see previous section Reduction in suicide rates (PHOF) Baseline:	M32	Raise awareness of organisations that offer support to people considering suicide by disseminating information through engaging with at least 20 staff and community forums per year Review the current contract with organisations that offer support to people considering suicide – this is a Mersey wide funded service. Halton is an associate commissioner Training for Primary Care staff on how to recognise and help people at risk of suicide.	New suicide strategy in development. Suicide event has taken place and task and finish developing new strategy. CALM commissioned to provide support for further 12 months. Training ongoing. HIT also developing e-learning tool.	Through the year until review (below) is complete Review complete by September 2013	Health Improvement Team Public Health Health Improvement Team	
Older People (65+)							

Outcomes	Targets			Actions	Timescales	Lead Officer	
More people will have good mental health	Reduction in the number of lonely older people.	M33	Work with Public Health England to scope suitable projects for Halton.	Integration of Older Peoples Services with Health Improvement Team to improve links to community services.	2013	Public Health / HIT/ Adult & Com	
	Reduction in the number of older people with low to moderate mental health conditions in Care Homes and for those that receive domiciliary care.	M34	Review health improvement services for older people that link them to community activities. E.g. Reach for the Stars.	Work with Community Wellbeing Practices to enhance local offer.	2013	HIT/ Adult & Com	
		M35	Implementation of 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.		2013	Health Improvement Team	
Improved integration of services and support for people with dementia	Review of dementia strategy	M36	Final sign off through Mental Health Partnership Board	Completed	May 2013	Adults and Communities	
	Completion of carers strategy	M37	Final sign off through the Health and Well-being Board	Ongoing. Commissioning intentions to be developed to reflect Care Bill	April 2013	Adults and Communities	
	Evaluation of the Later Life and Memory Service pathway completed	M38	6 month evaluation report signed off		October 2013	Adults and Communities	

REPORT TO: Health and Wellbeing Board

DATE: 13th May 2015

REPORTING OFFICER: Strategic Director Communities

PORTFOLIO: Health and Wellbeing

SUBJECT: Winterbourne View update

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To highlight to the Board Winterbourne View Two Years On, Transforming Care: Next Steps, January 2015 and Winterbourne View – Time for Change report, November 2014.

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

3.0 **SUPPORTING INFORMATION**

3.1 Following the Winterbourne View scandal, the Government pledged to move all people with learning disabilities and/or autism inappropriately placed in such institutions into community care by June 2014. "Transforming Care: A National Response to Winterbourne View Hospital (DH final report) was produced in December 2012 and included an Action Plan with 63 areas to be implemented nationally. The areas that were identified as the responsibility of the Clinical Commissioning Groups (CCGs) and Local Authorities were reported to SMT on 17th July 2013.

3.2 A Winterbourne View Concordat Action Plan was developed locally for these specific areas and progress has been monitored regularly through the Winterbourne Strategic Group that meets on a quarterly basis, represented by both HBC and the NHS Halton CCG.

3.3 The original Winterbourne View report and pledge to move all people with learning disabilities and/or autism inappropriately placed failed nationally due to various reasons, including:

- Resistance from some of the organisations involved and
- Some Councils were/are unsure of how to deal with service-users who challenge services; and
- Limited incentives for organisations to make the changes along with a lack of understanding of how the changes could create cost savings as well as improving people's quality of life.

3.4 In order to achieve progress nationally, NHS England commissioned

the Transforming Care and Commissioning Steering Group to implement a new national framework to be delivered locally, to achieve the growth of community provision needed to move people out of inappropriate institutional care.

3.5 Winterbourne View – Time for Change (November 2014), is a report detailing 11 recommendations to act as a driver for change to make a reality of the Winterbourne pledge (full detail attached at Appendix).

3.6 The 11 recommendations are split into five categories, detailed here:

Strengthening Rights

i) The Government should draw up a Charter of Rights for people with learning disabilities and/or autism and their families, and it should underpin all commissioning.

ii) The Government should respond to "the Bradley Report Five Years On".

iii) People with learning disabilities and/or autism and their families should be given a "right to challenge" decisions to admit or continue keeping them in inpatient care.

iv) NHS England should extend the right to have a personal budget (or personal health budget) to more people with learning disabilities and/or autism.

v) The Government should look at ways to protect an individual's home tenancy when they are admitted to hospital.

Forcing the pace on Commissioning

vi) The Government and NHS England should require all local commissioners to follow a mandatory commissioning framework.

vii) Community-based providers should be given a "right to propose alternatives" to inpatient care.

Closures of inpatient institutions

viii) The commissioning framework should be accompanied by a closure programme of inappropriate institutional inpatient facilities

Building capacity in the community

ix) Health Education England, Skills for Care, Skills for Health and partners should develop a national workforce "Academy" for this field, building on the work already started by Professors Allen and Hastings and others.

x) A "Life in the Community" Social Investment Fund should be established to facilitate transitions out of inpatient settings and build capacity in community-based services.

Holding people to account

xi) Action on the recommendations above should be accompanied by improved collection and publication of

performance data, and a monitoring framework at central and local level.

3.7 A number of the recommendations above are Nationally driven and require further guidance to be published over the coming months. Others slot into the Concordat Action Plan and link into Actions 33, 39 and 57, and will be reviewed as part of the Winterbourne Strategic Group. Recommendation x) is a new investment fund that will be established. The Policy Team will pick this up once it is published.

3.8 **Winterbourne View Two Years on and Transforming Care: Next Steps**

At the end of January 2015, the Winterbourne View Two Years On and Transforming Care: Next Steps was published by ADASS, DH, LGA and NHS England. The Winterbourne View Two Years On sets out a collective account from partners across the health and care system of the progress up to now. Transforming Care: Next Steps sets out the plans for the next stage of this work. All partners involved in Transforming Care have agreed the need for a single programme with a single plan, building on the recommendations of Winterbourne View – A Time for Change. From the original Action Plan and Concordat, any outstanding actions will be carried forward into the Transforming Care new programme.

3.9 The new publications strengthen the fact that Health and Wellbeing Boards have a role to provide leadership by ensuring that there is strong integrated local health and care commissioning and housing support and encourage the use of pooled budgets.

3.10 **Update on Halton's position**

The Winterbourne View Strategic Group co-ordinates Halton Council and CCG response to the Winterbourne View concordant action plan, ensuring submissions are completed.

The Strategic group also monitors the Learning Disability Inpatient Bed usage and Out of Borough placements to repatriate individuals to Halton were appropriate.

3.11 **Out of Borough Placements**

The Winterbourne View Strategic Group continues to monitor the Out of Borough Cohort on a quarterly basis. The below table provides an overview of the Out of Borough cohort, (excluding Older People). For each team; Complex Care Runcorn. Complex Care Widnes and the Mental Health Recovery Team.

	Number of individuals out	Number of individuals out	Number of individuals

	of borough 2013/14*	of borough 2014/15*	no longer out of borough
Complex Care Runcorn	11	11	1
Complex Care Widnes	13	14	1
Mental Health Team	13	10	2
Total	37	35	4

Work continues to identify service users to repatriate to Halton, ensuring a multi-agency approach to each case, linking into commissioning and development of new services to provide bespoke packages of support.

*number of individuals can increase or decrease throughout the period therefore the number returned is not directly proportionate depending on the time of the data collection.

3.12 **Inpatient Usage Learning Disability (LD)**

Current bed usage 2014/15 (January) is 1 individual, there have been 4 LD Inpatient admissions during the financial period 2014/15, each individual has received support from Care Management teams, Learning Disability Nurses, PBSS team and Bridges Learning Disability team to ensure a robust response to ensure the inpatient admission is kept at a minimum.

In 2013/14 the total number of admissions was 10; this was a considerable increase on previous years.

Appendix A provides an overview of the bed usage of Byron Unit, with neighbouring CCG's included for context and comparison and Appendix B provides the Length of Stay information.

3.13 **Secure Inpatient Usage (LD)**

There is currently 1 Halton resident in a secure inpatient bed, and 1 Knowsley resident with a Halton GP. Both LA and CCG commissioners attended reviews in December 2014 as part of the Improving Lives Review for all Secure Patients, the individuals remain the responsibility of Specialised Commissioning, with support to facilitate discharge form LA and CCG commissioners when appropriate.

4.0 **POLICY IMPLICATIONS**

4.1 In February 2014, NHS England and the Local Government Association developed "Ensuring quality services: Core principles for

the commissioning of services for children, young people, adults and older people with learning disabilities and/or autism who display or are at risk of displaying behaviour that challenges." This document builds on the initial Winterbourne View report and restates a model of care which is known to represent best practice. A local version is currently being developed to be implemented in March 2015.

5.0 FINANCIAL IMPLICATIONS

5.1 None identified.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**
None identified.

6.2 **Employment, Learning & Skills in Halton**
None identified.

6.3 **A Healthy Halton**
Safeguarding service-users continues to be at the forefront with all the Winterbourne View work. When reviewing Out of Borough placements to bring service-users back to the local area, all aspects of the person are considered, including safeguarding.

6.4 **A Safer Halton**
Safeguarding service-users continues to be at the forefront with all the Winterbourne View work. When reviewing Out of Borough placements to bring service-users back to the local area, all aspects of the person are considered, including safeguarding.
None identified.

6.5 **Halton's Urban Renewal**

None identified.

7.0 RISK ANALYSIS

7.1 Failure to implement the recommendations from the Winterbourne View report will have a number of implications, including financial implications from high cost placements and service-users not being in the most appropriate placements.

8.0 EQUALITY AND DIVERSITY ISSUES

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

INPATIENT WARD - BYRON -

The below table is captured from the Commissioning quarterly report published in October 2014.

Admissions

By CCG 2013-14	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
NHS HALTON CCG	2	2	1	1	1		1	1	1				10
NHS KNOWSLEY CCG	1	4	3	1	1	4		4	1	1	1	2	23
NHS LIVERPOOL CCG						1							1
NHS ST HELENS CCG			2										2
NHS WARRINGTON CCG	1					1	1			1	1	1	6
NHS WIGAN BOROUGH CCG					1	1		2				1	5
NHS GREATER PRESTON CCG												1	1
Grand Total	**4**	**6**	**6**	**2**	**3**	**7**	**2**	**7**	**2**	**2**	**2**	**5**	**48**

By CCG 2014-15	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
NHS HALTON CCG	1	0	0	1	0	0	0	0	0	0	0	0	2
NHS KNOWSLEY CCG	2	1	0	1	2	1	0	0	0	0	0	0	7
NHS LIVERPOOL CCG	0	0	0	1	0	0	0	0	0	0	0	0	1
NHS ST HELENS CCG	0	1	1	2	0	0	1	0	0	0	0	0	5
NHS WARRINGTON CCG	0	0	0	0	0	0	1	0	0	0	0	0	1
NHS WIGAN BOROUGH CCG	0	0	1	0	0	0	1	0	0	0	0	0	2
NHS GREATER PRESTON CCG	0	0	0	0	0	0	1	0	0	0	0	0	1
Grand Total	**3**	**2**	**2**	**5**	**2**	**1**	**4**	**0**	**0**	**0**	**0**	**0**	**19**

Winterbourne Update – Inpatient Ward Byron

The information within this table is captured from commissioning information supplied by 5 Boroughs Foundation NHS Trust 2014/2015.

Patient	Admitted	Discharged/ Planned discharge	Length of Stay (days)	Reason for admittance	Mental Health Act
1*	19/09/13	31/03/15	558	Mental health	3
2	16/04/14	10/07/14	86	Mental health	3
3	17/07/14	26/09/14	72	Mental health	2
4	19/11/14	03/12/14	15	Mental health	2

*Please note that Patient 1 is a complex patient and regular MDT's have been in place to manage and support this individual's hospital stay, and planning for discharge. A robust discharge plan is now in place and accommodation has been identified.

REPORT TO:	Health and Wellbeing Board
DATE:	8th July 2015
REPORTING OFFICER:	Director of Public Health
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Halton Child and Maternal Health Profile 2015
WARDS:	Borough-wide

1.0 PURPOSE OF THE REPORT

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

2.0 RECOMMENDED: That

1) **the Board note the contents of the 2015 Child Health Profile, the progress that has been made against a challenging baseline and programmes established to address areas of concern; and**
2) **feedback comments to the Director of Public Health**

3.0 SUPPORTING INFORMATION

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

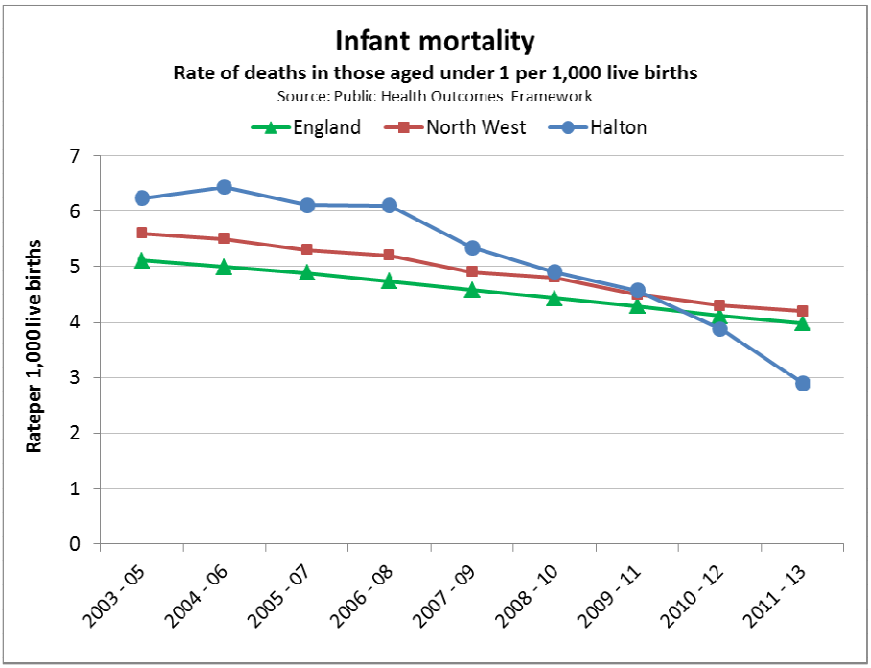
3.2 Health outcomes are very closely related to levels of deprivation; the more deprived an area the poorer health outcomes that would be expected. Overall the health and wellbeing of children in Halton is generally worse than the England average, as are the levels of child poverty. Halton is the 27th most deprived borough in England (out of 326 boroughs) and as such would be expected to have lower than average health outcomes. The infant and child mortality rates have both improved and are now similar to the England average.

Halton progress

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

- Infant and child mortality rates have reduced and are now below the England average rate. This is a great success, given the level of

deprivation in the borough. Work that impacts upon this includes improving maternity services and women booking in early, accident prevention work and preventing sudden infant deaths (SIDs).



- Immunisations: MMR rates continue to improve (for the first dose by age 2 years), and is significantly better than the England average rate, at 96.3%. This has exceeded the 95% target, which provides good protection against an outbreak. Similarly the coverage of diphtheria, tetanus, polio, pertussis and Hib immunisations by age 2 years is significantly better than the England average at 96.3%. Immunisation coverage for children in care in Halton is also significantly better than the England average.

- Child development at the end of reception has improved from 37% to 45.6%. However performance remains well below the England average of 60.4%. Child development is one of the priority areas for the Health and Wellbeing Board, and as such has a targeted action plan, this work is continuing with additional focus on bonding and parenting.

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

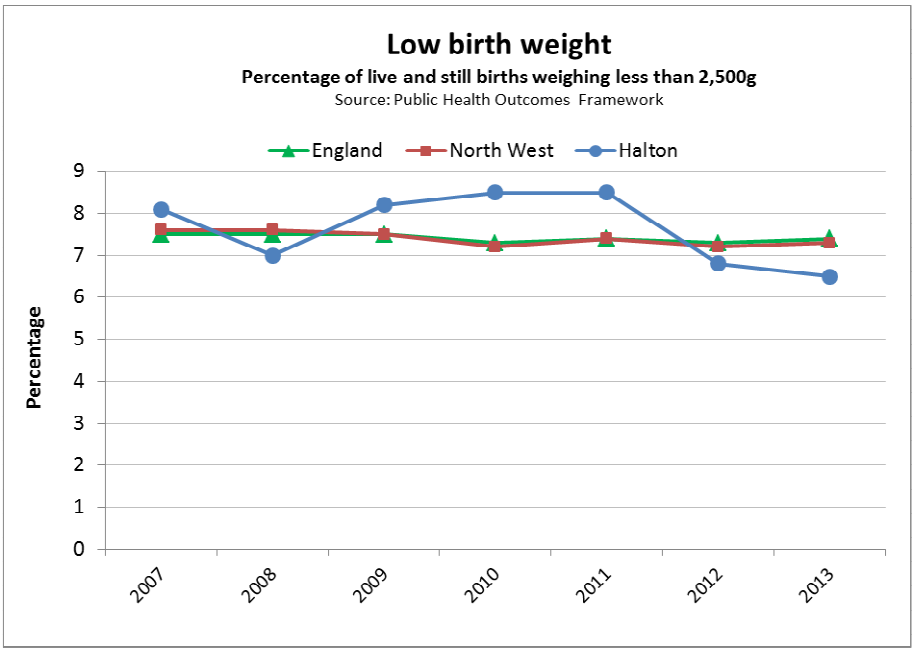
- First time entrants to youth justice system reduced again in 2013 and was better than the England average, but not significantly so.

- The percentage of children living in poverty has reduced but remains worse than the England average.

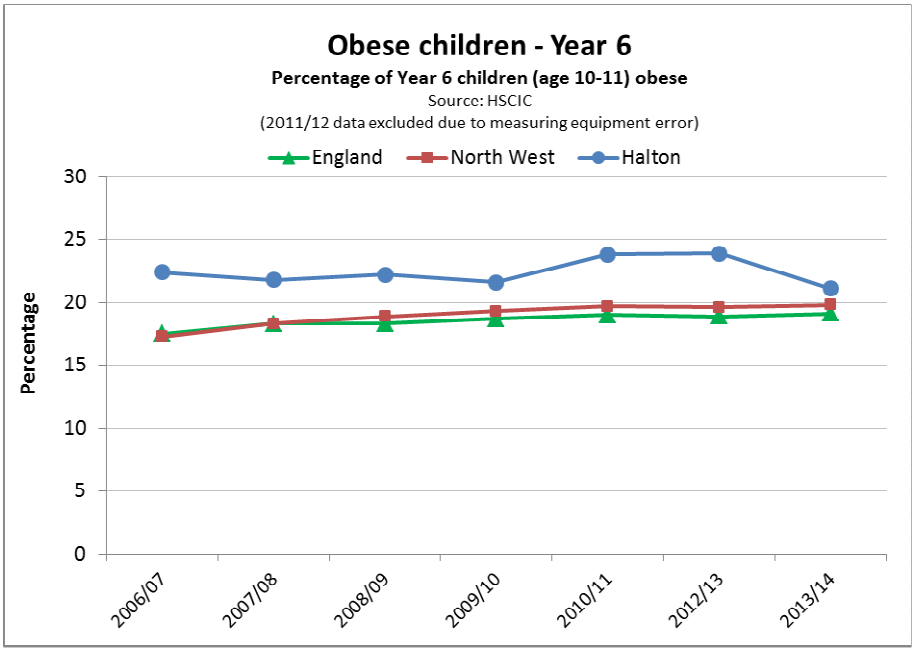
- Statutory family homelessness has improved and remains significantly better than the England average.

- Children killed or seriously injured in road traffic accidents has reduced, closing the gap between the Halton and England average.

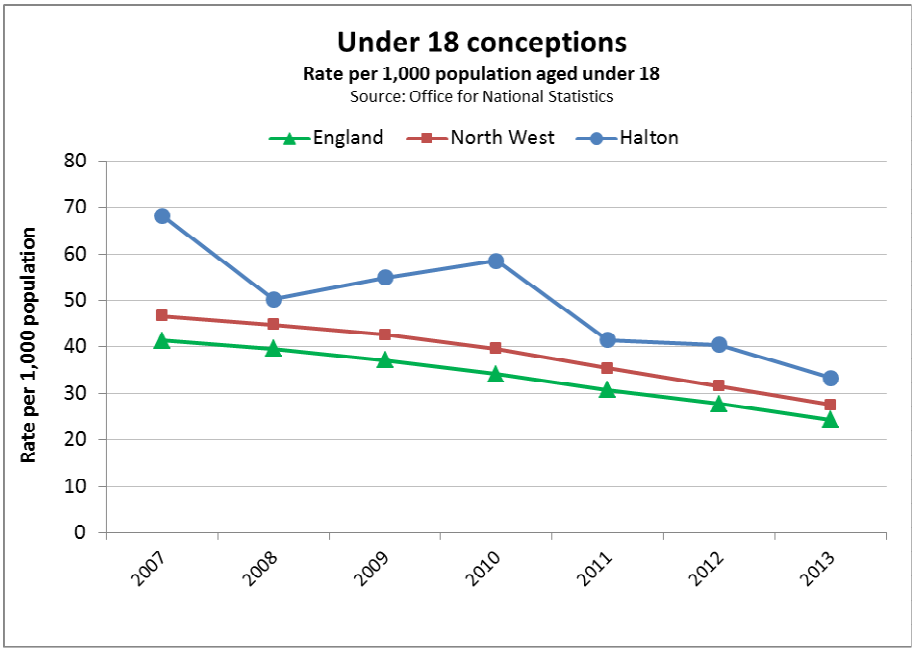
- The number of low birth weight babies has improved and the Halton percentage is now below the England average. Improvements in birth weight are achieved through maternity services, smoking cessation and improving maternal health.



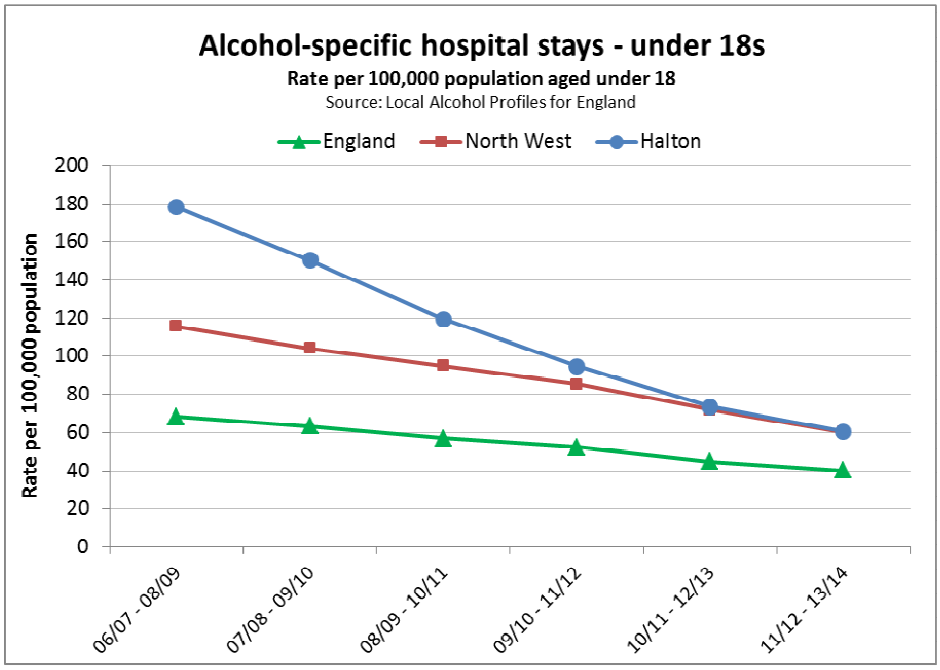
- Halton's percentage of obese children in Year 6 (age 10-11) has significantly improved; at 20.4% it is similar to the England average. There is a comprehensive weight management programme delivered in the school setting with children and families.



- The teenage conception rate has shown a significant improvement from 41.5 to 33.3 and is now almost at the North West average. The chart below shows the extent of the reduction since 2007. Halton has maintained a similar percentage of deliveries to teenage mothers (1.5% in 2012/13 and 1.4% in 2013/14). This is close to the England average of 1.1%.



- Halton has seen a reduction in the rate and number of 0-18 year olds being admitted to hospital for alcohol specific conditions. The chart below shows the improvements that have been made since 2006/7-2008/09.



Halton challenges

3.6 Halton continues to be challenged in a range of areas. This year's profile indicates we are lagging behind the national average with the number of children in care, overweight and obese early years children, hospital admissions due to substance misuse in children aged 15-24, injuries in children age 0-14 and injuries in young people aged 15-24 and for self harm in people aged 10-24, A&E attendances in children age 0-4 and breastfeeding initiation.

3.7 Programmes to address challenges include:

Early Years obesity: There are a number of initiatives underway to address this issue. An Early Years Nutrition Strategy and Action Plan is under development with input with a wide range of stakeholders. Responsibility for Health Visiting will transfer to Halton Council in October and there will be a renewed contract with an emphasis on early years feeding. A new section of the Health improvement team is being developed with an emphasis on early years. A new Infant Feeding Coordinator has just been appointed to work with staff and Children's Centres.

Hospital admissions for self harm and substance misuse: Halton continues to prioritise the Prevention of Mental Health Conditions as a Health and Wellbeing Board priority. The Halton Emotional Health and Wellbeing Strategy has a comprehensive action plan which takes a life course

approach and places equal importance on the prevention, promotion, early detection, effective treatment and recovery from mental ill health. A new Targeted Service for Children and Young people has been procured as a partnership between NHS Halton CCG and the Council, as well as a specialist service for Children in Care.

Young Addaction now provides a universal and targeted youth service offer, along with specialist community treatment for substance misuse. All secondary schools have been provided with access to self-harm awareness training, and the Widnes Vikings deliver an anti-cyber bullying project as part of the Healthitude programme.

Breastfeeding: Halton and St Helens division of Bridgewater community health care trust have achieved UNICEF baby friendly stage 1 and 2, and are due to be inspected on the final stage in July 2015. Stage 3 involves an audit of patient's experience of midwifery and health visiting services, against the BFI standards. The successful completion of BFI stage 3 is an indication that the healthcare services fully support, encourage and enable women in their care, to breastfeed.

Support to breastfeed is available to all Halton women who choose to do so. An antenatal infant feeding workshop is offered to all families, to support women in making their feeding choice. After the baby has been born all staff are trained to support breastfeeding and peer support services are available both while in hospital and in the community. The Baby Welcome award is also maintained across Halton. This is displayed in the window of shops, cafes, restaurants and schools (etc.) and notifies breastfeeding women, that they would be welcome to feed their baby on the premises.

Hospital admissions for injury: A piece of analysis on this area is now underway for the Children's JSNA so we can really understand what is happening. Likewise a bespoke campaign based on local insight is being developed. Accident prevention equipment for early years is available for all parents through Children's Centres.

A & E attendances: There has been a big increase in A & E attendances as parents are now using the Walk In Centres for their children. We are however working with both Acute Trusts and the GPs to place paediatric expertise in the community so children do not go to A & E with inappropriate conditions and so children with complex needs are better managed and remain out of hospital.

4.0 POLICY IMPLICATIONS

4.1 The Halton Child Health Profile 2015 highlights a number of key health issues for Halton. The Health and Wellbeing Strategy together with a number of related strategies is already addressing many of the issues highlighted.

5.0 FINANCIAL IMPLICATIONS

5.1 There are no direct financial implications as a result of this report. Actions identified within the Health and Wellbeing Strategy and associated strategies however, may have implications that will be reported to the relevant boards as they arise.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES *(click here for list of priorities)*

6.1 **Children and Young People in Halton**
Improving the Health of Children and Young People is a key priority in Halton and will continue to be addressed through the Health and Wellbeing Strategy whilst taking into account existing strategies and action plans so as to ensure a joined-up approach and avoid duplication.

6.2 **Employment, Learning and Skills in Halton**
The above priority is a key determinant of health. Therefore improving outcomes in this area will have an impact on improving the health of Halton residents

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

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

6.5 **Halton's Urban Renewal**
The environment in which we live and the physical infrastructure of our communities has a direct impact on our health and wellbeing and should therefore, be a key consideration when developing strategies that examine the wider determinants of health and wellbeing.

7.0 RISK ANALYSIS

Developing strategies to address the issues outlined by Halton Child Health Profile 2015 in itself does not present a risk. However, there may be risks associated with the recommended actions. These will be assessed as appropriate. There are no financial risks associated directly with this report. The recommendations are not so significant that they require a full risk assessment.

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

Document	Place of Inspection	Contact Officer
Halton Child Health Profile 2015	www.chimat.org.uk/profiles	Katherine Woodcock

Appendix

Health outcomes for children and young people in Halton, comparing 2015 CHIMAT data to the 2014 profile.

Indicator Number	Indicator	Halton 2014	2014 Signif to Eng	Halton 2015	2015 Signif to Eng	↑/↓/=
1	Infant mortality rate	4.1		3.3		↓
2	Child mortality rate (age 1-17 years)	9.8		8.4		↓
3*	MMR immunisation (by age 2 years)	94.4		96.3		↑
4*	Diphtheria, tetanus, polio, pertussis, Hib immunisations (by age 2 years)	95.5		97.7		↑
5	Children in care immunisations	94.4		95.2		↑
6	New sexually transmitted infections (including chlamydia)	N/A	N/A	3561.5		not comparable
7	Children achieving a good level of development at the end of reception	37.0		45.6		↑
8	GCSE achieved (5A*-C inc. Eng and maths)	62.5		57.2		↓
9	GCSE achieved (5A*-C inc. Eng and maths) for children in care	0.0		-	-	no's too small
10	16-18 year olds not in education, employment or training	8.9		8.4		↓
11	First time entrants to the Youth Justice System	594.0		364.0		↓
12	Children in poverty (aged under 16 years)	26.7		25.6		↓
13	Family homelessness	1.3		0.6		↓
14	Children in care	51.0		75.0		↑
15	Children killed or seriously injured in road traffic accidents	32.2		26.7		↓
16	Low birthweight of all babies	6.8		6.5		↓
17	Obese children (age 4-5 years, residents)	11.8		12.8		↑
18	Obese children (age 10-11 years, residents)	23.1		20.4		↓
19	Children with one or more decayed, missing or filled teeth	33.6		Same data as previous		no update
20	Teenage conception rate (age under 18 years)	41.5		33.3		↓
21	Teenage mothers (age under 18 years)	1.5		1.4		=
22	Hospital admissions due to alcohol specific conditions	72.3		60.5		↓
23	Hospital admissions due to substance misuse (age 15-24 years)	150.3		177.9		↑
24*	Smoking status at time of delivery	18.9		19.0		not comparable
25*	Breastfeeding initiation	52.3		51.6		not comparable
26*	Breastfeeding prevalence at 6-8 weeks after birth	22.1		21.7		not comparable
27	A&E attendances (age 0-4 years)	511.2		1303.0		↑
28	Hospital admissions caused by injuries in children (0-14 years)	130.6		155.0		↑
29	Hospital admissions caused by injuries in young people (15-24 years)	211.1		229.9		↑
30	Hospital admissions for asthma (age under 19 years)	296.1		282.7		↓
31	Hospital admissions for mental health conditions	82.1		92.4		↑
32	Hospital admissions as a result of self-harm (10-24 years)	636.4		779.1		↑

* PCT value for 2014 (and 2015 for indicators 3 & 4)

N/A Not included in previous profile/new indicator

\- Data suppressed or not available

not significantly different to England average

significantly better than England average

significantly worse than England average

significance not tested

For the definitions of the indicators please see the ChiMat profile

REPORT TO: Health and Wellbeing Board

DATE: 8th July 2015

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Wellbeing

SUBJECT: Halton Health Profile 2015

WARDS: Borough wide

1.0 PURPOSE OF THE REPORT

1.1 The purpose of this report is to present the Health and Wellbeing Board with information relating to Halton's Health Profile 2015 and provide analysis regarding the findings from a local perspective.

2.0 RECOMMENDATION: That

1) **the Board note progress in health outcomes and programmes established to address areas of concern; and**
2) **feedback comments to the Director of Public Health.**

3.0 SUPPORTING INFORMATION

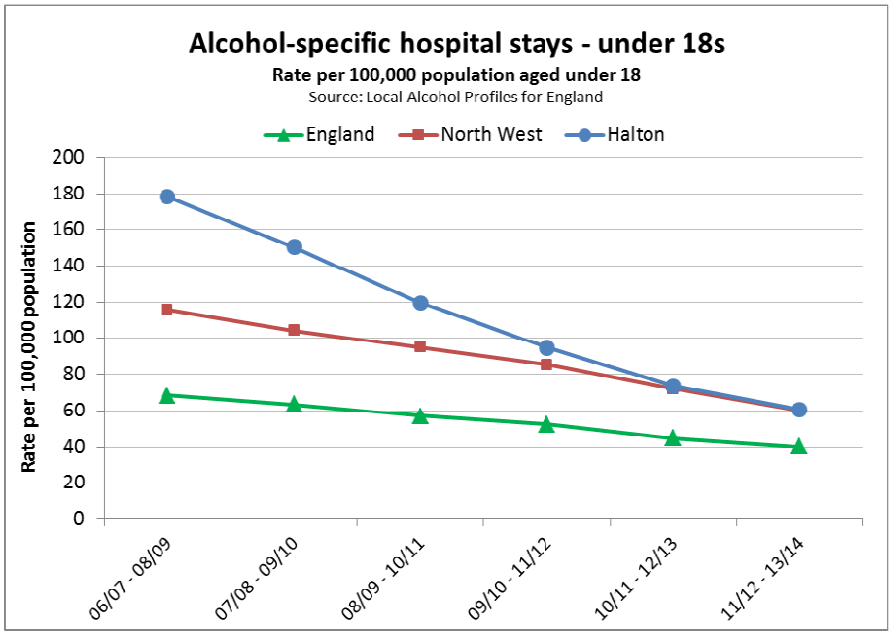
3.1 Every year Public Health England release a health profile of Halton which compares it to the England average. It is designed to help local government and health services understand their community's needs, so that they can work to improve people's health and reduce health inequalities.

3.2 The Halton Health Profile 2015 shows that half of all local residents live in the most deprived areas in England. Given the direct relationship between poverty and poor health it is unsurprising that Halton's health statistics are worse than the national average. Using a traffic-light rating system, the profile ranks those better than the England average as green, those similar to the England average as amber and those performing worse than the England average as red.

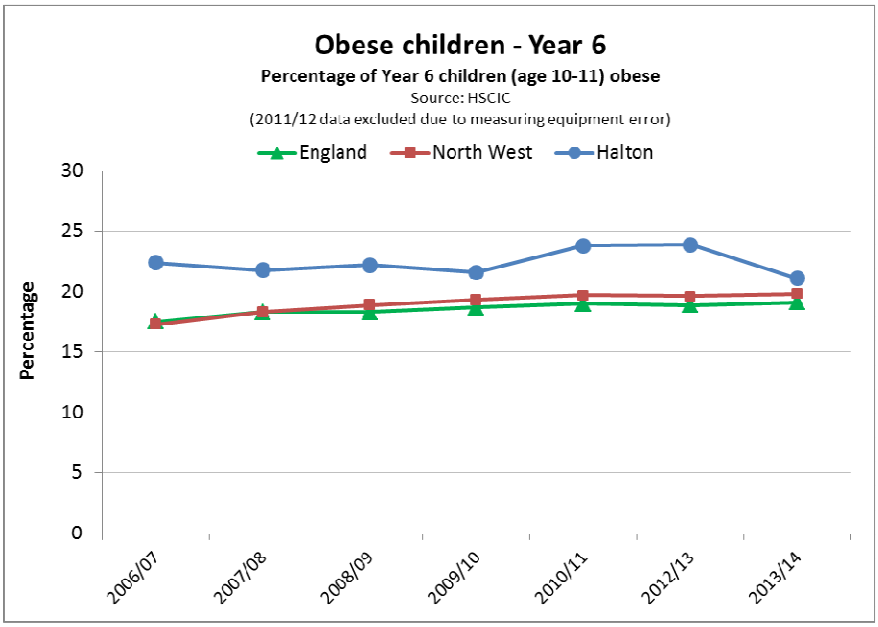
3.3 The Appendix contains a table comparing this year's profile to that of 2014. This shows that although Halton is not better than the England average on the whole, there have been improvements on the previous year's figures in 10 out of 27 comparable indicators, remained static for 9 and worsened in 8.

Halton progress

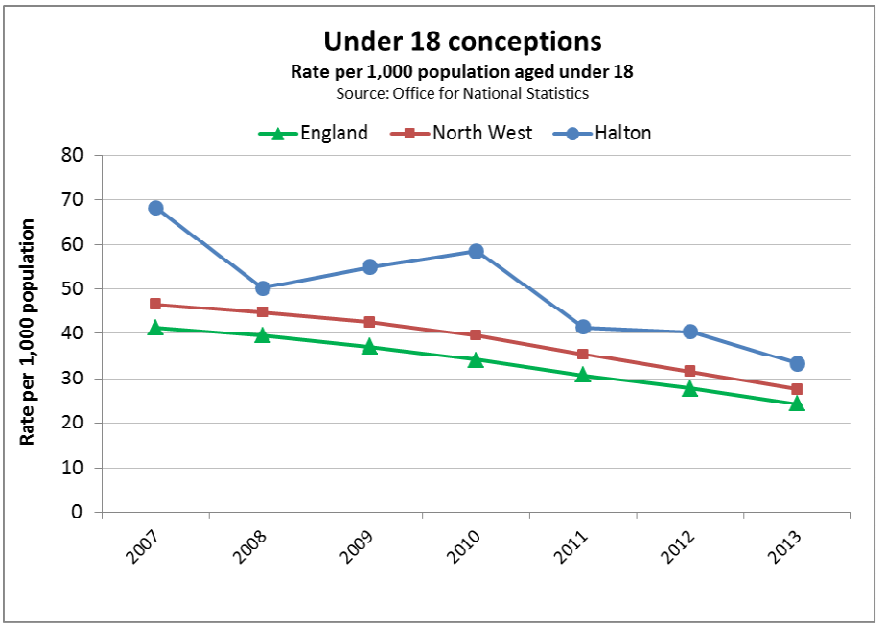
3.4 The data for Halton shows that if we compare the 2015 profile with the 2014 profile we have made very good progress in the Health and Wellbeing Board priority areas connected to reducing harmful levels of drinking, child development, cancer and mental health. This is reflected in the drop in *alcohol specific stays (under 18s)*, *obese children (Year 6)*, *under 18 conceptions, infant mortality, smoking prevalence and long term unemployment.*



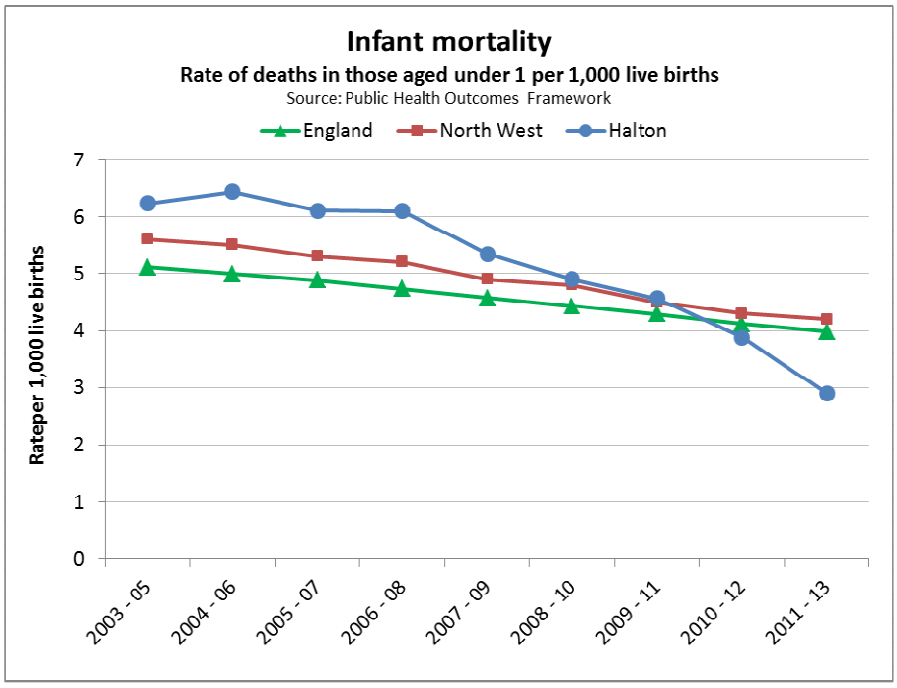
Alcohol-specific hospital stays (under 18s): Halton has reduced from the worst in England to the North West average.



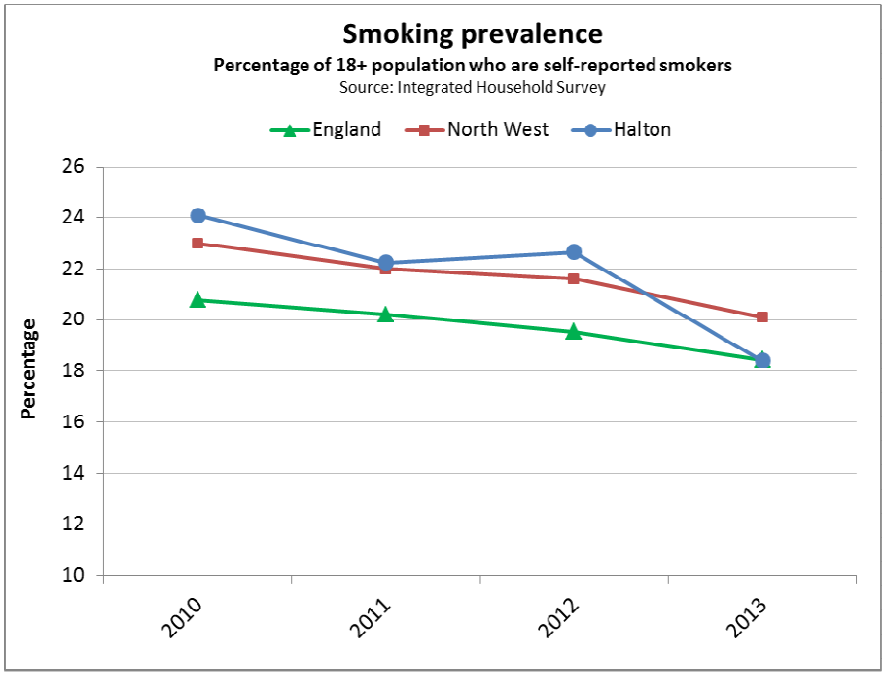
Obese children – Year 6: Halton has significantly reduced in 2013/14 and is now similar to the England and North West averages.



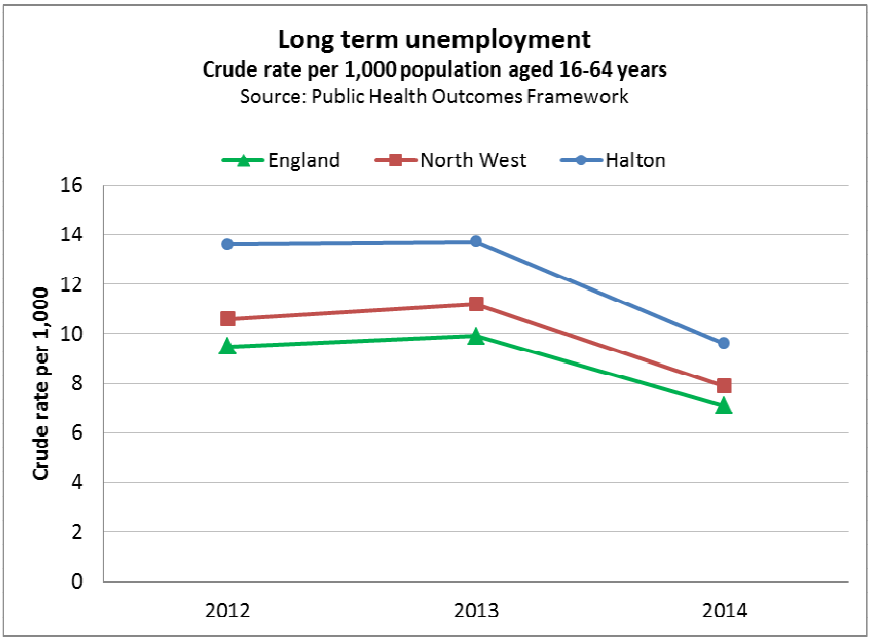
Halton's under 18 conceptions have reduced each year since 2010 and are now at their lowest level since 1998.



Halton's infant mortality rate has decreased each year since 2006-08 and the rate is now lower than the national and regional averages.

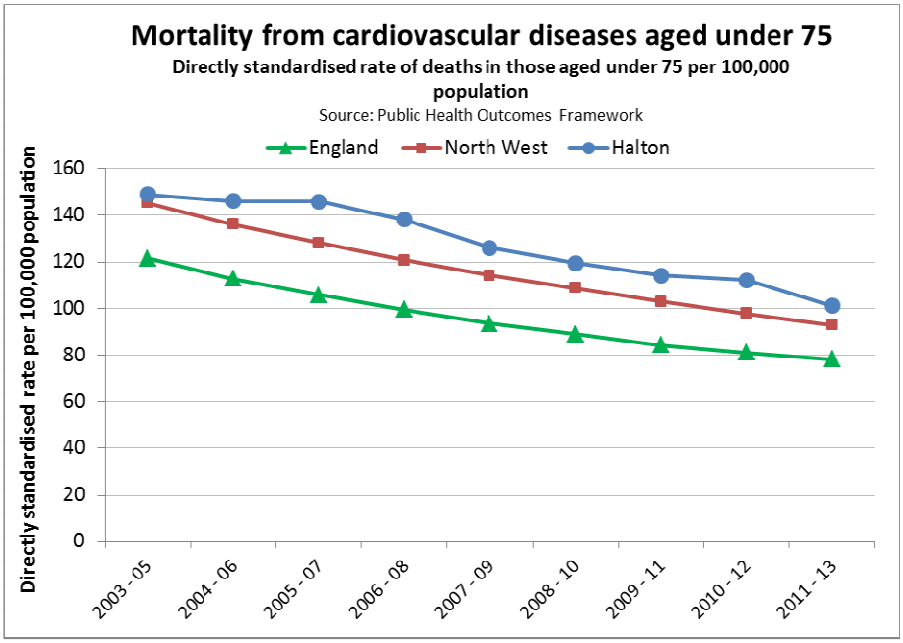


Smoking prevalence in Halton has reduced in 2013, below the North West average and on a par with the England average.



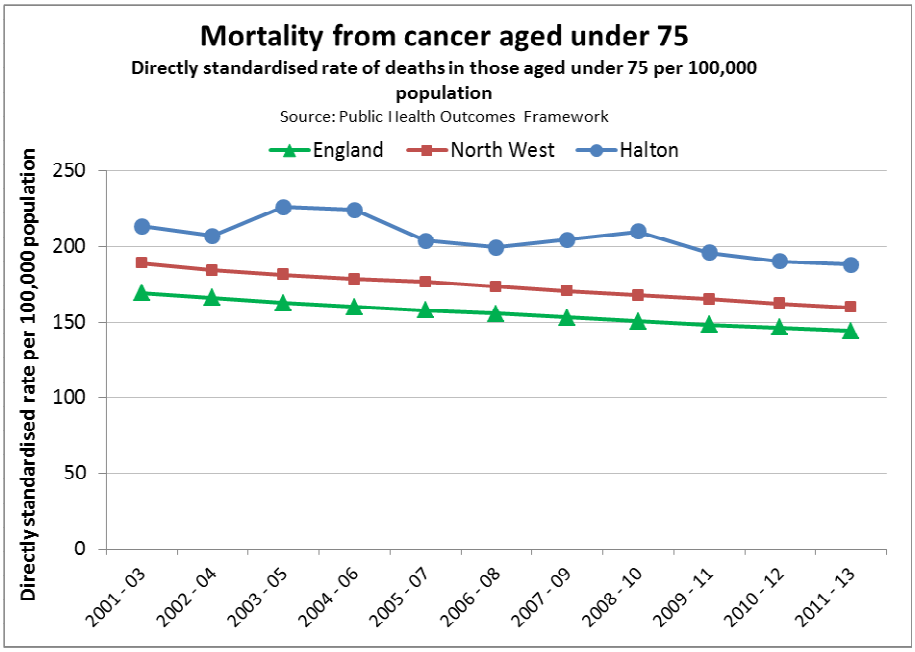
Long term unemployment has reduced in Halton between 2013 and 2014, narrowing the gap with the England and North West averages.

3.5 Halton has also made significant progress in premature mortality from cardiovascular diseases.



Premature mortality from cardiovascular diseases has decreased each year in Halton since 2003-05.

3.6 Halton has made slight improvements in terms of children in poverty, physically active adults, under 75 mortality from cancer.



Halton's premature cancer mortality rate has decreased each year since 2008-10 but remains higher than the national and regional average.

3.7 Halton remains better than or not significantly worse than the England average regarding statutory homelessness, GCSEs achieved, incidence of skin cancer (malignant melanoma), incidence of drug misuse, incidence of tuberculosis, incidence of sexually transmitted infections, excess winter deaths, suicide and the number of people killed or seriously injured on roads.

Programmes to address areas of challenge.

3.8 Halton continues to be challenged in a range of areas. This year's profile indicates we are lagging behind the national average in breastfeeding initiation, adult obesity, adult alcohol related harm, hospital stays for self harm and falls. We are addressing these challenges in a comprehensive manner as outlined below:

- *Breastfeeding initiation*:
  - UNICEF inspects community health services (midwives and health visitors) to ensure they are compliant with UNICEF BFI standards, to ensure that health services support women to breastfeed. Bridgewater have achieved Stage 1 (policy's and processes) and Stage 2 (staff) and are due to be inspected in July for Stage 3, the final stage which tests women's experiences.
  - A team of breastfeeding support workers work through community venues to support women to breastfeed.
  - A press release and awareness raising events have been arranged for June for Breastfeeding awareness week.
  - A leaflet is being sent to schools in September, to support them to incorporate breastfeeding into the national curriculum.
  - Infant nutrition strategy being developed.

- *Adult obesity*: Within Halton there is a multi-tiered approach to adult obesity delivering an extensive programme of universal services through to a specialist bariatric level pathway.

  The service is delivered as a collaborative between a number of partners which includes Halton Borough Council, Halton and Warrington Hospitals NHS Foundation Trust and 5 Boroughs NHS Foundation Trust. The service aim being to increase the number of individuals in Halton who are a healthy weight, particularly focusing on reducing the prevalence of overweight and obese individuals.

  This approach is delivered by a highly skilled multi-disciplinary team that can address the potential complex issues of the client base which:

- Delivers flexible group and individual programmes in a variety of settings thereby meeting the requirements of clients.
- Offers an intensive first-stage programme covering topics which include the core themes of behaviour, diet and physical activity, which lasts between 6 and 12 months depending on the complexity of the client.
- Provides intense practical support around healthy eating - shopping, menu-planning and cooking.
- Highlights the importance and support families to adopt a “whole-family” approach to making healthy lifestyle changes.
- Empowers and facilitates sustainable improvements in eating habits, activity levels, self-esteem and confidence amongst individuals and family members.
- Following on from the intensive first stage programme the service offers a subsequent 12 – 18 month review programme (depending on length of intensive first stage programme) with follow up appointments at regular key stages as well as options for drop in/phone calls/short follow-ups in between and after completion.
- Develops self-assessment and monitoring skills among participants to aid long term weight management.
- Offers a variety of drop-in maintenance sessions to all clients as a means of open access and support.
- The programme follows up clients 2 years after completion of the service to identify impact/success of intervention.
- Develops an understanding of barriers to change and identify approaches to overcome them.
- Provides flexible outreach and engagement to attract adults to use the service and complete programmes.
- Develops leads and provides appropriate specialist input into a multi-disciplinary team which will form the Local Specialist Obesity Service for the purposes of assessment of eligibility and referral of clients for bariatric surgery. This team and the eligibility assessment fulfils the prevailing NHS England guidelines and local specifications for bariatric referral.
- In partnership with relevant agencies work is in place to develop and implement a care pathway and training for staff working with patients in residential, nursing or domiciliary care. The training will enable care staff to prevent adults becoming underweight, identify underweight individuals and put in place preventative measures for adults who are underweight and living in the community.
- Provides training to health and social care staff to increase the number of individuals of a healthy weight in the community.

- *Adult alcohol related harm*: Alcohol harm reduction continues to be a priority area within the Health and Wellbeing action plan. An alcohol harm reduction strategy for Halton has been developed. The strategy was developed in partnership with colleagues from health, social care, education, voluntary sector, police and the community safety team. The strategy sets 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. Key activity includes:
  - Holding a Halton Alcohol Inquiry to increase knowledge of alcohol related harm within local communities and develop community led responses.
  - Developing a coordinated alcohol awareness campaign plan including a social marketing campaign to promote an alcohol free pregnancy
  - Ensuring the early identification and support of those drinking above recommended levels.
  - Reviewing alcohol treatment pathways
  - Ensuring the local licensing policy supports alcohol harm reduction agenda
  - Working with local premises to adopt more responsible approaches to the sale of alcohol (e.g. promotion of Arc Angel and the local pub watch schemes within Halton).
  - Promoting a diverse night-time economy
  - Working to influence government policy and initiatives around alcohol: 50p minimum unit price for alcohol, restrictions of all alcohol marketing, public health as a fifth licensing objective.

- *Self harm*: Halton continues to prioritise the Prevention of Mental Health Conditions as a Health and Wellbeing Board priority. The Halton Emotional Health and Wellbeing Strategy has a comprehensive action plan which takes a life course approach and places equal importance on the prevention, promotion, early detection, effective treatment and recovery from mental ill health. A new Targeted Service for Children and Young people has been procured as a partnership between NHS Halton CCG and the Council, as well as a specialist service for Children in Care.

  Young Addaction now provides a universal and targeted youth service offer, along with specialist community treatment for substance misuse. All secondary schools have been provided with access to self-harm awareness training, and the Widnes Vikings

deliver an anti-cyber bullying project as part of the Healthitude programme.

- *Falls*: Falls performance in Halton has been identified as a significant issue over the past three years. The 2015 Health Profile shows that in 2013/14 Halton had the highest rate of hip fractures per 100,000 people aged 65 and over. This equates to 156 actual hip fractures and compares to 107 and 141 in the previous two years. Although this figure is extremely disappointing it is appropriate to apply the wider context and also consider performance in the last 12 months. Provisional local data indicates the rate of hip fractures has reduced in from 156 to 89 in 2014/15. This will be published in next year's Health Profile.

  Since the completion of the falls strategy in 2013, a number of interventions have been developed including:
  - increased access to postural stability classes for people at risk
  - greater use of the Falls Risk Assessment Tool (FRAT)
  - improved partnership working
  - increased training of frontline staff
  - awareness raising of the public
  - specific training for staff in care homes
  - additional triage process installed into falls pathway for improved risk identification.

4.0 POLICY IMPLICATIONS

4.1 The Halton Health Profile 2015 highlights a number of key health issues for Halton. The Health and Wellbeing Strategy together with a number of related strategies is already addressing many of the issues highlighted.

5.0 FINANCIAL IMPLICATIONS

5.1 There are no direct financial implications as a result of this report. Actions identified within the Health and Wellbeing Strategy and associated strategies however, may have implications that will be reported to the relevant boards as they arise.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES *(click here for list of priorities)*

6.1 **Children and Young People in Halton**
Improving the Health of Children and Young People is a key priority in Halton and will continue to be addressed through the Health and Wellbeing Strategy whilst taking into account existing strategies and action plans so as to ensure a joined-up approach and avoid duplication.

6.2 **Employment, Learning and Skills in Halton**
The above priority is a key determinant of health. Therefore improving outcomes in this area will have an impact on improving the health of Halton residents

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

6.4 **A Safer Halton**
Reducing the incidence of crime, improving Community Safety and reducing the fear of crime have an impact on health outcomes particularly on mental health.

There are also close links between partnerships on areas such as alcohol and domestic violence.

6.5 **Halton's Urban Renewal**
The environment in which we live and the physical infrastructure of our communities has a direct impact on our health and wellbeing and should therefore, be a key consideration when developing strategies that examine the wider determinants of health and wellbeing.

7.0 RISK ANALYSIS

Developing strategies to address the issues outlined by Halton Health Profile 2015 in itself does not present a risk. However, there may be risks associated with the recommended actions. These will be assessed as appropriate. There are no financial risks associated directly with this report. The recommendations are not so significant that they require a full risk assessment.

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

Document	Place of Inspection	Contact Officer
Halton Health Profile 2015	www.healthprofiles.info	Katherine Woodcock

Appendix

Halton Health Profile: changes 2014 to 2015

Please click indicator for trend chart where available

Indicator Number	Indicator	2014 Halton Value	2014 Signif to Eng	2015 Halton Value	2015 2014 Signif to Eng	Trend
1	Deprivation	48.8		48.8		No update
2	Children in poverty (under 16s)	26.7		25.6		↓
3	Statutory homelessness	0.3		0.9		↑
4	GCSE achieved (5A*-C inc. Eng & Maths)	62.5		57.2		↓
5	Violent crime (violence offences)	12.8		13.2		=
6	Long term unemployment	13.7		9.6		↓
7	Smoking status at time of delivery	18.9		19.0		=
8	Breastfeeding initiation	52.3		51.6		↓
9	Obese children (Year 6)	23.9		21.1		↓
10	Alcohol-specific hospital stays (under 18)	73.5		60.5		↓
11	Under 18 conceptions	40.4		33.3		↓
12	Smoking prevalence	22.6		18.4		↓
13	Percentage of physically active adults	49.8		51.5		↑
14	Obese adults	35.2		35.2		No update
15	Excess weight in adults	70.2		70.2		No update
16	Incidence of malignant melanoma	17.4		20.7		↑
17	Hospital stays for self-harm	325.9		361.0		↑
18	Hospital stays for alcohol related harm	814.4		814.0		=
19	Drug misuse	8.4		8.4		No update
20	Recorded diabetes	7.2		7.3		=
21	Incidence of TB	0.0		0.5		=
22	Acute sexually transmitted infections	Not comparable		677.0		Not comparable
23	Hip fractures in people aged 65 and over	553.1		838.0		↑
24	Excess winter deaths (three year)	9.5		15.2		↑
25	Life expectancy at birth (male)	77.1		77.3		=
26	Life expectancy at birth (female)	80.6		80.4		=
27	Infant mortality	3.9		2.9		↓
28	Smoking related deaths	415.5		416.0		=
29	Suicide rate	7.8		9.6		↑
30	Under 75 mortality rate: cardiovascular	112.2		101.1		↓
31	Under 75 mortality rate: cancer	190.2		188.0		↓
32	Killed and seriously injured on roads	32.1		31.8		=

not significantly different to England average
significantly better than England average
significantly worse than England average

Source: Public Health England

REPORT TO: Health and Wellbeing Board

DATE: 8th July 2015

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Wellbeing

SUBJECT: Reduction in Public Health funding

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 The purpose of this report is to provide the Health and Wellbeing Board with information regarding the proposed cuts to Public Health funding and asks that the Board advocates against these cuts in year to the ring fenced budget.

2.0 RECOMMENDATION: That

1. **This Health and Wellbeing Board recognises the importance of Public Health interventions to deliver on key priorities and improve the overall health and wellbeing of the Halton population.**

2. **This Board advocates that the government honour its previous commitments to public health funding as set out in the local government finance settlement in March 2015.**

3. **The Board asks that if the Public Health grant cuts do proceed they are assessed based on local need and levels of deprivation.**

3.0 SUPPORTING INFORMATION

3.1 Halton Borough Council has successfully set a balanced budget for 2015/16, including full allocation of the public health grant, based on the information provided by the Government in the local government finance settlements, and reiterated by the Chancellor in March's Budget.

5th June 2015, the Government announced new cuts for this financial year which included the reduction of the ring fenced public health grants to local authorities by £200 million – equivalent to approximately £630,000 for Halton.

3.2 The cuts will particularly impact on the health of people in deprived areas, such as Halton, that disproportionately suffer from lower life expectancy, long term conditions, cancer and heart disease. It is therefore a potential disaster

for the NHS, whose future depends on the preventative approach as outlined by the Chief Executive of NHS England in the Five Year Forward Plan.

The public health grant commissions a wide range of services from the NHS, including sexual health services such as STD clinics, HIV services and family planning, infection control and children's public health nursing including health visitors and school nurses.

The grant also commissions services from a wide range of providers including alcohol and drug services, weight management, mental health services, older people's health promotion and falls prevention, healthy schools, early years services and infant feeding.

4.0 POLICY IMPLICATIONS

4.1 A reduction in the ring fenced Public Health budget will impact on the ability of the NHS and the Council to deliver a wide range of treatment and prevention services to improve the health and wellbeing of the people of Halton.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 The Health and Wellbeing Board will be unable to commission services that meet its priority areas due to the proposed reduction in budget.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

The Health and Wellbeing Strategy identifies improving child development as a key local priority. Reduction to funding in this area will be detrimental to improving the health and wellbeing of children and young people.

6.2 Employment, Learning & Skills in Halton

Employment, Learning and Skills is a key determinant of health and wellbeing and is therefore a key consideration when developing strategies to improve health. Reduction in funding for areas such as alcohol harm reduction and improving mental health will have a negative effect on improving outcomes in this area.

6.3 A Healthy Halton

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

6.4 A Safer Halton

Excessive alcohol consumption is associated with higher levels of crime and

disorder, anti-social behaviour and domestic violence. Therefore, a reduction in funding to reduce the harm from alcohol will also have a negative impact on this priority area.

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. Therefore, removing funding for public health will have an impact on issues such as alcohol associated anti-social behaviour and mental health.

7.0 RISK ANALYSIS

7.1 Reduction in year of the Public Health ring fenced grant places improved health and wellbeing and the meeting of Halton's Health and Wellbeing Board priorities at serious risk.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 The cuts will particularly impact on the health of people in deprived areas, such as Halton, that disproportionately suffer from lower life expectancy, long term conditions, cancer and heart disease.

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

None

REPORT TO: Health and Wellbeing Board

DATE: 8th July 2015

REPORTING OFFICER: Simon Banks

PORTFOLIO: Health and Wellbeing

SUBJECT: CCG Quality Premium – Measures for inclusion in 2015/16

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To inform the HWBB of the 2015/16 CCG Quality Premium measure selection

2.0 **RECOMMENDATION: That the Board note the measures selected and approve the list for 2015/16**

3.0 **SUPPORTING INFORMATION**

3.1 NHS E Quality Premium template

4.0 **POLICY IMPLICATIONS**

4.1 No policies are affected by the selection of the quality premium measures

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 The maximum quality premium award available to the CCG for 2015/16 is approximately £640,000

5.2 Any payment due in relation to the 2015/16 quality premium will not be made until September / October 2016 (i.e. 2016/17 financial year)

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

6.1 **Children & Young People in Halton -** Two measures relating to the health and wellbeing of young people in Halton form part of the CCG's 2015/16 Quality premium, these are;

- Maintaining or reducing the number of unplanned hospitalisation for asthma, diabetes and epilepsy in children
- Maintaining or reducing emergency admissions for children with lower respiratory tract infections

6.2 **Employment, Learning & Skills in Halton –** One measure has been selected that relate to this priority;

- Increase the proportion of adults in contact with secondary mental health services who are in paid employment

6.3 **A Healthy Halton –** Most measures selected for the CCG's quality premium are designed to improve the health of the residents of Halton, including;

- Reducing the potential years of life lost through causes amenable to healthcare
- Maintaining or reducing the number of avoidable emergency admissions
- Reducing the number of delayed transfers of care
- Improving the waiting time in A&E for people with mental health related needs
- Improving the health related quality of life for people with a long term mental health condition
- Reducing the number of antibiotics prescribed in primary care
- Reducing the proportion of broad spectrum antibiotics prescribed
- Increasing the diagnosis rates for people with dementia
- Increasing the proportion of people on appropriate treatment for stroke risk management

6.4 **A Safer Halton -** None

6.5 **Halton's Urban Renewal -** None

7.0 **RISK ANALYSIS**

7.1 *The is no financial risk attached to 2015/16 budget, however an estimate of the likely 2015/16 award will need to be made when setting the 2016/17 budget, an incorrect forecast or late adverse changes to performance could result in a potential shortfall in the income estimate and result in savings required to be made elsewhere in the 2016/17 budget.*

7.2 *The measures chosen for 2015/16 represent areas where NHS Halton CCG with partners in the Local Authority and wider Health economy have planned to make investments during the financial year and although the targets are challenging performance will be monitored throughout the year and reported at CCG Quality and Performance and Finance committees and the CCG Governing Body on a monthly basis and any variance from target will be investigated and acted upon.*

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 *Any Equality and Diversity implications arising as a result of the proposed action should be included – None identified*

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

None within the meaning of the Act.

Halton Clinical Commissioning Group

2015/16 Quality Premium Measures

HWBB 08/07/2015

1. The 2015/16 CCG Quality premium selection was split into 5 sections by NHS England
    a. Nationally mandated measures with nationally mandated targets
    b. A menu of nationally mandated urgent and emergency care measures and targets from which the CCG could choose the measure and the proportion of the Quality Premium award to assign to success
    c. A menu of nationally mandated mental health measures and targets from which the CCG could choose the measure and proportion of the quality premium to assign to success
    d. Locally chosen measures and targets which require both HWBB sign off and NHS E approval.
    e. NHS constitution measures for which no award is made of the achievement of the target however the value of any award would be reduced should the constitution standard not be met.
2. Where the CCG had an element of choice, this was done through consultation with commissioners, clinicians and individuals from the Local Authority and Public Health with CCG approval done through the Executive Management Team.
3. Table 1 below shows the indicator, amount of quality premium award attached to success and target. Table 2 shows the NHS template with accompanying rationale for measure and target selection.
4. The Health and Wellbeing Board is asked to approve the measures and targets listed below in Table 1

Table 1: NHS Halton CCG 2015/16 Quality Premium Measures, Targets and Awards

Measure	Target	Potential Award
Potential Years of Life lost	Log-linear trend reduction of at least 1.2% between 2012 and 2015	£64,000
Urgent Care Menu Measures		£192,000
Avoidable emergency admissions Composite measure of: a) unplanned hospitalisation for chronic ambulatory care sensitive conditions (all ages); b) unplanned hospitalisation for asthma, diabetes and epilepsy in children; c) emergency admissions for acute conditions that should not usually require hospital admission (all ages); d) Emergency admissions for children with lower respiratory tract infection.	Overall <=3076	£76,800
The total number of delayed days caused by delayed transfers of care in 2015/16 should be less than the number in 2014/15	<2931	£76,800
Increase in the number of patients admitted for non-elective reasons, who are discharged at weekends or bank holidays.	>=15.5%	£19,200
Mental Health Menu Measures		£192,000
Reduction in the number of patients attending an A&E department for a mental health-related needs who wait more than four hours to be treated and discharged, or admitted, together with a defined improvement in the coding of patients attending A&E.	>= average 4 hour wait target OR >=95% PLUS >=90% primary diagnosis code field compete in A&E	£76,800
Increase in the proportion of adults in contact with secondary mental health services who are in paid employment.	Q4 2014/15 baseline not yet available, however 2013/14 Halton was 6.3% >6.3%	£96,000
Improvement in the health related quality of life for people with a long term mental health condition	<0.179. Although 2014/15 baseline is not available ambition is for the gap to be reduced the gap for 2013/14 was 0.179	£19,200
Improved antibiotic prescribing	Composite indicator - 3 parts	Can be achieved independently
a) Antibiotic prescribing Primary Care	Reduction of 1% or more on 2013/14 value in	£32,000

	2015/16	
b) Broad Spectrum antibiotic prescribing in primary care	A 10% reduction in the proportion of these prescribed as a percentage of selected antibiotics of from 2013/14 OR below 11.3%	£19,200
c) Antibiotic prescribing data Secondary care	Secondary care (St Helens and Warrington) antibiotic prescribing data certified by PHE	£12,800
Local Measures		
Estimated diagnosis rate for people with dementia	75%	£64,000
The number of people on appropriate Treatment for Atrial Fibrillation	>=90%	£64,000
The measures below don't attract an award if the target is met, however if the target is missed then the amount of potential award is reduced.		
RTT (Admitted)	>=90%	-£64,000
RTT (Non admitted)	>=95%	-£64,000
RTT (Incomplete)	>=92%	-£64,000
4 hour wait A&E	>=95%	-£192,000
14 day suspected cancer GP referral	>=93%	-£128,000
8 minute Red 1 ambulance calls	>=75%	-£128,000
Adverse variance to planned surplus	<Plan	-£640,000

TABLE 2

Quality Premium 2015/16

NHS Halton CCG

CCGs are required to include their choice of urgent and emergency care indicators (plus targets), choice of mental health indicators and target for reducing potential years of lives lost through causes considered amenable to healthcare.

Reducing Potential years of lives lost through causes considered amendable to healthcare

Level of Ambition	Rationale	HWB sign off
2767.4	The calculation method for this is the average trend percentage reduction achieved between the years 2012 and 2015. In 2012 the CCG's baseline was 2801.1 (https://indicators.ic.nhs.uk/webview/) (2801.1 / 100)*1.2 = 33.61 2801.1 – 33.61 = 2767.49 NB Percentage reduction should be no less than 1.2%	

Urgent and emergency care

Indicator	Chosen as QP indicator	Proportion of 30%	Level of ambition	Rationale	HWB sign off
Avoidable emergency admissions Composite measure of: a) unplanned hospitalisation for chronic ambulatory care sensitive conditions (all ages); b) unplanned hospitalisation for asthma, diabetes and epilepsy in children; c) emergency admissions for acute conditions that should not usually require hospital admission (all ages); d) Emergency admissions for children with lower respiratory tract infection.	Yes	40%	<=3076.0	To qualify for the quality premium the annualised trended change over four years from 2012/13 to 2015/16 should be <=0. In Halton the 2012/13 baseline was 3076.0 http://ccgtools.england.nhs.uk/loa/flash/atlas.html Halton's focus on out of hospital care, with schemes such as the Urgent Care Centres will reduce the number of avoidable emergency admissions.	

The total number of delayed days caused by delayed transfers of care in 2015/16 should be less than the number in 2014/15	Yes	50%	<2931 (2014/15)	The baseline for this quality premium is the 2014/15 Actual This has been calculated as 2,931 per 100,000 pop (18+) NHS Halton CCG along with Halton Borough Council have been working together to reduce the number of delays both Community Mental Health Providers and Acute providers. This effort will continue through 2015/16 to minimise delayed transfers of care	
Increase in the number of patients admitted for non-elective reasons, who are discharged at weekends or bank holidays.	Yes	10%	>=15.5%	NHS Halton have calculated that during 2014/15 (to Feb 15) 15% of non-elective admissions were discharged on a weekend or bank holiday 15% + 0.5% = 15.5% NHS Halton CCG recognises that there is further scope for improvement and the continued effort to improve the efficient discharge within the trusts should improve this.	

Mental Health

Indicator	Chosen as QP indicator	Proportion of 30%	Level of ambition	Rationale	HWB sign off
Reduction in the number of patients attending an A&E department for a mental health-related needs who wait more than four hours to be treated and discharged, or admitted, together with a defined improvement in the coding of patients attending A&E.	Yes	40%	>= average 4 hour wait target OR >=95% PLUS >=90% primary diagnosis code field compete in A&E	NHS Halton CCG has analysed the average 4 hours wait for patients coded with either 14 or 35 and for the period 2014/15 (to Feb 15) this was 90% against an average of 95.7%, therefore this is an area which NHS Halton CCG will work to improve through the psychiatric liaison within A&E to ensure that parity is established in A&E NHS Halton has analysed the A&E data sets and 98% of primary diagnosis fields are complete, therefore NHS Halton CCG will continue to monitor this situation through 2015/16 to ensure this high level of data	

				completeness continues. "A&E Quality Premium work - Log 309 - Mar 14 to Feb 15"	
Reduction in the number of people with severe mental illness who are currently smokers	No	0%		NHS Halton CCG does not believe that the data quality underpinning this measure is sufficiently robust to choose as a quality premium, in addition although NHS Halton CCG supports colleagues in Public Health around general smoking cessation services there are no specific schemes targeting patients with Severe Mental Illness.	
Increase in the proportion of adults in contact with secondary mental health services who are in paid employment.	Yes	50%	Q4 2014/15 baseline not yet available, however 2013/14 Halton was 6.3% >6.3%	Although the 2014/15 baseline is not yet available NHS Halton CCG has used the most recent 2013/14 baseline https://indicators.ic.nhs.uk/webview/ NHS Halton CCG has specific commissioning intentions during 2015/16 which target unemployment in adults with mental health problems, it is anticipated that these schemes and the planned increase IAPT access and recovery rates will lead to greater rates of sustained long term employment in people with mental health problems	
Improvement in the health related quality of life for people with a long term mental health condition	Yes	10%	<0.179. Although 2014/15 baseline is not available ambition is for the gap to be reduced the gap for 2013/14 was 0.179	In the 2013/14 data https://indicators.ic.nhs.uk/webview/ NHS Halton CCG is below the England average in the EQ5D score for both MH LTC patients and all LTC patients. However the EQ5D score for MH patients is still below that for all LTC patients. The investment NHS Halton is making in MH services such as increasing access to IAPT will reduce the size of the gap between MH LTC and all LTC EQ5D scores	

Improved antibiotic prescribing in primary and secondary care

Indicator	Level of ambition	Rationale
Reduction in the number of antibiotic prescribed in primary care	<=1.401 antibacterial items / STAR PU	Baseline NHS Halton CCG (FY 2013/14) = 1.415 antibacterial items/STAR PU Target for NHS Halton CCG 2015/16 = 1.401 (or less) antibacterial items/STAR PU There is considerable work to achieve the 1% reduction and this will be built into the quality prescribing initiative scheme for GP practices for 2051/16 with individual practice reduction targets being set. Bridgewater are required to audit antibacterial prescribing by their non-medical prescribers via the quality schedule but further work is needed to assure the CCG that appropriate prescribing in line with the local formulary is being driven by the trust at all levels. Similarly UC24 will need to be engaged to ensure appropriate prescribing in line with local formulary in order to achieve this target.
Reduction in the proportion of broad spectrum antibiotics prescribed in primary care	<11.3%	Baseline NHS Halton CCG (FY 2013/14) = 10.9% Target for NHS Halton CCG 2015/16 = below 11.3% (England median) The CCG currently sits below this target and as such the main drive will be to stay at our current level and not increase prescribing of these high risk drugs. Again all Halton community prescribing will affect this target and as such engagement with providers is needed to ensure this is maintained.
Secondary care providers validating their total antibiotic prescription data	Y	Currently secondary care use of antibiotics is difficult to benchmark due to the lack of any validated data, this part of the premium will ensure robust validated data is in place for acute trusts and as such they can then be benchmarked and a reduction target applied for future financial years. This will be driven by Public Health England in terms of provision of validation tool to trusts and validating the submitted data. NHS Halton CCG will work with St Helens And Warrington Trusts to take part in the process - The validated data will be available for each trust at the end of the financial year on the PHE gov.uk website.

Local measures

A shortlist of four measures have been identified as areas where the CCG should be able to show improvements in 2015/16, two of these measures will be selected as the quality premiums for NHS Halton CCG for 2015/16 following final decision at the Executive Management Team meeting on 1st May 2015 and ratification with the HWBB and NHS-E

QP No.	Name of QP	Rationale	Has this QP been chosen before? If yes, what is the latest position?	Data source / quality?	Is this QP from the CCG Outcomes Framework or an area that has been highlighted as a priority area for the CCG?	Proposed numerator	Proposed denominator	Target	Any additional comments
2	CCG C2.13 Estimated diagnosis rate for people with dementia	NHS Halton has made great improvements in dementia diagnosis rates to reach 70% however the Alzheimer's Society report suggests 75% would be a more reasonable figure and St Helens CCG has already achieved this benchmark. NHS Halton CCG believes that further work in this area with practices would enable the 75% target to be achieved.	This has not been chosen before but this is a CCG OIS 2.13 (the latest figure (March 2015) shows NHS Halton CCG on 70.4%	https://www.primarycare.nhs.uk/default.aspx	YES CCG OIS 2.13	924	1232	75%	https://www.primarycare.nhs.uk/default.aspx
5	The number of people on appropriate Treatment for Atrial Fibrillation	NHS Halton CCG performs well of most stroke measures however it is believed that not all patients are on the most appropriate treatment based on a CHA2DS2-VASc score (or have even had a CHA2DS2-VASc score) as per NICE guidance. Discovering and amending treatment will reduce the likelihood of stroke.	A baseline figure of approximately 80% was found in 2013/14.	Local GP registers	NO	Of the people in the denominator those with a CHA2DS2-VASc score AND who are on appropriate treatment (such as anticoagulation)	Number of people on AF register in Halton – excluding those who have refused appropriate treatment or where appropriate treatment is contra-indicated	>=90%	Figures for 2014/15 have not yet been calculated, however the AF register as at 31/03/2014 was 1,794 (65+)

REPORT TO: Health and Wellbeing Board

DATE: 8th July 2015

REPORTING OFFICER: Simon Banks

PORTFOLIO: Health and Wellbeing

SUBJECT: Better Care Fund – Change in Non-Elective Activity target for 2015

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To inform the HWBB of a necessary change to the original targeted reduction in 2015 Non-elective activity as submitted in the Halton Better Care Fund (BCF) Plan

2.0 **RECOMMENDATION: That the Board note the required changes and approve the amended Non Elective activity target in the BCF.**

3.0 **SUPPORTING INFORMATION**

3.1 Better Care Support Team NEL revisions table.

4.0 **POLICY IMPLICATIONS**

4.1 No policies are affected by the alteration of the target figures

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 The required amendment of the Non Elective target in the CCG's 15/16 activity plan should not have any material impact on the funding of the schemes within the BCF. However over performance on non-elective admissions will create demands on both BCF and CCG reserves.

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

6.1 **Children & Young People in Halton -** None

6.2 **Employment, Learning & Skills in Halton -** None

6.3 **A Healthy Halton –** By reducing the target reduction for Non Elective admissions in the BCF this has had reduced the anticipated number of people expected to have been prevented from being admitted to hospital, the original plan anticipated that 545 people

would have avoided a hospital admission through BCF schemes, this has reduced to 375. The CCG has been required to plan for an increase of 206 admissions.

6.4 **A Safer Halton -** None

6.5 **Halton's Urban Renewal -** None

7.0 **RISK ANALYSIS**

7.1 *A potential reputational risk has been created by NHS-E by the requirement for CCG's to plan for an increase in non-elective activity of 1% whilst* ***at the same time*** *requiring BCF plans to show planned reductions in non-elective activity. Both planned figures cannot be reconciled and this could lead to potential problems in future discussions with both NHS-E and Acute Care Providers. This can mitigated by the explanation that the 2% reduction in the BCF is what is planned for, the 1% growth in the CCG plan is a prudent contingency allowing for unforeseen events such as a particularly harsh winter, the gap between the -2% and +1% is funded through reserves.*

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 *Any Equality and Diversity implications arising as a result of the proposed action should be included – None identified*

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

None within the meaning of the Act.

Halton Clinical Commissioning Group

Changes to 2015 Better Care Fund Non-Elective Activity planned reduction

HWBB 08/07/2015

1. In 2015 Monitor made a decision that required St Helens & Knowsley Teaching Hospitals NHS Trust to record all attendances at the GPAU (General Practitioner Assessment Unit) and CHOBS (Children's Observation Unit) to be recorded as a non-elective admission rather than an assessment. The impact of this for Halton is an additional 939 non-elective admissions on both the 14/15 baseline and subsequent 15/16 planned activity
2. During the 15/16 CCG planning round NHS E area team fed back a requirement from the national team that CCG plans must take into account the national picture for Non-Elective growth, especially since the 14/15 Winter was mild and growth was still witnessed. In was felt nationally that local CCG plans did not adequately reflect the nationally seen picture and that the expectation was that growth in the region of 1% was expected at CCG level plans.
3. NHS Halton CCG amended its finance and activity plans to take into account both changes listed above.
4. The net effect of these changes on non-elective activity has been to change the CCG plan from a 3.3% reduction to a 1.1% growth. (Row 3 in the table)
5. The impact of the changes in baseline and the failure to achieve a reduction in Q1 of the BCF means that the original plan reduction of 3.3% has now reduced to a 2.1% reduction (row 4 in the table)
6. It should be noted that April 2015 (the first month of 15/16 Q1) shows NEL to be 3.8% under the 15/16 plan CCG figures and a FY forecast of 17448 against the BCF pay for performance figure of 17599.
7. The HWBB is asked to confirm acknowledgment of the required changes and agree the revised plan figures.

Better Care Support Team NEL revisions table.

	Baseline - Non-Elective Activity					Revised HWB Plans - Non-Elective Activity						
HWB Name	13-14 Q4	14-15 Q1	14-15 Q2	14-15 Q3	Baseline Total	14-15 Q4 revised	15-16 Q1 revised	15-16 Q2 revised	15-16 Q3 revised	Total	NEL target	% Change
Halton	4,242	4,220	4,133	4,164	**16,759**	4,248	4,034	3,951	3,981	**16,214**	545	3.3%
15/16 PLAN CCG plan figures	4477	4439	4440	4618	**17974**	4548	4483	4484	4665	**18180**	(206)	-1.1%
Revised BCF Plan figures	4477	4439	4440	4618	**17974**	4548	4292	4293	4466	**17599**	375	2.1%

The table above is adapted from the Better Care Support Team NEL revisions e-mail of 15/06/2015 and shows growth as a negative figure.

REPORT TO: Health and Wellbeing Board

DATE: 8th July 2015

REPORTING OFFICER: Simon Banks

PORTFOLIO: Health and Wellbeing

SUBJECT: CCG forward view and 2015/16 operational plan

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To inform the Board of the NHS Halton CCG forward view and 2015/16 operational plan

2.0 **RECOMMENDATION: That the Forward view and 15/16 operational plan be approved as demonstrating the strategic direction of the CCG in relation to the wider health economy in Halton.**

3.0 **SUPPORTING INFORMATION**

3.1 NHS Halton CCG Forward View and 2015/16 Operational Plan

4.0 **POLICY IMPLICATIONS**

4.1 None identified in the plan however it is likely that individual schemes within the forward view may have future policy implications.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 Significant financial investment needs to be made by NHS Halton CCG to achieve the actions within the forward view and operational plan, this investment and associated risks are highlighted in the supporting paper. Additional financial resources are being made by both the Local Authority and the CCG within the Better Care Fund of which a separate but linked operational plan has been produced. This report indicates that the level of financial savings achievable within the CCG financial and operational plans are attainable

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

This plan is in line with the high level priorities set by the HWBB, a separate report on specific commissioning intentions and links to partner's priorities is available here.

http://www.haltonccg.nhs.uk/Library/public_information/April_2015/Final%20Papers%20Emailed%20April%2015%20V2.pdf

6.1 **Children & Young People in Halton -**
Specific commissioning intentions supporting the high level priorities have been identified in the Technical Annexe available in the link above these highlight the integrated work to be undertaken between the CCG and the Council in providing services to children and young people as part of the operational plan.

6.2 **Employment, Learning & Skills in Halton –**
Specific actions have been identified in the operational plan which will have a direct impact on employment, learning and skills, particularly for people with learning difficulties and those with mental health problems.

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

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

6.5 **Halton's Urban Renewal -** None

7.0 **RISK ANALYSIS**

7.1 *A financial risk assessment and mitigation is included on page 52 of the supporting information*

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8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 *No specific equality and diversity issues have been raised*

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

None within the meaning of the Act.

Halton Clinical Commissioning Group

NHS Halton CCG Forward View and 2015/16 Operational Plan

Forward View and 2015/16 Operational Plan summary

1. In response to the NHS England's Five Year Forward View, NHS Halton Clinical Commissioning Group (CCG) and its partners have refreshed and aligned its previously published five year strategy 2014 - 2019. This document clearly sets out our vision for the future and progress made to date. Our commissioning intentions for 2015/16 can be seen within the separate technical annexe document. This plan explains what health and wellbeing priorities Halton's Health & Wellbeing Board has agreed to tackle as identified through the Joint Strategic Needs Assessment (JSNA). It has been developed with partner organisations that deliver and oversee health and care services including, Halton Borough Council, Halton Local Authority Public Health, Local acute and community health care providers, Public Health England, NHS England and many more. Patient groups, voluntary and third sector organisations and groups, Health Watch Halton, clinicians and independent providers and experts have all provided their advice and support over the previous 12 months to create a collective view on how we can improve and maintain the health and wellbeing of our local population. With its creation and our collective intentions we have been able to close the gap for a number of health inequalities for the population of Halton.

2. This strategy brings together an analysis of health and wellbeing needs in Halton and identifies key priorities focussing on quality, prevention and early intervention. NHS Halton CCG has responded to the Five Year Forward View and the needs of its local population and evidence of this can be seen throughout this plan and the supplementary technical annexe document.

3. NHS Halton CCG has within its constitution an agreed vision to "involve everybody in the health and wellbeing of the people of Halton" and this vision is shared with all partners and key stakeholders. It is our aim to continue to tackle inequalities and improve the outcomes for the population of Halton and to help people to live healthier and happier lives. To realise this vision, and to move from ideas to action making the vision a reality, NHS Halton CCG in partnership with stakeholders have agreed to tackle the above challenges over the next 4 years. This strategy identified eight key priority areas that will enable this to happen.

Priority 1 – Maintain and Improve Quality Standards.
Priority 2 – Fully Integrated Commissioning and Delivery of Services across Health and Social Care
Priority 3 – Proactive Prevention, Health Promotion and Identifying People at Risk
Priority 4 – Harnessing Transformational Technologies
Priority 5 – Reducing Health Inequalities
Priority 6 – Acute and Specialist Services will only be utilised by those with Acute and Specialist Needs
Priority 7 – Enhancing Practice Based Services around Specialisms
Priority 8 – Providers Working Together across Interdependencies to Achieve Real Improvements in the Health and Wellbeing of our Population

4. The key themes and priorities to improving health and wellbeing in Halton have been identified using evidence from the Joint Strategic Needs Assessment (JSNA). This assessment provided us with a long list of potential priorities to choose from.

5. Whilst the JSNA provides us with evidence to help us to determine priorities we also know that the skills and experience of local communities are a crucial part of painting a fuller picture of local need. Therefore, in developing our strategy and deciding on our strategic and clinical priorities we continuously assess, consult and review with key partners, local people, including children and young people and community groups, to gain their views on how we are doing.

6. The clinical priorities identified for action through the JSNA by the Health and Wellbeing Board are as follows:

1. Prevention and early detection of cancer.
2. Improved Child Development.
3. Reduction in the number of fall in adults.
4. Reduction in the harm from alcohol.
5. Prevention and early detection of mental health conditions.

7. Progress against priorities will be reviewed on an annual basis and further on-going analysis via the JSNA will be used to determine whether these initial priorities are still relevant and continue to reflect need.

8. The full list of commissioning intentions, associated metrics and targets to achieve the ambitions and priority areas is published in the technical annexe available here.

http://www.haltonccg.nhs.uk/Library/public_information/April_2015/Final%20Papers%20Emailed%20April%2015%20V2.pdf

Recommendation – **That the forward view and 15/16 operational plan be approved as demonstrating the strategic direction of the CCG in relation to the wider health economy in Halton.**

Halton Clinical Commissioning Group

Forward View And 2015/16 Operational Plan

V1.9 13th May 2015

Table of Contents

1 Introduction

In response to the NHS England's Five Year Forward View, NHS Halton Clinical Commissioning Group (CCG) and its partners have refreshed and aligned its previously published five year strategy 2014 - 2019. This document clearly sets out our vision for the future and progress made to date. Our commissioning intentions for 2015/16 can be seen within the separate technical annexe document. This plan explains what health and wellbeing priorities Halton's Health & Wellbeing Board has agreed to tackle as identified through the Joint Strategic Needs Assessment (JSNA). It has been developed with partner organisations that deliver and oversee health and care services including, Halton Borough Council, Halton Local Authority Public Health, Local acute and community health care providers, Public Health England, NHS England and many more. Patient groups, voluntary and third sector organisations and groups, Health Watch Halton, clinicians and independent providers and experts have all provided their advice and support over the previous 12 months to create a collective view on how we can improve and maintain the health and wellbeing of our local population. With its creation and our collective intentions we have been able to close the gap for a number of health inequalities for the population of Halton.

This strategy brings together an analysis of health and wellbeing needs in Halton and identifies key priorities focussing on quality, prevention and early intervention. NHS Halton CCG has responded to the Five Year Forward View and the needs of its local population and evidence of this can be seen throughout this plan and the supplementary technical annexe document.

NHS Halton CCG is the organisation that is principally responsible for the planning and purchasing of health services for approximately 128,000 people who live in or who are registered with 17 GP practices in Halton. The CCG is also responsible for commissioning emergency care for other people from outside of Halton whilst they are in the Borough.

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

Halton's population has increased over the last 10 years. The 2001 Census estimated the population to be 118,200. The 2011 Census estimated it at 125,800 with an increase of 7,600 residents. Health has been improving in Halton over the last decade. Overall death rates have fallen, mostly because of falling death rates from heart disease and cancers. This means that the people of Halton are living an average of around two years longer than a decade ago. However, they are still not living as long as the national average.

A number of factors have contributed to this picture of improving health. In particular the fall in the number of adults who smoke, as well as how quickly people are diagnosed with health problems, together with improvements in the treatments available. Some of the main improvements and challenges are summarised below.

Improvements:

- Life expectancy has consistently risen for both males and females over time.
- Deaths from heart disease and cancers have fallen.
- The number of adults who smoke has fallen.
- There has been an improvement in the diagnosis and management of common health conditions such as heart disease and diabetes.
- Detection and treatment of cancers has improved.
- The percentage of children and older people having their vaccinations and immunisations has improved.
- The number of adults and children killed and seriously injured in road traffic accidents has reduced.
- The percentage of children participating in at least three hours of sport/ physical activity per week is above the national average.

Despite these improvements, the borough still faces a range of tough challenges.

Challenges:

- There are significant differences (inequalities) in how long people live (life expectancy) across the borough.
- People in Halton are living a greater proportion of their lives with an illness or health problem that limits their daily activities than in the country as a whole.
- The proportion of women who die from cancer is higher in Halton than anywhere else in the country. A lot of this is due to lung cancer caused by smoking.
- Significant numbers of people suffer mental health problems such as depression. 1 in 4 people will develop depression during their life. Mental health problems account for the single largest cause of ill health and disability in the borough.
- As Halton's population ages it is predicted that there will be more people with diabetes. This is also linked to being obese.
- The ageing population will mean more people living with dementia.
- The rates of hospital admissions due to falls are higher in Halton than for England and the North West. Rates are especially high for those over the age of 65 were rates in Halton were the highest in England for 2010-11.
- Due to previous high levels of smoking, it is also predicted that more people will develop bronchitis & emphysema.
- Alcohol and substance misuse continue to create challenges for both the health service and wider society, in particular crime / community safety. Admissions to hospital due to alcohol related conditions continue to rise each year.
- Hospital admissions due to alcohol for those under the age of 18 are amongst the highest in the country (2007-2010 figures). Admissions due to substance misuse (age 15-24 years) were the highest in England (2008-2011 figures).
- Teenage pregnancy rates remain high and have been resistant to change, despite the effort local partnerships have put in. Having a child before the age

of 18 can negatively affect the life chances and health of both the parent and the child.

- A range of child health indicators remain poor. Child obesity levels at both reception and year 5 remain above the national average.
- A greater percentage of women continue to smoke during pregnancy and fewer women start breast feeding than the national rates.
- Halton has high levels of people admitted to hospital as an emergency case compared to the country as a whole and many other boroughs. The poorer parts of the borough have higher emergency admission rates than those that are not as poor.

NHS Halton CCG has within its constitution an agreed vision to “involve everybody in the health and wellbeing of the people of Halton” and this vision is shared with all partners and key stakeholders. It is our aim to continue to tackle inequalities and improve the outcomes for the population of Halton and to help people to live healthier and happier lives. To realise this vision, and to move from ideas to action making the vision a reality, NHS Halton CCG in partnership with stakeholders have agreed to tackle the above challenges over the next 4 years. This strategy identified eight key priority areas that will enable this to happen.

Below we have updated our Plan on Page that demonstrates our case for change and co-ordinated approach to delivering a sustainable health and social care for the future.

NHS Halton CCG Operational Plan on a page 2015/16

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

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

- Outcome Ambition 1 – To continue to secure additional years of life for the people of Halton with treatable mental and physical health conditions.
- Outcome Ambition 2 - Improving the quality of life for people with long term conditions
- Outcome Ambition 3 - To reduce the number of avoidable emergency admissions to hospital by 2.8%
- Outcome Ambition 4 - To Increase the proportion of people living independently at home
- Outcome Ambition 5 - To Increase the number of people having a positive experience of hospital care
- Outcome Ambition 6 - To increase the number of people having a positive experience of care outside hospital
- Outcome Ambition 7 - To reduce hospital avoidable deaths

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

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

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

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

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

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

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

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

Governance

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

Overseen through the following governance arrangements

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

Sustainability

NHS Halton CCG faces a 2015/16 finance gap of £2.8m.

For the health economy to be sustainable the goals are:

-All organisations within the health economy are financially viable in 2015/16

-System objectives are achieved

-Reduction seen in Type 1 A&E activity

-Reduction seen in inappropriate non-elective admissions into secondary care

Five year forward view response

- Multispecialty Community Provision –new model of care
- Urgent Care Centre continued development, integrated with new model of care
- Delegated Commissioning of Primary Care

1.1 5 -Year Strategy and 2 Year Operational Plan Update

NHS Halton CCG has made significant steps in delivering the objectives as set out in the 5-year strategic plan and within the eight strategic priority areas. As previously stated these strategic priorities were identified through extensive consultation with partners which provide real improvements in the health and wellbeing for the people of Halton. These improvements are highlighted within this plan, with some of the key actions completed in 2014/15 (see tables below).

The key themes and priorities to improving health and wellbeing in Halton have been identified using evidence from the Joint Strategic Needs Assessment (JSNA). This assessment provided us with a long list of potential priorities to choose from. Whilst the JSNA provides us with evidence to help us to determine priorities we also know that the skills and experience of local communities are a crucial part of painting a fuller picture of local need. Therefore, in developing our strategy and deciding on our strategic and clinical priorities we continuously assess, consult and review with key partners, local people, including children and young people and community groups, to gain their views on how we are doing.

The clinical priorities identified for action through the JSNA by the Health and Wellbeing Board are as follows:

1. Prevention and early detection of cancer.
2. Improved Child Development.
3. Reduction in the number of fall in adults.
4. Reduction in the harm from alcohol.
5. Prevention and early detection of mental health conditions.

To consolidate, confirm and approve the clinical priority areas the Health & Wellbeing Board used a prioritisation tool to enable them to score the emerging priorities and make evidence based decisions about the priorities they would need to focus upon. A copy of the prioritisation tool is available in the appendices section of the strategy. It scores the priority against a range of factors including strategic fit, health inequalities, strength of evidence, value for money, clinical benefit and number of people benefitting.

Progress against priorities will be reviewed on an annual basis and further on-going analysis via the JSNA will be used to determine whether these initial priorities are still relevant and continue to reflect need.

Implementing the priorities has been the responsibility of the commissioners, providers and responsible clinical leads. The actions are progressed through task and finish groups, formal committees or operational front line multi-disciplinary teams. The successful implementation of the plan has meant staff working in new ways, including co-ordinated commissioning, co-production of plans and partners trained and supported to work together enabling new and innovative approaches. NHS Halton CCG and its partners have successfully broken down previous organisational barriers and silo working and have been greatly enthused by the integrated team and partnership approach.

The Health and Wellbeing Board in partnership with Halton Borough Council and the CCG have developed the idea of Wellbeing practices. Where the approach is to seek to deliver a culture change by enabling patients to improve their health and wellbeing by accessing local services and facilities, using self-help tools, accessing training and participating in the local community.

The 8 priority areas below will demonstrate the progress made in the specified areas and the commitment NHS Halton CCG and its partners have made to continually improve and maintain the health and wellbeing of the population of Halton.

Priority 1 – Maintain and Improve Quality Standards.

Maintaining and Improving quality is at the heart of everything we do. Significant progress has been made during 2014/15 and demonstrable evidence can be seen throughout this plan.

Quality schedules within contracts include national quality standards alongside locally development indicators, metrics and targets. This process of standard setting and contract monitoring has enabled quality improvements to be defined and measured.

The Quality Committee reports to NHS Halton CCG Governing Body on the development, improvement and monitoring of all areas of quality. This includes clinical effectiveness, patient safety and patient experience. The Committee provides assurance on the systems and processes by which the CCG leads, directs and controls its functions in relation to quality of care in order to achieve the organisational objectives. The full terms of reference is available here http://www.haltonccg.nhs.uk/public-info/CCG_Committees.aspx

Priority 2 – Fully Integrated Commissioning and Delivery of Services Across Health and Social Care

Integrated commissioning is a priority area for Halton and has brought together a new model approach centred around people, ensuring everyone's needs are met through and integrated health and social care model. This supports GP's and GP practices working together, Community, mental health and wellbeing, social care,

urgent care, acute and primary care including pharmacy services all wrapped around local delivery points.

NHS Halton CCG and Halton Borough Council have developed an approach to integrated commissioning which is now well embedded and delivering improved outcomes for patients. The model of integration with adult social care though joint appointments (Director of Transformation) and pooled budgets for health and social care has enabled flexibility of commissioning approaches and has improved access, quality and value for money across the commissioning areas.

The Better Care Fund Committee and Health & Wellbeing Board receive regular updates on progress and monitors achievements to date. But how do we know we are successful? An outcomes framework that includes overall outcome measures and key performance indicators can measure and demonstrate how we are doing. As we achieve our desired outcomes we will review our priorities and change them if appropriate.

Priority 3 – Proactive Prevention, Health Promotion and Identifying People at Risk

The Public Health team within Halton Local Authority have worked with NHS Halton CCG and its local practices to develop practice level Joint Strategic Needs Assessment for all 17 practices within the borough. This has enabled an understanding of the local population and the inequalities within the practice population. NHS Halton CCG has developed and supported through its commissioning programme in 14/15 the on-going development and embedding of a Multi-Disciplinary Team approach to the identification of high risk patients and a proactive case management system. The team around the practice includes wellbeing services, mental health, drug and alcohol services, community nursing and social care and has provided the spring board for the One Halton approach to Multi speciality provision. This approach of using the JSNA has enabled local teams to target certain areas and patient/population groups to improve the health and wellbeing of those identified at risk.

Priority 4 – Harnessing Transformational Technologies

NHS Halton CCG with its partners has successfully produced an approved Information, Management and Technology (IM&T) strategy.

The implementation of the actions identified through the IM&T strategy are monitored through a committee structure and the use of assistive technologies and information technology will continue to improve patient care, access to care, patient experience, delivery of clinical outcomes, health record keeping and value for money. Harnessing transformational technologies such as telehealth and telecare with our partners in Halton Borough Council will continue to support our intentions in bringing care closer to home. Managing people's health and health care in the right place at the right time

in the right setting is a priority and early detection, prevention and intervention are key objectives within this strategy. Significant progress has been made with the universal use of the NHS Number and the use of Emis Web. Further on going technological advances are continuing to support local service interoperability not only between organisations but between services lines and patients.

Priority 5 – Reducing Health Inequalities

In order to reduce health inequalities NHS Halton CCG and the Public Health Team within Halton Local Authority have worked with its local practices to develop practice level Joint Strategic Needs Assessments. This work has enabled an understanding of the local population and the inequalities within the practice population. Work is on-going with GPs to identify the hidden 40% of the Halton population who do not access GP services or any other service within the borough. 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.

In identifying those hard to reach, 40% hidden Halton population we aim to continue to tackle inequalities by a targeted work programme.

Priority 6 – Acute and Specialist Services will only be utilised by those with Acute and Specialist Needs

Significant progress has been made during 2014/15 with the development of the two Urgent Care Centres. Both sites will be operating a multispecialty community provision model centred around hubs of care to deliver increased out-of-hospital care. So far the evidence suggests that with the proposed model, NHS Halton CCG will see a 2.8% decrease of unnecessary hospital admissions in 2015/16.

The Multi-Disciplinary teams are promoting self-care and proactive case management to tackle unplanned care and unnecessary avoidable admissions.

The Strategy for General Practice and delegated commissioning for primary care will enable the CCG to focus even greater resources on primary and community care to ensure that acute and specialist services are only used by those with acute and specialist needs.

Priority 7 – Enhancing Practice Based Services around Specialisms

NHS Halton CCG General Practice strategy has been developed with the practice population and clinical leads to enhance services for the local population. Significant improvements have been made and plans to further develop the multi-speciality community provision will only further enhance and support this model locally.

The community hub model will only support this approach and significant progress has been made with local partnership agreements and joint working on areas such as access, 7/7 and out of hours care provision.

Priority 8 – Providers Working Together across Interdependencies to Achieve Real Improvements in the Health and Wellbeing of our Population

Through a robust and thorough prioritisation process the health strategy sub group a sub-committee of the Health and Wellbeing Board identified a number of key priority areas based on population need. This process firmly embedded the need for each provider to work seamlessly together across interdependencies to achieve real improvements. The Health and Wellbeing strategy became an enabler with a strategic approach with all partners working together to deliver joint commissioning, bringing about a culture change and joint advocacy and policy work.

An example of this joint approach can be seen in the stroke service where by NHS Halton CCG developed in collaboration with its commissioning and provider partners a local Stroke Group which has facilitated and enabled joint working across both local acute providers in the aim for consistency of delivery and improved quality outcomes. The group has agreed a set of stretch quality targets for both providers and identified the areas for improvement in service delivery. The trajectories are based on performance in the national stroke audit (SNAP) and enable clear benchmarking across services.

Table 1 – Eight Strategic Priority Areas

2014/15 Improvement Intervention Update	
1 – Maintain and improve quality standards.	YTD
Specific targets have been written in the quality schedule of the Community healthcare provider to increase the rate of medication error reporting as this has been highlighted as below the national average.	
The quality of services will be reported at GP practice level at as near to real-time as possible. (ADD141503)	
The Friends and Family test will be piloted with GP practices and rolled out to the Mental Health and community care providers. (ADD141504)	
CQUINs developed with the providers to implement the commissioning outcomes of both the Francis report and the government response. Reviewing performance against last year and against Cavendish review, 'patients first' government response and Berwick re patient safety collaborative. This will be supported by evidence of duty of candour, quality strategy and training programmes including mandatory training. (ADD141505)	

Quality standards improved in the acute sector providers by appropriate use of SHMI and HSMR mortality figures to identify areas for further investigation and evidence of improvement actions taken where appropriate. (ADD141506)	
Investigate the reasons behind the number of people who do not attend appointments (DNA's) review practices and develop methods for reduction. (ADD141501)	
Develop clear and transparent process for applying for grants from the CCG. (ADD141507)	
2 – Fully integrated commissioning and delivery of services across health and social care.	
Better Care Fund plan actions are implemented. (ADD141509)	
Further develop integrated services between the NHS and Local Authorities for people with complex needs. (ADD141508)	
Develop an integrated approach with Halton Borough Council with community pharmacies. (ADD141512)	
Deliver single specification with the Local Authority to deliver Children's speech and language services. (WCF141505)	
Deliver revised Tier 2 CAMHS specification as a joint project with the Local Authority. (WCF141508)	
Secure provision of community services from 2015, VfM contract to reflect the needs of the population supporting more integrated care. (PCI141514)	
3 – Proactive prevention, health promotion and identifying people at risk early	
Examining the evidence to introduce a targeted screening programme to increase early detection rates of lung cancer. (PC141505)	
To work with the NHS England Merseyside area team in the shared pursuit of improving uptake and early diagnosis of bowel, breast and cervical cancers. (Public Health Commissioning Intentions 2014/15 – Merseyside Area Team)	
To review access to lifestyles service for patients with cancer, for example breast cancer, weight loss and exercise programme. (PC141508)	
Review provision of services for people with diabetes who have developed foot problems with the desired outcome of reducing the number of complications associated with foot problems in people with diabetes. (PC141513)	
Securing 1 day service provision for people who have had a TIA. (PC141510)	

Strengthen the GP's role at the heart of out of hospital care by identifying people at risk of hospital admission and introducing named accountable clinician. (PCI141501)	
Explore the potential for introduction of a programme of care for Familial hypercholesterolemia. (PCI141512)	
Roll out learning disabilities physical health checks to under 16s. (MHUC141510)	
Delivery of the Direct Enhanced Service for dementia within general practice, to increase awareness and screening for dementia. (MHUC141511)	
Reduce the level of antibiotic prescribing. (ADD141510)	
4 – Harnessing transformational technologies	
Consider the use of technology to manage sleep apnoea in the community. (PC141501)	
Implement the EPACCs IT system – Improve the use of special patient notes in end of life care. (PC141506)	
Develop an integrated Health & Social care IM&T strategy & work plan. (PCI141510)	
5 – Reducing health inequalities	
Reviewing the phlebotomy and pathology provision to increase the equity of provision. (PC141520)	
Increase access to and equity of provision of community Gynae services. (PC141517)	
Improve outcomes for people experiencing domestic abuse with a review of the Halton Women's centre. (WCF141511)	
Supporting NHS England in ensuring quality in primary care, reducing the variation seen across membership practices. (PCI141508)	
Develop local services to reduce suicide attempts. (MHUC141501)	
Review the AED liaison psychiatry model, ensuring that acute and emergency care for people in mental health crisis is as accessible and high quality as for physical health emergencies. (MHUC141502)	
Develop and launch 'safe in town' initiative across Halton to increase the number of people in vulnerable groups feeling safe in their communities. (MHUC141503)	

Work with other North West CCG's to secure provision of an IAPT service for military veterans. (MHUC141504)	
Review current eating disorder service to improve outcomes for patients. (MHUC141506)	
Implement the action plan from the Health Needs Assessment for Learning Disabilities. (MHUC141507)	
Develop alternative employment opportunities for vulnerable groups to improve the emotional wellbeing and support individual personal development. (MHUC141508)	
Develop mechanisms to ensure we listen to the whole population, including young people and BME communities. (ADD141502)	
6 – Acute and specialist services will only be used by those with acute and specialist needs	
Procurement of community paediatric consultant service. (WCF141502)	
Expand community provision for special schools orthoptic service. (WCF141503)	
Review possible procurement of community midwifery service. (WCF141504)	
Evaluate the Mersey QIPP pilot for children's community nursing service. (WCF141510)	
Amend existing asthma care provision to divert emergency admissions and A&E presentations to the new Urgent care centres. (WCF141512)	
Support the regional procurement of NHS 111. (MHUC141513)	
Implement the Urgent Care redesign preferred model to reduce inappropriate A&E attendances and subsequent admissions. (MHUC141514)	
7 – Enhancing practice based services around specialisms	
To support GP practices to deliver services over above their core contractual responsibilities. (PCI141505)	
Develop the strategy for sustainable general practice in Halton. (PCI141506)	
8 – Providers working together across inter-dependencies to achieve real improvements in the health and wellbeing of our population	
Review pathways for patients with cancer attending hospital to explore alternative models of follow up i.e. telephone follow up or GP led. (PC141509)	

Increase integration in the musculoskeletal (MSK) pathway. (PC141515)	
Review the design of community services to focus on outcome based services. (PCI141503)	
Establish a single supplementary specialist service for dementia patients that is able to effectively respond and meet the multiple and complex needs of a care home population through the provision of enhanced support. (MHUC141515)	

1.2 Two Year Operational Performance

As part of the progress made to date NHS Halton CCG and its partners can demonstrate through our two year operational performance dashboard the improvements in outcomes during 2014/15.The most significant improvement can be seen in the reduction in our Potential Years of Life Lost with an overall reduction of 8% narrowing the gap between Halton and the national average. During 15/16 and onwards Halton aims to reduce that gap even further and see improvements in the health and welling of the population of Halton. To achieve this objective a series of commissioning intentions has been developed, a full list of these is detailed in the technical annexe document. These commissioning intentions are built on the work done in 2014/15 and consultation with stakeholders and have been prioritised as the best way to achieve NHS Halton CCG's stated objectives.

Table 2 – 2 Year operational plan: Performance Dashboard

2014/15 Two year plan outcome measures						
Metric	**Actual 13/14**	**Plan 14/15**	**Actual 2014/15**	**RAG**	**Plan 2015/16**	**Narrative**
Outcome Indicators						
Potential years of life lost	2856 (2012)	2856 (2013)	2575 (2013)	Green	2492 (2014)	Halton has witnessed 2-year reductions in PYLL is the key areas of Cerebrovascular diseases (-13%) Ischaemic heart disease (-9%), however no reduction has been seen in years of life lost to respiratory diseases and an increase has been seen in years lost to neoplasms (+15%) The overall reduction in PYLL of 8% narrows the gap between Halton and the national average, and in 15/16 Halton aims to reduce this gap further
Improving health Related Quality of Life for people with long term conditions	0.668 (12/13)	0.672 (2013/14)	0.685 (2013/14)	Green	0.693	People with a long-term condition in Halton reported a small improvement in their Quality of life, this improvement was slightly better than Merseyside as a whole and much better than the National figure which showed a reduction in health-related quality of life, Halton aims to reduce the gap to the National figure further in 2015/16

IAPT Access	8.66% (annual)	10.5% (2.63% per quarter)	3.6% (Q3 2014/15)	Green	3.75%	During 2014/15 NHS Halton CCG changed IAPT provider to 5 Boroughs Partnership, significant work has been done to increase access rates and are now very close to achieving a quarterly target of 3.75% This is a significant improvement on the average of 2.2% access rate seen in 2013/14
Dementia Diagnosis	60.10%	67%	70%	Green	75% (Q4 2015/16)	NHS Halton CCG has worked closely with the NHS and General Practice to increase the diagnosis rates to the 70% level at the end of March 2015, Halton has greater ambitions and has set a target for 75% of people with dementia to have a formal diagnosis by the end of 2015/16
IAPT recovery rate	36%	50%	38% (To Dec 14)	Red	50%	Recovery rates have improved considerably since the start of the year, however the low level of recovery seen between April and July is having an impact on the cumulative year to date position. The monthly recovery rate for December 2014 was 46% and initial figures suggest a further improvement in January. The target for 2015/16 is reach and maintain at least a 50% recovery rate and the additional resources being made available to Mental Health should help achieve this.
Unplanned hospitalisation for chronic ambulatory care	1193 (12/13)	1163	1012 (FOT)	Green	984	Excellent progress has been made in reducing the number of admissions to hospital which could have been avoided through treatment elsewhere, reductions have been seen in all categories with the exception of unplanned admissions for asthma in children where a small increase is being seen. The reduction being seen in admissions for conditions that should not usually require an admission is having a positive impact on the overall Non-elective activity measure, which although not meeting the target is forecast to be below the 2013/14 out-turn. It is expected that through NHS Halton CCG's plan for more out-of-hospital care that reductions will be seen again in 2015/16.
Unplanned hospitalisation for asthma, diabetes and epilepsy	402	350	422 (FOT)	Red	410	
Emergency admissions for acute conditions that should not usually require hospital admission	1845.5	1794	1400 (FOT)	Green	1361	
Emergency admissions for children with Lower respiratory tract infections	488 (12/13)	476	439 (FOT)	Green	426	
Proportion at home 91 days after reablement	64 (12/13)	68	68 (FOT)	Green	70	It is anticipated that the 2014/15 target will be met and a further improvement is planned for 2015/16 through schemes identified in the better Care Fund, this will close the gap to the national average which has been increasing in recent years.
Quality						
Friends & Family test (A&E) Warrington Hospital)	n/a	n/a	84%	n/a	87%	A change to the method of calculation in 2014 has unfortunately meant that comparisons to previous data are not possible and that the targets set for 2014/15 are no longer measureable against. The actual performance seen in 2014/15 at our local acute providers has been positive with performance generally above the National average with regard to patients who would recommend the service, this high level of recommendation is forecast to continue in 2015/16. The
F&F A&E Whiston	n/a	n/a	95%	n/a	95%	

F&F Inpatient Warrington Hospital	n/a	n/a	94%	n/a	95%	only exception being performance at Warrington A&E which is slightly below national average, this has been selected as a quality premium measure for Halton in 2014/15 and improvements have been seen and are forecast to continue into 2015/16
F&F Inpatient Halton Hospital	n/a	n/a	98%	n/a	98%	
F&F Inpatient St Helens Hospital	n/a	n/a	100%	n/a	100%	
Composite measure of GP services	6.7 (2012/13)	6.5	6.3 (2013/14)	Green	6.3	Patient experience of General Practice has been positive and although the target has been missed for Out-Of-Hours satisfaction 76% of patients would still rate the experience as 'fairly good' or 'very good' this is higher than the England average, we anticipate that the work being done to expand out-of-hours provision in 2015/16 will increase patient satisfaction further.
Patient Experience GP Out of Hours	80%	80%	76%	Red	80%	
Patient Experience GP Overall	84%	85%	85%	Green	86%	
MRSA	0	0	0	Green	0	Halton have reported no Healthcare acquired MRSA infections in 2014/15 however the number of C-Diff cases has increase over 2013/14 and is significantly above plan. The 2014/15 plan was set by NHS E based on part year data which did not include the winter period and took into account the exceptionally low C-Diff figures seen in 2013/14. The plan set by NHS E for Halton for 2015/16 is a more realistic assessment.
C-Diff	26	20	38 (FOT)	Red	36	
Activity						
Ordinary Admissions	3444	3524	3168 (FOT)	Green	3012	During 2014/15 there has been a positive change in how patients are treated with a move towards Daycase treatment and away from a more traditional overnight admission (ordinary admission) the pace of this change was not full anticipated in the 2014/15 plans. There has also been an overall increase in the number of admissions of 3% on 2013/14 actuals, which is approximately 1/3rd demographic change and 2/3rds increase due to non-demographic changes such as increased expectations of the NHS. The movement towards Daycase and away from overnight admissions is forecast to continue in 2015/16
Daycase admissions	15443	15583	16212 (FOT)	Red	17264	
Non-elective admissions	16941	16512	17106 un adjusted. (18045 adjusted)	Red	18225	The planned reduction in Non-Elective Activity has not been seen in 2014/15 due to the delay in making the urgent care centres fully operational, A particularly high number of non-elective admissions in the early part of 2015 has meant that Halton has slightly increased the number of non-elective admissions over 2013/14 levels. Counting changes at St Helens have meant that the 15/16 plan of 18225 should be compared to the 18045 adjusted figure. This represents a 1% increase. This plan includes a level of contingency for system resilience in case of a harsh winter or other un-expected event, the level of this contingency takes the planned 2.8% reduction to a 1% growth.
GP referrals (General & Acute)	26537	26712	28364 (FOT)	Red	29788	As seen across the country, there was a significant increase in the number of GP referrals in 2014/15, in Halton at the beginning of 2014/15 an additional factor was the ending of the

Other referrals	16606	15264	16715 (FOT)	Red	18474	contract with the community ENT provider which led to increased referral rates to secondary care providers. The GP referral rates reduced in the latter part of 2014/15 and this reduced level of increase has been forecast to continue into 2015/16. The increased GPO referral rates and end of the community ENT contract has also led to an increase in outpatient appointments. Although NHS Halton CCG has currently forecast further increases in Outpatient and GP referrals this may be revisited following detailed planning negotiations with providers and the impact of increased community provision may reduce the 2015/16 plan in the coming months.
1st Outpatients	38419	38700	40607 (FOT)	Red	42733	
A&E attendances (excluding Walk in centre)			47664 (FOT)	Green	48097	Due to the recent developments in the urgent care centres and the anticipated reclassification of Widnes form a type 4 to a type 3 site the figures reported here only relate to type 1 and 3 activity. Although NHS Halton CCG has planned a 2.8% reduction in activity a contingency has been built in to allow for unexpected events and a small (1%) growth has been factored into this contingency.

1.3 Better Care Fund Update.

The £5.3bn Better Care Fund (formerly known as the Integration Fund) was announced by the Government in June 2013, to ensure a transformation in integrated health and social care. The Better Care Fund (BCF) is a critical part of the NHS Halton CCG 2 year operational plan and the 5 year strategic plan.

NHS Halton CCG and Halton Borough Council's Better Care Fund plan submission was approved by NHS England in 2014/15, this plan has over £9 million in additional funding made available over and above committed pooled allocations. The schemes identified and funded through the plan will make significant improvements in the outcomes for Halton residents and will ensure that more care happens out of hospital. Specific targets have been set for 2015 including reducing non-elective admissions to hospital by 3.25%. Although following the particularly high level of non-elective activity seen at the start of 2015 this was subsequently reduced to a 2.8% reduction. An example of the schemes in place is the planned reduction in the number of readmissions due to falls, which has also been chosen as a quality premium measure for the CCG. Adjustments have been made in the main acute non-elective care provider's budgets to reflect the plans in place in the Better Care Fund plan, including the significant impact of the Urgent Care Centres in reducing both A&E attendances and non-elective admissions.

1.4 System Resilience

The creation of Urgent Care Working groups (UCWG) presented a unique and valuable opportunity for NHS Halton CCG and Halton Borough Council and partner organisations to co-develop and co-produce plans to manage urgent care demand. In doing so the urgent care working group evolved into a system wide resilience group (SRG) expanding its role and remit to cover elective (planned) as well as non-elective care (un-planned). Particular emphasis was on clinical pathways and representation from each provider group.

The overarching goals of the Halton SRG are twofold: to bring together both urgent un-unplanned care and elective planned care together and to enable systems to determine appropriate arrangements for delivering high quality services to the population of Halton.

1.4.1 Winter Monies

As part of the budget for 2015/16 winter monies now form part of the CCG baseline however this amount is less than received in 2014/15. This is £969k for Halton in 2015/16 compared with £3,269k received in 2014/15.
The planning process for winter 2015/16 will begin in earnest in April 2015 at the System Resilience Group meeting, in preparation for this schemes identified

elsewhere (such as in the BCF) and schemes known to have worked in the past will be assessed for their inclusion in the SRG plan. This will be completed by July 2015 to enable providers to make any necessary adjustments for winter 2015/16. Although less money has been received in 2015/16 than 2014/15 the fact that the amount is known well in advance will make winter planning more timely and enable providers to have certainty, months in advance, of the resources that available to fund winter pressure schemes.

1.4.2 Urgent and Emergency Care Network

Urgent and Emergency Care is one of the new models of care as set out in the Five Year Forward View. The Urgent and Emergency Care Review proposes a fundamental shift in the way urgent and emergency care services are provided. NHS Halton CCG has responded well to this suggestion and has progressed with the Urgent Care Centres delivering a new model of care for the population of Halton. The Urgent Care Centres provide a highly responsive service that delivers care as close to home as possible, minimising disruption and inconvenience for families. For those people with serious or life threatening emergency care they can be treated in the appropriate care setting with the right advice in the right place at the right time.

1.5 Workforce Implications

1.5.1 Local Education & Training Board (LETB)

The Local Education and Training Board (LETB) for Merseyside has a nominated senior representative from St Helens CCG for all Merseyside CCG's. Feedback from the LETB is received at CCG Network and Chief Nurse's meetings. This enables NHS Halton CCG to be involved with discussions with LETB and influence as appropriate the work programs.

Chief Nurses have LETB issues on their agenda for their bi-monthly meetings with NHS England and all chief nurses are linked up with the work in progress being delivered by Health Education England including:

Integrated workforce planning

Practice Nurse Education – including access to the Practice Nurse Specialist Practice Qualification (SPQ)

Development of short introduction programme to Practice Nursing.

NHS Halton CCG is linked into the work with LETB around new roles in urgent care regarding the training and competency requirements, and also in the preparation of the training and competency requirements for the new roles of health and social care assistants.

1.5.2 Working Across Boundaries

NHS Halton CCG does not see any restrictions in artificial boundaries and works cooperatively with all providers, stakeholders and commissioners. Evidence of cross border working can be seen in a number of specified areas and our contribution to the wider networks can be seen with benefits realised through our priorities and commissioning intentions.

1.5.2.1 Nursing and Midwifery Revalidation

NHS Halton CCG currently commissions a programme for nursing revalidation delivered by a local university which includes preparing all practice nurses for revalidation and preparation of portfolios. As the process for revalidation is agreed via the Nursing and Midwifery Council the CCG will ensure that local nurses and midwifes are informed of the requirements for revalidation.
In April 2015 all practice nurses will go through this process and if interest is high enough this will be offered to registered nurses in care homes.

Providers are required to evidence the actions they have taken to prepare for revalidation and present that evidence to NHS Halton CCG.

1.5.3 Primary Care Workforce

"General Practice is often described as the cornerstone of the NHS, with roughly one million people visiting their general practice every day" (NHS England, A call to action, April 2014). Nine in every ten patient contacts are at GP surgeries.[1]

However, the demands placed upon GPs and their teams have never been greater. Primary care sees more patients than ever, with more complex needs and greater expectations; it offers a wider range of services and it is seeking to maintain and improve ever higher standards of care. At the same time, the GP workforce is changing. Significant numbers of experienced GP principals are nearing retirement age, the GP workforce is becoming increasingly sessional and/or part-time, and many areas are experiencing difficulty with recruitment.

GP workload has increased from an average of 4 consultations per person, per year in 1995 to 5.5 consultations per person, per year in 2009 (HSCIC, 2012) and funding of General Practice as a percentage share of total NHS expenditure has reduced from 10.7% in 2005/06 to 8.4% in 2011/12 (GB)

In response to 'A Call to Action' and to inform the challenges facing general practice and provide a sustainable future for membership practices, NHS Halton CCG has begun working with its member practices and key stakeholders to undertake a review of its services and their sustainability. To meet the increasing challenges

[1] *"Effective primary care enables improved health outcomes and lower costs" (Starfield at al, 2005; Atun, 2004).*

faced, there is a need to reshape the range of services offered within general practice, thereby enhancing the sustainability of practices whilst preserving the local roots of general practice that are valued highly by patients.

Data sourced from the Health and Social Care Information Centre demonstrates that as of 30th September 2013, Halton had the following number of GPs (excluding Registrars and Retainers):

Table 3. Full time Equivalent GP's

Under 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	Total
2	9	9	9	10	8	12	5	1	66

This demonstrates that 27.1% of current practitioners in Halton are 55 and over.

Having considered the information and evidence available and through a process of engagement with member practices and stakeholders, the conclusion was reached that **General Practice in Halton is not sustainable** in its current guise.

It is proposed that a new model (the Multispecialty Community Provision model) is established with community services centred around people, ensuring everyone's needs are met through an integrated health and social care delivery model. This will see GP practices working together, in a much more integrated way with Community, Mental Health and Wellbeing, Social Care, Urgent Care and Pharmacy services all wrapped around local delivery points.

At present, there are 17 practices operating as 17 separate delivery organisations in 17 different locations. This model is predicated on the practices starting to work together to create a number of community 'hubs', although the specific configuration of this will be for the General Practices and staff to determine.

1.5.3.1 Adult Community Nursing

The Adult Community Nursing services within Halton are currently provided via an NHS block contract through Bridgewater Community Healthcare NHS Trust.

These services include:

- Community Matrons
- Continence
- District Nursing
- Heart Failure
- IV Therapy
- Macmillan
- Stroke Services

- Tissue Viability
- Treatment Room

It is a well-known fact that over the next five years NHS Halton CCG, Halton Borough Council, and our partners face significant financial challenges.

People are living longer, and the numbers of older persons will increase markedly in the coming decades. The health needs of this population are changing, and significant numbers will have multiple health and social care needs.

This changing landscape means NHS Halton CCG and Halton Borough Council need to do things differently, and transform all aspects of health and social care and wellbeing.

Part of this transformation will include the redesign of primary care, and integrating clinical pathways across acute and community services with an emphasis on moving care closer to home, thus enabling a seamless approach to patient care.

One of the key pillars in this transformation is the development of an Integrated Adult Community Nursing Team forged around primary care and natural geographies.

NHS Halton CCG's Vision for Integrated Adult Community Nursing

The overarching vision for how care will be delivered is through an effective Integrated Adult Community Nursing Model that focuses on prevention, early identification and intervention. By bringing together primary and community care the Model ensures:

- Patients are in control of their health and their care
- Tailored, personalised care including co-ordination and care planning for those who would benefit
- Co-ordination of care including lifestyle support and advice with an emphasis on self - management
- Reduced avoidable admissions to hospital and early supported discharge where admission is necessary

Developments within NHS Halton CCG that Support the implementation of an Integrated Adult Community Nursing Model

Co-Commissioning which will achieve greater integration of health and social care services, especially out of hospital care, and raise standards of quality with General Practice services

Integrated Commissioning Function with the Local Authority to make best use of the Better Care Funding which will be spent locally on health and social care to enable closer integration to improve outcomes for people with care and support needs

The Development of an NHS Halton CCG Primary Care Strategy will enable General Practice to play an even stronger role at the heart of integrated, out of hospital services

The Development of an Integrated Health and Social Care IT system will support the adoption of modern, safe standards of electronic record keeping, and the development of integrated electronic care records that are universally available at the point of care for all clinical and care professionals

A New Way of Working: Supporting the Delivery of an Integrated Community Adult Nursing Model

An Integrated Adult Community Nursing Model aims to give the population of Halton, a transformational, affordable and sustainable service that is needed to improve local health outcomes.

Adult Community Nursing Services will play an important role in supporting the delivery of integrated care and putting patients at the heart of service delivery, through placing an emphasis on prevention, early identification, early intervention, supporting self-management as well as supporting those with complex needs.

1.6 Future Service Model for Halton

The future service model is a significant strategic development within the 5-year strategy; it builds on Halton's emphasis on out of hospital care through the use of Multispecialty Community Provision.

NHS Halton's CCG future service model is underpinned by 10 key principles

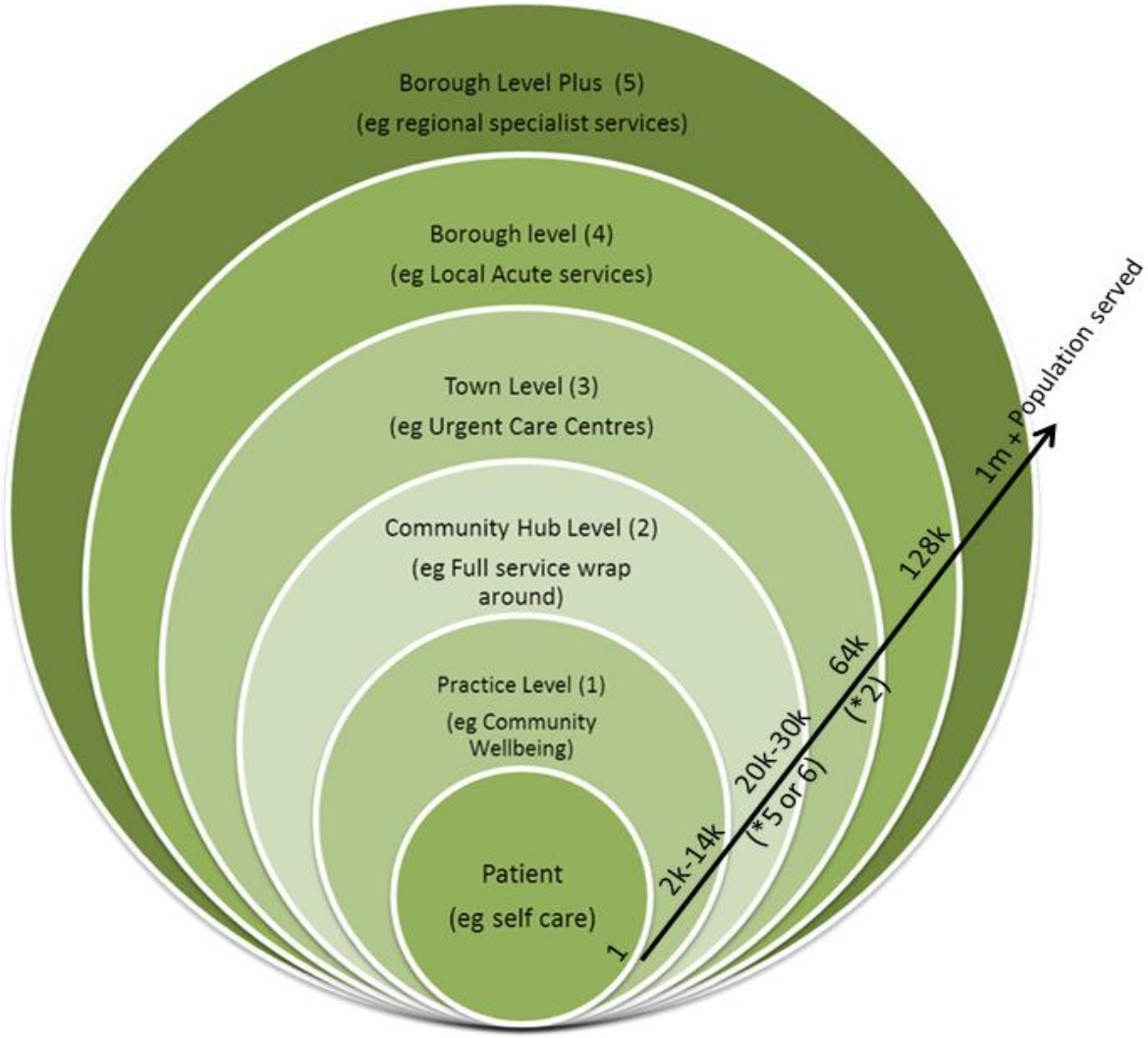
1. Consistent high quality care for every local resident
2. Care continuity for patients with long term conditions
3. Reduced unwarranted variation
4. Strong local clinical leadership
5. Offering services at scale, delivered locally to the individual
6. High levels of population and public engagement and co-design
7. Commissioning and contracting for outcomes, not inputs or processes
8. Services working in greater collaboration
9. Improving access and better pathway co-ordination
10. Focus on Prevention

The out of hospital care provided through Multispecialty Community Provision will require providers from across the Halton to work together.

The multispecialty community provision (MCP) model in Halton will be considered for each and every service, different approaches will need to be taken depending on the service and the level at which that service can be provided. There are five levels at which services can be delivered, the 'community hub' level will bring a local focus to the MCP concept and the Hubs will see practices working together, alongside the

range of providers and partners. Each hub will determine the best configuration to meet its population needs. The 17 Practices in Halton are currently determining these hub arrangements and NHS Halton CCG is supporting those discussions to ensure the optimum hub design, based on geography and a value-based approach to working together.

Figure 1



- Level 1, Practice level – services that are provided to individual practices
- Level 2, Community Hub level – services are provided across more than one practice, across wards and communities
- Level 3, Town level – services are provided across the two towns, potentially around the Urgent Care Centres or other delivery points in Runcorn and Widnes.
- Level 4, Borough level – Services are developed on a whole-borough basis, with one team or service servicing the whole population.
- Level 5, Borough Plus level – Services, probably specialist in nature, developed and delivered across more than one CCG, across Mid Mersey, pan Merseyside, Merseyside and Cheshire or beyond.

We will continue to work with partners, establishing a One Hospital Programme Board as we work collaboratively to implement this strategy and ensure it aligns with the broader system design and demands.

As stated earlier the Public Health team in Halton have identified seven areas of focus where the future service model can have the biggest impact. These areas build on and add to the areas identified in the Health & Wellbeing Board plan for Halton as part of the JSNA.

Table 4: Seven Areas

Area	Rationale
Mental Illness	Highest cost to NHS, largest contribution to disability adjusted life years (DALYs) lost in Halton; 4th largest contribution to local mortality
Cancer and CVD	Two largest causes of premature mortality; 2nd and 3rd biggest contributor locally to DALYs lost. 1st and 2nd largest cause of potential years of life lost (PYLL) inequalities gap
Unplanned / Urgent care	Highest rate of 30 day re-admissions in the north-west
Hypertension	Largest disease register and biggest prevalence gap
Gastrointestinal including liver disease	Worst rate of premature mortality, 4th largest contribution to PYLL, inequalities gap
Respiratory disease	Large cause of hospital admissions, 4th largest contributor to disability and 3rd to mortality locally, 3rd for PYLL, inequalities gap
Accidents	Inequalities gap, Halton is an outlier for children's accidents.

2. NHS Forward View – NHS Halton CCG Perspective

2.1 Creating a New Relationship with Patients & Communities

2.1.1 Prevention

2.1.1.1 Cardiovascular Disease

NHS Halton CCG with its partners in Public Health, Halton Borough Council and NHS England are developing a cardiovascular strategy for Halton which will address some of the issues identified, including the prescribing of antihypertensive medication to patients at risk of or already diagnosed with cardiovascular disease.

2.1.1.2 Smoking

NHS Halton CCG is working with colleagues in Public Health to review the support available for smoking cessation services. The Halton Stop Smoking Service is provided by Halton Borough Council. In 2013/14 52.1% of people entering the service successfully quit after 4 weeks, it is planned that this will increase to 53.4%[2]

The implementation of the successful Wellbeing practice model to provide holistic health care within GP practices in order to better respond to social determinants will allow a straightforward path into smoking cessation services.

2.1.1.3 Alcohol

An alcohol harm reduction strategy for Halton has been developed and was launched during alcohol awareness week (17-23 November 2014). 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 and will be rollout during 15/16.

During 2015/16 we will be recruiting 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

[2] *While PH is happy to share these targets and report on actions/progress, these are PH targets and not to be held accountable via CCG. In sharing the targets the aim is to combine efforts to achieve the outcomes, it is not expected that either PHE or CCG will attempt to performance manage PH using these data*

issue in Halton. The project is being run by community engagement specialists “Our Life” and funded by Halton Council. A health education campaign will be developed promoting an alcohol free pregnancy. We will work together to develop a joint alcohol communications campaign agreed by all partners, delivering a social norms campaign within schools. The alcohol treatment pathways will be reviewed and we will work together to ensure the local licencing policy supports the alcohol harm reduction agenda and that local premises adopt a more responsible approach to the sale of alcohol.

The plans for 2015/16 are to not exceed the thresholds set in 2014/15 for 64.3 under 18 alcohol specific admissions per 100,000 population (2011/12 to 2013/14 crude rate) and 811.8 alcohol-related admissions per 100,000 (narrow – DSR per 100,000)

2.1.1.4 Obesity

Halton offers a range of weight management services 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 are under review and opportunities to enhance provision are being identified. Halton’s level 1 and 2 weight management programme for adults and children was transferred from Bridgewater to Halton Borough Council in October 2014; both these levels are to be reviewed in early 2015. The level 3 weight management service (dietetics, CBT) is to be retendered with an expected start date of service of 01/09/2015.

The Implementation of successful Wellbeing Practice Model to provide holistic health care within GP practices in order to better respond to social determinants of health, will enable patients to access weight management services through the GP.

2.1.1.5 Diabetes

NHS Halton CCG developed in partnership with the Merseyside Diabetes Network (MDN) an Impaired Glucose Regulation (IGR) pathway for General practice. In Halton the successful implementation of this pathway resulted in the number of people on the IGR register increasing from 1955 as of 31/03/2013 to 2554 on 31/03/2014. This pathway is still in operation and new cases are still being identified.

2.1.1.6 Employment

As part of the wider population health and our shared vision “involve everybody in the health and wellbeing of the people of Halton” NHS Halton CCG will continue to work with partners and stakeholders to support our population through employment initiatives and accessing the right support for individuals.

An example of this are the increased resources into the IAPT service, which is helping hundreds more people with low level mental health problems access services support, and an increasing recovery rate giving more people the capability

to return to work. NHS Halton CCG through its support with the Women's Centre is supporting women get back into work through providing meaningful activities.

2.1.1.7 Staff Health

NHS Halton CCG is committed to improving the physical and mental health and wellbeing of its staff, during 2015 staff are encouraged to take part in wellbeing exercises, through Wellbeing Enterprise and other external providers as well as taking part in physical exercise such as lunch time Nordic Walking.

2.1.1.8 Integrated Personal Commissioning

NHS Halton CCG is committed to working with the local Authority and other organisations including the third sector to build on the joint work already completed as part of the BCF and integrate further the provision of health and social care through the use of integrated personalised commissioning, this will allow individuals in Halton to direct how their budget is used with help through personal care planning.

Personalised budgets are already in place for people with complex needs with the CCG and the LA working together with a pooled budget to provide joint services and a voluntary sector provider in place to provide care planning, Community Nurses are already working with patients to complete and sign off care plans.

Additional work is already well under way in regards to children with a Statement of Educational Need (SEN) but we plan to extend this further to include people with long term conditions, learning disabilities or severe and enduring mental health problems. The CCG is putting additional resources in terms of personnel into this and the complex care lead will be helping to expand the service and provide a lead on this into 2015/16

2.1.1.9 Patients Entitlement to Choose (Mental Health)

Within Halton there are multiple providers offering mental Health services, including 5BP, Cheshire & Wirral partnership, Mersey care and Wellbeing Enterprises. The fact that there is no Payment by Results (PBR) or Any Qualifies Provider (AQP) for mental health services will be limiting the number of providers somewhat. However in Halton we are confident that there is sufficient choice in the market place across a range of services to provide patients with options as to their treatment, in addition both Adults Improving Access to Psychological Therapies (IAPT) and Child and Adolescent Mental Health Services (CAHMS) services are moving to self-referral.

2.1.1.10 Choice in Maternity

Choice within maternity services has not been restrictive for the population of Halton and women and their families are offered choice where and whenever they choose. The local community provider is not affiliated to any specific acute provider and therefore women locally are offered the choice of four local acute providers.

2.2 Engaging Communities

2.2.1 NHS Citizen Approach

2.2.1.1 Hard to Reach Communities

NHS Halton CCG has been working with private providers and the 3rd sector to actively engage with hard to reach communities in Halton. We have been working with SHAP whose aim is to enable homeless, vulnerable, or disadvantaged people to take control of their own lives and to receive high quality housing and support, and the BME Halton network. SHAP have been working in partnership with other agencies including the Gypsy and Traveller Liaison officer in the Borough.

Some of the achievements include

- Getting the communities to set up a self-help Resident Association
- Getting the group to engage with Halton BME Umbrella Group
- Supporting 9 individuals to access mental health services
- Supporting 2 adults to access McMillan Cancer Service. There is however, on-going capacity building initiative to enable volunteers from the G&T site in Widnes to begin providing support to other members of the community.

In addition the Polish Family Group is also being supported through collaborative work with Halton BME Umbrella Group to set itself up as a self-help group.

2.2.1.2 Children & Young People Engagement

NHS Halton CCG is part of the Halton Children and Young people Forum (CYPVSF), INVOLVE3 [3] and youth events. We also invite young people and representatives to our take over day, board and committee meetings, consultation steering group and the Halton Peoples Health Forum (HPHF). During the recent procurement for Tier 2 CAMHS two young people from the Youth Cabinet were part of the interview panel.

NHS Halton CCG have worked with SPARC4 [4] (Supporting People Achieving Real Choice) to produce the six Halton Health Comics and animations to help Learning Disabled and other vulnerable groups to be informed and empowered about health topics

NHS Halton CCG is starting to work with and engage with east European migrant workers and their employers via the Chamber of Commerce and during the first half

[3] INVOLVE is a participation group whose role is to act as a critical friend to Halton's Children's Trust on participation, and has strong links with Halton Safeguarding Children Board.
[4] SPARC is a small charity which was first established in July 1995 they are based in the North West of England and support people with Learning Disabilities and family carers. Most of their work is currently based in Halton, Liverpool and Manchester.

of 2015 NHS Halton CCG will be working with SHAP is developing “Celebrating Cultural Diversity” to be themed around Dementia to be delivered across the three boroughs in the next two quarters.

NHS Halton CCG will be visiting youth groups and youth providers to discuss Patient Participation Groups (PPG’s) and virtual groups, and developing its use of websites, twitter and other social platforms. Youth parliament visit will be arranged with Catch 22[5] in the New Year.

2.2.1.3 Carers

NHS Halton CCG and Halton Borough Council have drawn up plans to identify and support carers and in particular how they could best work with voluntary sector organisations and GP practices to identify a) Young carers b) Carers who are more than 85 years old, in order to provide better support.

Plans focus on supporting young carers and working carers through the provision of accessible services and services to those carers who are themselves from a vulnerable group (over 85 for example). Further work is planned during 2015/16 and a number of key workshops and events are planned to align the support and ensure we capture the needs, ideas and experiences of those carers and their families.

2.2.1.4 Volunteering & Lay People

Voluntary and community sector groups have expressed a strong desire to play a key role in delivering services. In early 2015 Halton has begun to develop its volunteering policy, The CCG is committed to promoting health, reducing health inequalities and delivering the best possible care for our local population within the resources available. In order to achieve this, the CCG encourages and supports the involvement of patients and the public at all levels within the organisation to ensure that patients, carers and the public are involved in decision making processes and influence CCG services. The CCG sees volunteering as an essential aspect of our patient and public involvement work, which will help to build better links and relationships with our local community.

2015/16, following the completion of the volunteering policy, NHS Halton CCG will develop:

a) Arrangements for enhancing the impact of volunteers
b) Strengthening support and training
c) Better matching of people to available opportunities and information
d) Steps to raise the status of volunteering

[5] *Catch 22 works with troubled and vulnerable people, helping them to steer clear of crime or substance misuse, do the best they can in education or employment, and play a full part in their family or community.*

2.2.1.6 NHS Workforce Race Equality Standard

All providers commissioned by NHS Halton CCG have clear Equality and Diversity Key Performance Indicators within the quality schedule which includes NHS workforce race equality requirements. All providers are required to complete the Equality & Diversity toolkit and submit an action plan if any areas are highlighted for improvement.

NHS Halton CCG has an equality and diversity policy in line with equality and diversity requirements.

2.3 Early Intervention

Alongside the prevention work discussed earlier in this document NHS Halton CCG are also committed to working with the Children's Trust, providers, patients and other services users to enhance the early intervention work with children being provided in Halton.

NHS Halton CCG is an active member of the Children's Trust board with clinical lead representation. In addition NHS Halton CCG is a member of the Commissioning Partnership Board, Halton Health in Early Years, Early help-closing the gap and Early Intervention Partnership Strategic Boards.

As part of the work with the Halton Health in Early Years board, NHS Halton CCG is working with Health Visitors on the high impact areas of Hospital Admissions and Minor illness.

NHS Halton CCG was actively involved in the December 2014 Ofsted Inspection of services for children in need of help and protection, children looked after and care leavers and review of the effectiveness of the local safeguarding children board[6].

Whilst the overall judgement was that children's services require improvement most areas received a positive outcome. A full breakdown of the inspection report is available here;
http://reports.ofsted.gov.uk/sites/default/files/documents/local_authority_reports/halton/051_Single%20inspection%20of%20LA%20children%27s%20services%20and%20review%20of%20the%20LSCB%20as%20pdf.pdf

6

http://reports.ofsted.gov.uk/sites/default/files/documents/local_authority_reports/halton/051_Single%20inspection%20of%20LA%20children%27s%20services%20and%20review%20of%20the%20LSCB%20as%20pdf.pdf

The judgements on areas of the service that contribute to overall effectiveness are:	
1. Children who need help and protection	Requires Improvement
2. Children looked after and achieving permanence	Good
2.1 Adoption performance	Good
2.2 Experiences and progress of care leavers	Good
3. Leadership, management and governance	Requires Improvement

NHS Halton CCG has specific commissioning intentions for 2015/16 around developing and improving services for children with an Autistic Spectrum Condition (ASC), Attention Deficit Hyperactivity Disorder (ADHD), Tier 2 Child & Adolescent Mental Health Services (CAMHS), Children's community equipment provision and Childhood asthma, for the full details of these commissioning intentions please see the separate technical annexe document.

2.4 New Deal for Primary Care

As part of the General Practice Strategy a number of key themes have been identified targeting those hidden 40% plus the areas of significant improvement within the borough of Halton. This prioritisation has led to the establishment of 4 working groups (Cancer, Hypertension, Care Homes, 7 day access). The CCG has commissioned additional resource to support the programme based approach and has appointed a Project Manager on a temporary basis since July 2014.

It is proposed that a new model (the Multispecialty Community Provision model) is established with community services centred around people, ensuring everyone's needs are met through an integrated health and social care delivery model. This will see GP practices working together, in a much more integrated way with Community, Mental Health and Wellbeing, Social Care, Urgent Care and Pharmacy services all wrapped around local delivery points.

A key element of the General Practice Strategy is developing the role of Community Pharmacy and closer working with General Practice.

The CCG is exploring the benefits of the co-commissioning of Community Pharmacy for potential introduction in 2016/17, considering developing a Community Pharmacy leadership role and considering the role of optometry and dentists in our Health & wellbeing plans.

The Implementation of successful Wellbeing Practice Model to provide holistic health care within GP practices in order to better respond to social determinants of health is

a key theme for 2015/16 and the CCG will be expanding the Care at the Chemist scheme. With all 30 pharmacies actively engaged and a re-launch is planned for April 2015.

NHS Halton CCG has been working with the Commissioning Support Unit (CSU) and Practice Leads to develop a quality dashboard which will be utilised to inform practice support. This will capture and respond to all areas of quality improvements in General Practice and ensure structures and processes are in place. To support this NHS Halton CCG has developed a standardised approach to Significant Event Audits (SEAs) in General Practice via the Primary Care Quality & Development Group and Members Forum.

In February 2015 NHS Halton CCG was formally approved as one of 64 CCGs across the country that will take on full delegated responsibility for commissioning the majority of GP services from April 2015.

GP led Clinical Commissioning Groups will have more influence over the wider NHS budgets and will enable a shift in investment from acute to primary and community services and is a critical step in Halton's Development of Multispecialty Community Provision focussing on out-of-hospital care and the Strategy for General Practice.

2.5 Priorities for Operational Delivery in 2015/16

2.5.1 Improving Quality & Outcomes

2.5.1.1 Seven Sentinel Indicators

1 Potential Year's Life Lost (PYLL)

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.

Excellent progress have been made in both the reduction in the number of potential years life lost but also in the development of a local method of performance management which monitors significant elements of the PYLL indicator on a quarterly basis.

NHS Halton CCG has seen as reduction of 8.1% on the number of PYLL from 2012 figure of 2801 to 2013 figure of 2575 per 100,000, we were one of only two Merseyside CCG to achieve the 2013/14 Quality premium award for reductions in PYLL, and the 2013 figure of 2575 exceeds the target set for 2015/16 of 2676. However, we are not complacent and local quarterly monitoring of the major factors

underpinning PYLL (circulatory, cancer, respiratory and liver disease) have shown continuing reductions in 2014 in all but mortality from respiratory disease (which showed a small increase) therefore we are confident that the work being undertaken by the CCG and Public Health are having a continuing impact on premature mortality and we expect the PYLL measurement to reduce further in 2014 with the expectation that we will achieve our 5-year target reduction of 15% early.

2 Health Related QoL EQ5D

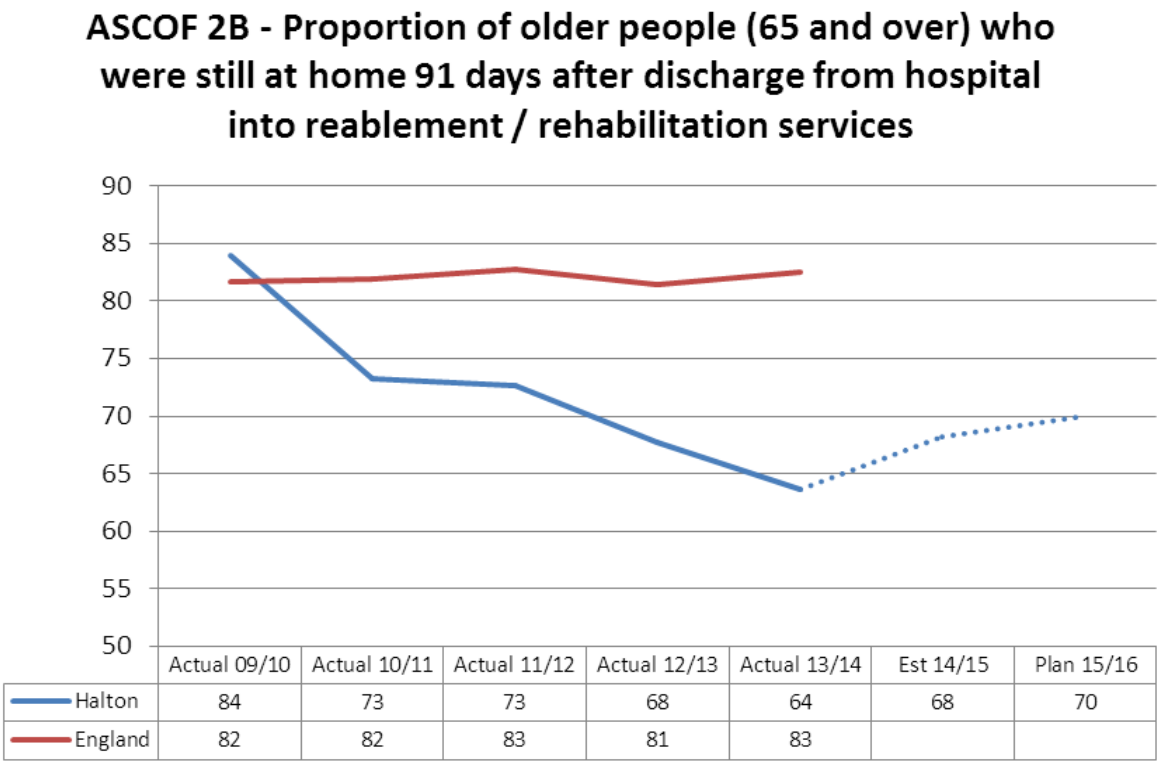
In 2011 the average EQ5d score was 65.8 per 100 patients, this increased to the 2012 baseline of 66.3 (average Eq5d score) this has further increased to 67.8 in 2012/13 this is an annual increase of 2.25% and exceeds the plan of 5 year increase of 7.7% to a target value of 71.4 by 2018/19. For comparison the England average score fell from 73.1 to 73.0 in the same period and the average England 5 year plan is for an increase of 3.8%

3 Emergency Admissions

Significant progress has been seen in Halton with regard to reducing Emergency admissions, from a baseline of 3076 per 100,000 in 2012/13 to 3044 in 2013/14 and a current 2014/15 year end forecast of 2414. This measure is made up of four component parts and reductions in admissions in three of the four areas have been seen, the most marked reductions have been in Children with Lower respiratory Tract Infections (LRTI's) which has fallen from 488 admissions per 100,000 to 230 per 100,000 and in emergency admissions for acute conditions which should not usually require hospital admission. These forecasts do not include the winter period, however even taking this into account a significant reduction in emergency admissions is expected to be seen in 2014/15

4 Proportion of Older People Still at Home 91 Days After Discharge

Chart 1



	Actual 09/10	Actual 10/11	Actual 11/12	Actual 12/13	Actual 13/14	Est 14/15	Plan 15/16
Halton	84	73	73	68	64	68	70
England	82	82	83	81	83		

In 2013/14 Halton reported the lowest proportion in the north-west of people still home 91 days after discharge into intermediate care and the sixth lowest rate in the country. Halton also has the highest rates of readmissions into hospital after 30 days in the north-west. Halton has recognised that this is a priority and a group has been established with the CCG, Local Authority and representatives from the acute providers and NWAS to identify what the specific issues are relating to unwarranted admissions and how these can be addressed.

The development of adult community service specification and General Practice Strategy to align out of hospital care supports this. And the implementation of the multispecialty provider model will help to maintain people in the community rather than have a readmission to hospital.

5 Positive Experience of Hospital Care

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

6 Positive Experience of Care Outside Hospital

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

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

7 Eliminate Avoidable Deaths in Hospital

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

NHS Halton CCG has (as of November 2014) had no HCAI incidences of MRSA and is committed to maintaining this level of performance. Halton is also forecast to have a low reported incidence of Clostridium Difficile for 2014/15 of 40 cases, (26 as at end of November 2014) this is slightly higher than 2013/14 The target assigned by NHS England for 2015/16 is 36.

2.5.2 Quality of Care

2.5.2.1 CQC Inspections

NHS Halton CCG works closely with Health and Social care providers which have been subject to a CQC inspection. In 2014/15 Both the main acute hospital trusts (Warrington & St Helens) which NHS Halton CCG work with, were subject to unannounced CQC inspections and one trust (Warrington) was also subject to a Keogh review. The outcomes of these inspections were reviewed via CQPG and action plans developed for any areas of improvement identified.

One trust was identified as having an area for improvement around maternity services and an action plan for delivery of improvements is in place. The CQC identified no areas for improvement in the second trust.

NHS Halton CCG also works with the Local Authority with regard to the quality of care delivered in care homes and a Care Home quality dashboard has been developed to monitor the levels of care being delivered, where the CCG requests a review following a safeguarding issue of complaint these are reported via the dashboard and action plans agreed with the provider. The Care Homes are provided with support by the care Home support team which includes nurses, pharmacists,

therapists and we are currently in the process of recruiting two community matrons for care homes which will boost the level of support available.

This support is available to care homes not only following a CQC inspection but also where our own process have identified possible areas for improvement, as of February 2015 there are two care homes operating in Halton with areas identified as 'requires improvement' these are being managed with the local authority through the contract and quality route with CCG involvement. In 2015/16 we will be developing a clear specification for care and residential homes which will outline quality standards and joint contracts with the Local Authority will help enable the development of a quality initiative scheme.

2.5.2.2 Clear Clinical Accountability

NHS Halton CCG is working with General Practices to ensure implementation of named GP's to the appropriate cohort, substantial progress has been made in identifying the cohort and ensuring they are reviewed by a Multi-Disciplinary Team and a full care plan put into place.

2.5.2.3 "Sign up to safety" – local Patient Safety Collaborative

NHS Halton CCG is signed up to the "Sign Up To Safety"

The safety action plan will be formally introduced in April 2015 through the Quality Committee, however work has already commenced in the following areas

- Medicines Safety
- Pressure Ulcer prevention
- Transfers of clinical care
- Catheter Infections

The work plan will be delivered through the Mid-Mersey safer care collaborative which includes all Mersey CCG's and Warrington CCG, both acute providers (St Helens & Knowsley NHS Trust & Warrington and Halton NHS Foundation Trust) the Mental Health Trust and the Community Trust.

2.5.2.4 Sepsis

NHS Halton CCG is implementing the Sepsis Advancing Quality Framework across all providers, this consists of 11 measures, of which 9 are clinical and 2 are data collection. It is recognised that early recognition leads to better management. In Q1 2015/16 both acute providers will be collecting data with a requirement that at patients score at least a 50% composite care score, at the end of Q3 2015/16 performance will be reviewed and trajectories will be set for improvement from Q1 in 2016/17 with an aim for delivery of a 90% composite care score by the end of 2016/17. To support providers in achieving this a payment will be provided through CQUIN.

2.5.2.5 Acute Kidney Injury

NHS Halton CCG are implementing the Acute Kidney Injury Advancing Quality framework in St. Helens and Knowsley NHS Trust based on 6 clinical measures and one data measure. The measures will be fully implemented with a 50% composite care score by the end of 2015/16 and a trajectory set for improvement in 2016/17. To support providers in achieving this a payment will be provided through CQUIN.

2.5.2.6 Antibiotic Prescribing

In Halton, high prescribing practices requested to target audit of antibiotic prescribing via Prescribing Quality Initiative, on-going throughout the year until March 2015, the Antibiotic Guardian Campaign promoted via CCG Bulletin, The Medicines Management Team newsletter in November focussed on European Antibiotic Awareness Day including links to all resources for practices and pharmacies, display boards in several practices have been in place to promote the messages of appropriate antibiotic use, key messages about antibiotics have been included in October Halton community radio show and a press release was issued regarding better use of antibiotics. NHS Halton CCG plans to has a session at the Halton Peoples Health Forum to discuss patient opinions on antibiotics and how we can drive innovative approach to reducing antibiotic prescribing and we aim to continue to focus on high prescribing practices but feed in positive impacts from audits and from actions already taken by other practices, using peer support to change practice and introduce an education session for prescribers involving local microbiologists.

2.5.2.7 Clinical Standards for 7-Day Working

Negotiations in 2014/15 with the acute care providers Warrington & St Helen’s have meant that both trusts are already well on the way achieving the clinical standards for seven day working. St Helens made significant progress in 2014/15 and have recruited additional staff. The development of the Urgent Care Centres in partnership with both acute providers and the community provider has again helped in the provision of seven day services in Halton.

2.5.3 Achieving Parity for Mental Health

Halton has a borough wide all age Mental Health Strategy and an underpinning Action Plan to ensure delivery. The Strategy and the Plan follow the Marmot life course approach and there are specific actions related to improving support and care for young people, adults and older people. In line with delivery of the Strategy and Action Plan a number of initiatives have already commenced.

2.5.3.1 Parity of Esteem

To support the parity of Esteem Agenda the CCG is signed up to support the Pan Cheshire Declaration to achieve the requirements of the Crisis Care Concordat. In relation to young people a review of Tier 2 CAMHS services has been completed and a new service procured. The new service model is funded through collaboration on funding with the LA Public Health department and will provide training for staff in schools, and front line staff, to recognise children at risk, to provide web based counselling for young people and face to face 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.

To support older people with dementia NHS Halton CCG exceeded the target for 70% of the estimated number of people with dementia to have a formal diagnosis for 2014/15 and a more ambitious target of 75% has been chosen for 2015/16, The National Dementia DES toolkit has been rolled out to practices in Halton and significant increases have been seen. The CCG are committed to investing in an Admiral Nurse Service during 15/16 to support patients and carers with Dementia.

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, and training of school nurses in how to identify 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, and 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. Social and Emotional Aspects of Learning (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 the early identification of people with mild to moderate mental health problems. And using an improved range of services, self-help and other non-medical interventions we will improve levels of self-reported

wellbeing. We have commissioned Halton Citizens Advice Bureau (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.7

2.5.3.2 Mental Health Funding

NHS Halton CCG will increase overall funding for Mental Health services by £713,000, from £21,804k in 2014/15 to £22,517 in 2015/16. This equates to an increase of 3.3%, this includes additional funding made available for mental health services in the Better Care Fund and additional funding set aside for the IAPT service. This increase is above the percentage increase seen in the total programme allocation of 1.94%, however it should be noted that this includes seasonal resilience funding of £0.969m not in the 2014/15 allocation. Without this seasonal resilience funding the general growth increase for NHS Halton CCG is 1.37% therefore the growth seen in spending on mental Health services is approximately two and a half times greater than the general level of growth.

2.5.3.3 Improving Access to Psychological Therapies (IAPT)

During 2014/15 NHS Halton CCG changed the IAPT provider to 5 Boroughs Partnership NHS Trust, this change of provider has resulted in an increase in the recovery rate to near 50%. IAPT is now on target for 3.75% in Q4 2014/15 (annualised 15% rate) with confidence that this can be maintained in 2015/16.

Funding has been agreed with finance to meet the new additional, mental health standards. Service specification and KPI's have been agreed across the CCG by managerial and clinical leads.

In 2015 NHS Halton CCG plans to take part in the procurement process for IAPT for military veterans and procure the new service, and support the service with local mobilisation.

[7] Halton Sustainable Community Strategy 2011-2026

2.5.3.4 New Mental Health Standards

In 2015/16 NHS Halton CCG will be reporting against new mental health standards, these are listed below;

- The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period (95% by April 2016)
- The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period (75% by April 2016)
- Number of ended referrals in the period that received a course of treatment against those with a single treatment appointment (no standard set)
- Average number of treatment sessions (no standard set)
- More than 50% of people experiencing a first episode of psychosis will be treated with a NICE approved care package within two weeks of referral (in development) (>50% by April 2016)
- % of acute trusts with an effective model of liaison psychiatry (in development) 100% by 2020

In order that we are able to report against these new standards we have ensured that New Mental Health standards included in the relevant contracts, we plan to Review and performance manage the new standards and we need to ensure that our providers can meet these targets and have the appropriate resources to do so via demand and capacity planning, to this end additional resources have been made available to 5 Boroughs Partnership who provide our IAPT service.

2.5.3.5 Liaison Psychiatry

Service specification and Key Performance Indicators (KPI's) are agreed with commissioners and providers for AED psychiatry liaison. 5 Boroughs Partnership and Warrington & Halton NHS Foundation Trust agreed data collection points to report on KPI's.

In 2015 NHS Halton CCG planned to introduce the Care Home Liaison service to establish a single supplementary specialist service for dementia patients that’s able to effectively respond and meet the multiple and complex needs of a care home population through the provision of enhanced support

2.5.3.6 Crisis Care Concordat

In 2014/15 NHS Halton CCG agreed and signed both Cheshire and Merseyside Crisis Care Concordat declarations, and established a Halton task and finish group with members from NHS Halton CCG, providers and Halton Borough Council. A draft action plan has been developed by the task and finish group and in 2015/16 we plan to progress and develop the action plan for sign off at the mental health delivery group and relevant governance structures. In 2015/16 the task and finish group will be developed to include more service user input.

2.5.3.7 Eating disorders for Children & Young People

In 2014/15 NHS Halton CCG reviewed and redesigned current eating disorder service. Referrals into this service increased by approximately 50% and the service provider is working more proactively with primary care, and has presented at a members forum. In late 2014 the service identified practices that have not referred into the service and continuing into 2015 NHS Halton CCG and the practices will work proactively with these practices and begin to use local facilities to deliver the service to Halton patients. In 2015/16 NHS Halton CCG plan to continue to monitor the service and ensure increase in referrals into the service. Increase the number of sessions that are delivered within Halton.

2.5.4 Transforming Care of People with Learning Disabilities

2.5.4.1 Winterbourne

NHS Halton CCG has developed a local Halton Winterbourne action plan and strategic group. We have ensured that we have systems and processes in place to report to relevant organisations on current Winterbourne placements, and work is continuing to keep individuals within Halton. We are currently in a very good position with regards to Winterbourne.
In Halton we have a commitment to reduce reliance on inpatient care for people with learning disabilities; we have reduced the number of inpatient beds at 5 Boroughs partnership dedicated to people with learning disabilities from 12 to 8 and have greater provision available in the community.

2.6 Enabling Change

The principle approach throughout the programme of work to develop the commissioning Intentions has been about engagement with local practices, NHSE, providers and partners and the public and a range of patient groups. Initially we worked to develop a shared understanding of the problems we wished to solve and then worked on co-designing and co-producing a five year strategy with eight priority areas.

There are a range of national drivers that have influenced the work including NHS E's co-commissioning agenda[1] and the *Five Year Forward View*[2]. We believe that the timing of these national programmes complements and accelerates our local work and we have considered and aligned the approach accordingly.

The future model of service outlined in this document, Multispecialty Community Provision (MCP), owes much to the Multispecialty Community Provider approach in *the Five Year Forward View*. We have deliberately referred to Multispecialty Community Provision rather than of a Multispecialty Community Provider as it is important we define the functions we want our model to deliver (provision) before we discuss who it will be provided by and how. This approach is widely supported within Halton and the emergent model has been discussed and created through the local engagement and co-production across a range of local organisations.

The emerging themes and care model from the General Practice strategy have led to a broader borough-wide partnership approach called One Halton. This embraces the MCP approach and provides a greater focus on the wider Out of Hospital approach across Halton.

2.6.1 Harnessing the Information Revolution & Transparency

2.6.1.1 IM&T Strategy

NHS Halton CCG has a clearly stated intention to use transformational technologies (Priority area 4 in the HCCG five year strategy) to meet the needs of its patient population, users and staff; the CCG also sees Information Technology (IT) as a method for maximising the benefits from change.

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[1] *NHS England and NHS Clinical Commissioners (2014), Next steps towards primary care co-commissioning, [Online], Available: www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2014/11/nxt-steps-pc-cocomms.pdf*

[2] *Care Quality Commission, Health Education England, Monitor, NHS England, Public Health England and Trust Development Authority (2014). Five Year Forward View, [Online], www.england.nhs.uk/ourwork/futurenhs/*

Halton CCG is in the process of finalising the IM&T strategy which covers three years from 2015 to 2018. This includes three year plans for the implementation and development of technologies to support interoperability, integrated clinical environment, mobile working, telehealth-med and assistive technology, e-referrals, e-assessments and patient centred media.

The IM&T strategy is linked closely with the Halton view on Multispecialty Community Provision and the General Practice Strategy. The use of information and information technology will improve patient care, access to care, patient experience, and delivery of clinical outcomes, health record keeping and value for money.

Therefore, using and embracing technology to improve communication and interoperability of systems between practices and providers is essential, as is the development and use of assistive technologies to support the self-care agenda.

2.6.1.2 Interoperability

Identifying an interoperability solution to be delivered locally, connecting any healthcare system within a healthcare economy is a key priority. This will give users secure access to the whole-life health records. By mobilising this data via an interoperability solution, healthcare providers are able to deliver safer, more efficient care, based on a fuller understanding of a patient's medical records. There are currently a number of providers within the local health economy that have deployed an interoperability solution, the learning from which should be incorporated in the planning of this project. In additional there is a national focus on data sharing in relation to End of Life and the requirement for increased coverage across England of an Electronic Palliative Care Coordination System (EPACC's) so it is intended that palliative care would be the initial focus of the interoperability agenda, taking into account local hospice transition onto an electronic patient administration system.

A key element of the interoperability agenda is to ensure a mechanism by which data can be linked and as such it will be a requirement for all Providers to ensure the use of NHS number as the prime identifier. It is also acknowledged that the planning for this programme will need to incorporate a number of stakeholders and it will be more realistic for this to be part of the wider health economy IM&T strategy for which NHS Halton CCG are engaged with via the current IM&T support contract.

2.6.1.3 Integrated Clinical Environment (ICE)

ICE, provided by Sunquest, is a portfolio of products that enables pathology and radiology requesting and reporting. ICE is used within primary and secondary care services and is central to GPs making pathology and radiology requests online, and being able to see the results.

Benefit from providing ICE to a broader range of staff, particularly in primary and community services, is that information sharing will be easier; all users, with

appropriate access rights, will be able to view the latest patient pathology and radiology orders and results, acting on them to provide the most appropriate level of care.

2.6.1.4 IM&T Planning

A number of dependencies became apparent when reviewing the solutions; for instance allowing the use of staffs own devices (BYOD) can only be enabled once a reliable Wi-Fi network has been established. Similarly e-Referrals and e-Assessments may only be fully achievable once a technology platform, such as SharePoint has been set-up. As such a proposed 3 year plan has been developed in line with the interdependencies and what is achievable.

2.7 Driving Efficiency

2.7.1 Financial Drivers

The CCG is planning to find £4.8 million of QIPP savings (this excludes provider efficiencies included in tariff identified above). Of this £4.8m, £2.6m has been taken out of budgets leaving a balance of £2.2m savings to be found in year. Table 2 below details where these savings are expected to be found. In the main they are from savings in non-elective and accident and emergency pathways due to the opening of the urgent care centres within Widnes and Runcorn (£1.1m NEL, £0.480m A&E and £0.178m Direct Access), along with savings made from schemes put in place through the Better Care Fund. Other local QIPP schemes are anticipated to achieve a further £0.415m during 2015/16. The main areas of QIPP to be found are as follows (See Table 5).

Table 5: QIPP scheme areas

Scheme description	Area of spend	Value £000's
Running cost challenge	Running costs	115
A&E reduction due to UCC	Acute	480
NEL reduction due to UCC	Acute	1155
Direct Access	Acute	178
Prescribing	Primary care	300
		2,228

2.7.2 Aligning of Plans

As part of the 2015/16 planning process NHS Halton CCG have had regular planning meetings with all the major secondary care providers, community and mental health care providers to develop activity and financial plans.

Both St Helens NHS trust and Warrington & Halton NHS foundation trust are largely in agreement with the methodology in creating the activity and financial plans, which include both demographic and non-demographic growth with adjustments, made for the impact of the Better Care Fund and the Urgent care Centres. There is still a gap in the projected growth figures between NHS Halton CCG and St Helens Trust and it is recognised that there is a potential risk of over-performance. Currently both Warrington and St Helens Trusts are forecasting deficits for 2015/16, both trusts are requesting resilience monies above the core contract value and Warrington Trust in particular have stated that without this they are unlikely to deliver the Cost Improvement Programme (CIP) An additional complicating factor is that while NHS Halton CCG may agree the core contract figures Halton is not the co-ordinating commissioner for either trust and St Helens and Warrington CCG's will have their own cost pressures.

With Bridgewater and 5BP both activity and finances have been agreed has been reached in principle, although as the national tariff deflator has still not been agreed there is still an element of uncertainty regarding the final figures.

Additional funding has been made available for parity of esteem initiatives, with IAPT and psychiatric liaison in Wards and A&E receiving additional resources. During 2015 the CAMHS tier 2 service is out for procurement at a higher value than previously contracted for ensuring even greater resources are made available of Child and Adolescent mental health services, during this procurement exercise a weighting was applied for added social value.

In terms of providing social value, a 12 month contract was provided to the social enterprise "Wellbeing Enterprise" to work with GP practices to provide both direct services and signposting to improve the health and wellbeing of the people of Halton and reduce demand on both primary and secondary care.

A significant procurement exercise is being carried out in 2015 for the commissioning of the PTS contract for the next 5 years. In 2014/15 NHS Halton CCG is forecast to over perform by £120k, this is being funded through reserves that the CCG holds for this type of eventuality, however for 2016 onwards this may need to be built into the contract itself and form part of the recurrent spend, thereby reducing the amount available to be put into reserves to manage risk.

2.7.3 NEL Change in Marginal Rate

Currently the only NEL marginal rate adjustment is in relation to STHK, in 14/15 this equated to £364k. We currently have plans in place to reduce NEL admissions at both WHHT and STHK by £538k WHHT and £480k STHK due to the BCF schemes (ring fenced funding in BCF should these savings not transpire), consequently if we do get these savings out the baseline will reduce below the 2008/9 revised levels and wipe out this marginal rate adjustment. The net overall impact from 70% to 50% is only £103k therefore not material, in the budget setting process we have increased STHK plan by this value.

2.7.4 BCF Monitoring

The Better Care Board has been established and meets on a regular basis to discuss the monitoring of the delivery of schemes. Monitoring of the BCF and the transformation and integration agenda is reported via a robust governance arrangements and can be seen as part of the public documentation as reported via the Health and Wellbeing board.

2.7.5 1% on Non-Recurrent Spend

Our plans have set this 1% aside for the following schemes; we are also planning to retain the surplus at 1% in 15/16

Table 6

Item	Value
0.5% contingency	£944K
UCC Non recurrent spend (capital to WHHT)	£350k
Depreciation	£54k
Aqua funding	£90k
Gynae Physio pilot scheme	£20k
Non recurrent GPIT	£250k
Clinical support Maternity network	£40k
IAPT waiting list	£64k (remaining £436k in recurrent reserves)
MH ADHD ASD pilot	£56k
Total	£1,887k

2.8 Financial Plan 2015/16

Table 7 details the allocation for 2015-16, which at the time of writing this report this is believed to be the final allocation. The additional allocation of £15m in relation to primary care budgets delegated from NHSE are not yet included in the allocation as final agreement after due diligence has still to be concluded.

The budget is divided into 2 parts for which it receives distinct allocations from NHS England. The first is the Programme Allocation which is given to the CCG to commission healthcare services. The second much smaller allocation is the Running Costs Allowance which is intended to cover the costs of management, administration and commissioning functions carried out by the CCG.

Allocations

The CCG will receive a programme budget funding increase of 1.94% (£3.459m) in 2015-16 giving a total recurring allocation of £184.486m. This includes seasonal resilience funding of £0.969m which means that the general growth increase is circa 1.37%. This compares to a previous planning assumption of 1.7% for general growth previously included in the Long Term Financial Strategy. This leaves the CCG £0.592m worse off than anticipated. However it does provide certainty around the level of recurrent resilience funding for 2015/16 and beyond.

Table 7 Allocations Summary

Revenue Resource Limit			
£'000	Sign	Opening 2014/15 Allocation	2015/16
Programme Baseline allocation - Published Dec 14	-ve	178,269	181,728
Post Mth07 Recurrent Transfers In 14/15 Running Cost	+ve/(-ve)	-	-
Allocation - Published Dec 14	+ve	3,082	2,758
Total Notified Allocation		**181,351**	**184,486**
Additional Better Care Fund Allocation			**2,929**
Non Recurrent Allocations			
Other Non Recurrent Allocations	+ve/(-ve)	3,452	-
Return of Surplus/(Deficit)	+ve/(-ve	1,770	1,840
Non Recurrent Requirement	(-ve)	(4,457)	(1,817)
Non Recurrent Return	+ve	4,457	1,817
50% Non Elective Collection	+ve	536	-
50% Non Elective Return	(-ve)	(536)	-
Total Non Recurrent Allocation		**5,222**	**1,840**
Total Allocation		**186,573**	**189,255**
Closing Target Allocation Per Head	+ve	1,351	1,390
Allocation Per Head	+ve	1,379	1,401
Distance from Target		28	11
Distance from Target % (Dec14 Board Paper)		2.10%	0.80%

The reduction in running cost allocation of -£0.324m (-10.05%) is in line with previous planning assumptions, giving a total running cost allocation of £2.758m. This is extremely challenging particularly for smaller CCGs like Halton since CCGs will likely assume significant additional commissioning responsibilities around primary care and possibly specialised services.

The Better Care Fund allocation from national monies is £2.929m which is in line with previous plans. This represents a transfer to the CCG of the share of monies currently held by NHSE and paid directly to LAs under section 256 arrangements.

The CCGs allocation is based on an estimated registered population of 129,716. Using this population weighted for morbidity, age and sex gives a fair shares target allocation. Although the relatively low level of growth received by the CCG in 2015/16 has moved Halton CCG closer to its fair shares target allocation, it is still above target by 0.83% or £1.5m.

In relation to primary care and specialised allocations the table below summarises the notified "notional" allocations from NHSE. Formal agreement has still to be reached with NHSE over delegation of these funds to the CCG from NHSE as due diligence has still to be concluded on the transfer.

Table 8 Delegated Budgets Notional Allocations	2015/16
	£000's
Primary Care indicative Baseline GP Services	£15,602
Primary Care indicative Baseline Other e.g. dentists	£14,447
Sub Total Primary Care	£30,049
Specialist Services allocation mapped to Halton (although only a proportion will be delegated to the CCG to commission).	£31,021
Total Notional allocation	£61,069

Inflation & Efficiency

The original planning guidance stipulated a 1.93% deflation for provider contracts therefore this is the assumption that has been used to set the current budgets. Overall provider inflationary cost pressures (£3.7m) have been built into the budgets but these have been offset by tariff efficiencies of £5.66m in 2015-2016. The budget lines set in this Budget Book generally include the 2015-16 efficiency and inflation changes set out unless specifically noted as an exception.

The proposed 2015-16 acute tariff has been rejected due to 37% of provider organisations, representing more than the threshold of 51% of contracted value, objecting to the method for calculating national prices proposed in the consultation.

Consequently the planning process remains unclear on what efficiencies and inflation to use for 2015/16 contracts and budgets. A choice has consequently been offered to providers by NHSE to accept a slightly improved 2015/16 tariff (known as the Enhanced Tariff Option ETO) with the provider efficiency requirement reduced from 3.8% to £3.5% or keep at 2014/15 tariff prices but without the 2.5% CQUINS incentive. Providers have until the 4th March to choose which of these proposals will apply to their NHS contracts. Extra funding of £150m nationally has been made available to CCGs should providers choose the ETO option. At the time of writing this report it is unclear how this money will be distributed to CCGs or which option local providers will choose. Once the situation becomes clearer budgets will be updated to reflect this.

For the other CCG budgets, similar assumptions have been made about uplifts and efficiencies netting off. Prescribing has been funded in 2015-16 at 2104-15 outturn uplifted by 5% less a 4% efficiency saving, consequently investing £1.9m in prescribing in 2015/16. The current pooled budget has been increased for inflation at 2% (£170k) which is in line with the Council's decision to increase its net tariffs to nursing homes.

As part of the NHS planning assumptions NHS Halton has ensured that real term growth in relation to mental health is in line with the inflation growth it has received. The 2014-15 planning return shows the CCG spent £21.8m (on all areas of mental health spend). This has been increased to £22m in 2015-16 - a 1.1% increase. On top of this the Better Care Fund will include mental health spend of £0.471m thereby increasing spend to £22.5m in 2015-16 (thus achieving a 3.3% increase and meeting the "parity of esteem" target for MH budgets in Halton).

Running Costs

The CCG must keep its management costs within Running Cost Allocation (RCA). The CCG has set a budget for RCA which includes £0.874m of commissioning support from the Northwest Commissioning Support Unit (NWCSU), for contracting and procurement support, business intelligence, human resources, governance and communication back-office functions. Due to NWCSU not being awarded a place on the national commissioning support lead provider framework the budget has been set based on the 2014-15 contract value and again will be updated once the transition to alternative support arrangements is clearer. Halton is expected to continue to purchase the Shared Finance Team from Knowsley CCG and will itself host safeguarding services on behalf of the Merseyside CCGs.

Risk Assessment & Mitigation

In setting the Budget for 2015-2016 recognition must be given to potential risk that the CCG will be unable to achieve the financial requirements and duties set it by NHS England. The principle reasons why this might occur include:-

- Activity growth for services subject to cost and volume payment systems, e.g. PbR and Continuing Health Care (CHC)
- Prescribing growth, national generic price increases and the introduction of new drugs and devices in year.
- The delay or failure of QIPP schemes to deliver the planned savings
- Further unexpected cost pressures or allocation reductions.
- Unexpected cost pressures on running cost allocation.

Table 9 below details risks and mitigations identified during the financial planning development Should no risk materialise and reserves remain unused then the CCG's best case scenario would see a £4.23 m surplus in addition to the 1% target but should all risks fully materialise and all reserves were deployed to mitigate these risks then the CCG would be £5.301m overspent and would not be able achieve its target surplus or breakeven.

Table 9: 2015/16 Risks and Mitigations

Risks	Full Risk Value £'000	Probability of Risk Being Realised	Potential Risk Value £'000	Proportion of Total %	Commentary
Acute SLA's	2,000	50.0%	1000	21.2%	Over performance on acute contracts
Community SLA's	250	50.0%	125	2.7%	Community blocked – risk form AQP, additional investments increase in activity
Mental Health SLA's	700	75.0%	525	11.1%	IAPT service waiting lists may need investment to meet targets
Continuing care SLA's	300	75.0%	225	4.8%	Increase cases CHC – restitution cases – information paid by council not CCG
QIPP Under Delivery	2,528	50.0%	1264	26.8%	Under achievement of outstanding Qipp target
Performance			-	0.0%	
Primary Care			-	0.0%	Prop co and CHP property services lack of funding from NHSE
Prescribing	300	80.0%	240	5.1%	Increased budget to reduce risk of over performance but risk of new drugs and services coming on to the market

Running Costs	300	50.0%	150	3.2%	Risk not removing enough non pay and CSU costs from contract
BCF	3,000	35.0%	1050	22.3%	Risk of BCF not achieving NEL and A&E reduction form Acute Trusts
Other Risks	150	90.0%	135	2.9%	Propco charges higher that original allocation
Total Risks	9,528	49%	4,714	100.0%	
Mitigations	**Full mitigation Value £000**	**Probability of success of Mitigation**	**Expected Mitigation Value £000**	**Proportion of Total %**	**Commentary**
Uncommitted funds (Excl 1% Headroom)					
Contingency Held	947	100.0%	947	18.1%	
Reserves	2,315	100.0%	2,315	44.2%	Activity reserves and recurrent ma data investments
Investments Uncommitted	965	100.0%	965	18.4%	Uncommon reserves and uncommitted investments
Uncommitted Funds Sub – Total	4,227	100.0%	4,227	80.7%	
Actions to Implement			-	0.0%	
Further Qipp Extensions					
Non – Recurrent Measures	1,008	100.0%	1,008	19.3%	Uncommitted reserves and uncommitted investments
Delay/Reduce Investment Plans			-	0.0%	
Mitigations Relying on Potential Funding	-		-	0.0%	
Actions to Implement Sub – Total	1,008	100.0%	1,008	19.3%	
Total Mitigation	5,235	100.0%	5,235	100.0%	
Net Risk / Headroom	(4,293)	-12.1%	521		
Best Case Impact	4,227	100.0%	4,227		No risks materialises and funds remain uncommitted
Worst Case Impact	(5,301)	9.2%	(437)		All risks occur and further sections all unsuccessful, uncommitted funds mitigated only

Table 10: Programme Budgets 2015/16

Halton CCG - Budget 2015/16			
			15/16/Total Budget
Cost Centre	Summary level	Cost Centre Description	Total
526001	Mental Health	Mental Health Contracts	13,127,256.00
526006	Mental Health	Child and Adolescent Mental Health	8,250.00
526016	Mental Health	Improving Access to Psychological Therapies	1,184,352.00
526056	Mental Health	Mental Health Services - Other	1,268,078.00
Total Mental Health			15,587,936.00
526071	Acute	Acute Commissioning	84,388,759.00
526076	Acute	Acute Children Services	734,643.00
526081	Acute	Acute Elderly Services	0
526086	Acute	Ambulance Services	4,612,956.00
526091	Acute	Clinical Assessment and Treatment Centres/UCC	6,016,000.00
526096	Acute	Collaborative Commissioning	0
526101	Acute	End of Life	0
526106	Acute	High Cost Drugs	197,788.00
526111	Acute	Maternity Services	2,520,432.00
526116	Acute	NCAs/OATs	782,985.00
526131	Acute	Winter Pressures	96,900.00
Total Acute			100,222,563.00
526141	Primary Care	Central Drugs	683,731.00
526146	Primary Care	Commissioning Schemes	601,678.00
526151	Primary Care	Local Enhanced Services	1,355,493.00
526156	Primary Care	Medicines Management - Clinical	624,551.00
526161	Primary Care	out of Hours	1,031,403.00
526166	Primary Care	Oxygen	198,866.00
526171	Primary Care	Prescribing	22,742,251.00
526176	Primary Care	Primary Care IT	0
Total Primary Care			27,237,973.00
526182	Continuing Care	CHC Adult Fully Funded	9,112,871.00
526186	Continuing Care	Continuing Healthcare Assessment & Support	243,419.00
526187	Continuing Care	CHC Children	500,909.00
526191	Continuing Care	Funded Nursing Care	826,490.00
Total Continuing Care			10,683,689.00
526211	Community Health	Community Services	12,271,304.00
526216	Community Health	Carers	1
526221	Community Health	Hospices	1,320,043.00
526226	Community Health	Intermediate Care	2,645,346.00
526231	Community Health	Long Term Conditions	118,582.00
526236	Community Health	Palliative Care	
526241	Community Health	Wheelchair Service	
Total Community Health			16,355,276.00
526261	Other	Commissioning Reserve	11,100,347.00
526276	Other	Non Recurrent Programmes	0
526281	Other	Non Recurrent Reserve	1,889,986.00
526296	Other	Reablement	0
526301	Other	Recharges NHS Property Service Ltd	739,095.00
526308	Other	Safeguarding	614,198.00
526309	Other	NHS 111	179,574.00
Total Other			14,523,200.00