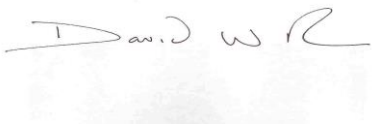
Public Document Pack

Health Policy and Performance Board

Tuesday, 21 June 2016 at 6.30 p.m.
Council Chamber, Runcorn Town Hall



Chief Executive

BOARD MEMBERSHIP

Councillor Joan Lowe (Chair)	Labour
Councillor Shaun Osborne (Vice-Chair)	Labour
Councillor Sandra Baker	Labour
Councillor Marjorie Bradshaw	Conservative
Councillor Ellen Cargill	Labour
Councillor Mark Dennett	Labour
Councillor Charlotte Gerrard	Labour
Councillor Margaret Horabin	Labour
Councillor Martha Lloyd Jones	Labour
Councillor Stan Parker	Labour
Councillor Pauline Sinnott	Labour
Tom Baker	Co-optee

Please contact Ann Jones on 0151 511 8276 or e-mail ann.jones@halton.gov.uk for further information.

The next meeting of the Board is on Tuesday, 20 September 2016

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

Part I

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

Agenda Item 3

REPORT TO: Health Policy & Performance Board

DATE: 21 June 2016

REPORTING OFFICER: Strategic Director, Community & Resources

SUBJECT: Public Question Time

WARD(s): Borough-wide

1.0 PURPOSE OF REPORT

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

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

2.0 RECOMMENDED: That any questions received be dealt with.

3.0 SUPPORTING INFORMATION

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

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

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

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

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

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

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

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

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

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

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

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

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

4.0 POLICY IMPLICATIONS

None.

5.0 OTHER IMPLICATIONS

None.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

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

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

6.3 **A Healthy Halton** – none.

6.4 **A Safer Halton** – none.

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

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

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

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

REPORT TO: Health Policy and Performance Board

DATE: 21 June 2016

REPORTING OFFICER: Chief Executive

SUBJECT: Health and Wellbeing Minutes

WARD(s): Boroughwide

1.0 PURPOSE OF REPORT

1.1 The Minutes relating to the Health and Wellbeing Portfolio are presented in DRAFT for information (they are to be agreed at the next meeting of the Health and Wellbeing Board on 6 July 2016).

2.0 RECOMMENDATION: That the Minutes be noted.

3.0 POLICY IMPLICATIONS

3.1 None.

4.0 OTHER IMPLICATIONS

4.1 None.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 **Children and Young People in Halton**

None

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

None

5.3 **A Healthy Halton**

None

5.4 **A Safer Halton**

None

5.5 **Halton's Urban Renewal**

None

6.0 RISK ANALYSIS

6.1 None.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

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

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

HEALTH AND WELLBEING BOARD

At a meeting of the Health and Wellbeing Board on Wednesday, 9 March 2016 at The Halton Suite - Select Security Stadium, Widnes

Present: Councillors Polhill (Chairman), Woolfall and Wright and S. Banks, L. Birtles Smith, P. Cook, G. Ferguson, T. Hill, L. McDonnell, A. McIntyre, E. O'Meara, D. Parr, M. Pearson, M. Pickup, C. Samosa, M. Saville, S. Semoff, R. Strachan, L. Thompson, S. Wallace Bonner, S. Yeoman

Apologies for Absence: Councillor Philbin and D. Lyon and H. Patel

Absence declared on Council business: None

ITEM DEALT WITH
UNDER DUTIES
EXERCISABLE BY THE BOARD

Action

HWB35 MINUTES OF LAST MEETING

The Minutes of the meeting held on 13th January 2016 having been circulated were signed as a correct record.

HWB36 INTEGRATING CHILDREN'S SERVICES

The Board considered a report which advised on developments for integrating Children's Services. An Integrating Child Health in Halton Workshop was held on 8th May 2015 with local acute trusts, community trusts, children's services, NHS CCG Halton and Public Health. The key note speaker was Dr. Hilary Cass President of the Royal College of Paediatric and Child Health. The outcome was consideration to pilot an innovative programme of joint working between providers and the placement of a local paediatrician in the local community. The report outlined the drivers for change towards an integrated service and the aims and outcomes which an integrated service could achieve.

Members were advised that the next steps in Halton would be to:

- agree a financial plan and work plan for a paediatrician in the community;

- agree GP hosts and pilot sites; and

- liaise with Health Education England for recognition as a pilot site.

RESOLVED: That the Board –

1. note the contents of the report; and

2. note that a paediatrician is available to work in the Halton Community from Warrington and Halton Hospital Trust.

HWB37 WELL NORTH PROGRAMME

The Board considered a report which provided information on the successful Well North bid that Halton Partners had submitted. The Board was advised that Well North was a Department of Health (DH) response to the Due North Report which highlighted the disparity in wealth and circumstances between the North and the South of England. The DH Well North team had allocated up to £9m to be available to nine local areas to improve health via innovative approaches.

It was noted that the programme must be delivered in wards in the top 10% of Index of Multiple Deprivation and the approach was to develop, test and pilot a set of linked interventions to improve the health of the poorest. The Well North methodology would involve co-production between Halton's partners and the Well North team. Full details of Halton's successful bid were outlined in the report.

As part of the next steps, a team of Halton staff from across key agencies and service areas would work with local communities and the Well North team through an initial stage to further define the proposals and intended outcomes for Halton. Initial sessions and visits had already taken place to provide a sense of place for the Well North team and a trip to Bromley by Bow for Halton partners to see a successful Wellness Place based approach in action. It was proposed that a two day workshop would be programmed for May 2016 to develop plans.

RESOLVED: That

1. the contents of the successful Well North bid and an

update of commencement of implementation be noted; and

2. any comments be fed back to the Director of Public Health and Director of Commissioning and Service Delivery.

HWB38 DELIVERING THE FORWARD VIEW: PLANNING GUIDANCE 2016/17- 2020/21

The Board was advised that the National Health and Care Bodies in England had come together to publish shared NHS Planning Guidance for 2016/17 – 2020/2021, setting out the steps to help local organisations deliver a sustainable, transformed Health Service and improve the quality of care, wellbeing and NHS finances. A copy of the guidance had been previously circulated to Members of the Board.

As part of the new planning process, NHS organisations had been asked to develop two plans.

1) A wider health and care system "Sustainability and Transformation Plan, covering the period October 2016 to March 2021; and

(2) A plan by organisation for 2016/17.

It was noted that the guidance had indicated that planning by individual organisations would increasingly be supplemented with planning by place for local populations. Providing a Sustainability and Transformation Plan (STP) on a larger geographical footprint would encourage a joint approach. On the 29th January it was confirmed that Halton would form part of the Cheshire and Merseyside STP footprint.

Members were advised on access to future transformation funding which was outlined in the Government Spending Review as an additional dedicated funding stream for transformational change, building up over the next five years. The most compelling and credible STPs would secure the earliest additional funding from April 2017 onwards. In addition the report also set out the timetable for submission of the Operational Plan and completion of the five year Cheshire and Merseyside STP. It also outlined nine "must do" priorities for local health economies which NHS England and the other NHS organisations had identified.

RESOLVED: That

1. the contents of the report be noted; and

2. the Council works collectively with Halton CCG and One Halton delivery partners to develop a local 5 year Sustainability and Transformation Plan with accompanying 12 month Operational Plan and contribute to the wider Cheshire and Merseyside footprint Sustainability and Transformation Plan.

HWB39 COMPLEX DEPENDENCY/EARLY INTERVENTION

The Board considered a report which detailed the arrangements for the introduction of Multi-Agency Front door as part of Complex Dependency Early Intervention model in Halton.

One of the key aims of the Complex Dependency Early Intervention project was to create a single, multi-agency front door for identification and assessment of complex individuals, Children and Families. In order to deliver a multi-agency front door in Halton, the process and practice of the current Contact and Referral Team (CART) had been reviewed. Through the implementation of the revised front door the aim was to provide a proportionate, timely and co-ordinated partnership approach to children, families and vulnerable adults. This approach should lead to a more appropriate allocation of resources to those children, families and vulnerable adults that required additional support due to them having multiple and complex needs.

Members of the Board were advised on staffing roles within the new integrated team, known as I-CART and noted that there would be a soft launch of the new approach at the end of March 2016.

It was noted that the aim of I-CART the aim was to see less inappropriate and repeat referrals, closer partnership working and clearer accountability, supported by information sharing protocols and pathways, improve confidence for those who access the service, identification of possible gaps in service and cost benefits.

RESOLVED: That the Board notes the progress to date in implementing a multi-agency front door and recognise the benefit of a defined route to services through a single point of access by a dedicated multi-agency team.

HWB40 SUMMARY OF CQC INSPECTION REPORTS OF GP PRACTICES

The Board considered a report of the Chief Officer, NHS Halton CCG, which presented a summary of the outcomes of the first wave of CQC inspections of general practices in Halton undertaken in September 2015. Of the eight practices inspected, seven received an overall rating of good, and one an overall rating of outstanding. An overview of each general practice inspection was detailed in the report.

RESOLVED: That the good outcomes of the first wave of CQC inspections of GP practices in Halton be noted.

HWB41 NHS ENGLAND UPDATE FOR LEARNING DISABILITIES PAPER - KAREN POWELL NHS ENGLAND

The Board considered a report from NHS England, which provided an update of the national, regional and local programme of work with regard to Transforming Care for people with Learning Disabilities. The Transforming Care programme was a national programme of work, aimed to improve care for people with learning disabilities and/or autism and behaviour that challenged (learning disabilities). The five areas in the Transforming Care programme were –

- Empowering individuals;
- Right care in the right place;
- Regulation and inspection;
- Workforce; and
- Data and information.

RESOLVED: That the report be noted and the Board support the implementation.

HWB42 PUBLIC HEALTH ANNUAL REPORT

The Board received an update on the development of the Halton Public Health Annual Report (PHAR) from the Director of Public Health. The Annual Report was the Director of Public Health's professional statement about the health of local communities, based on sound epidemiological evidence and interpreted objectively.

Each year a theme was chosen for the PHAR and for 2015 – 16 it was noted that the report would focus on the work on the Public Health Evidence and Intelligence Team. This topic had been chosen to highlight some key pieces of work and how they had been used or would be used by Halton Borough Council and its partner organisations. The

final version of the report would be presented to the Board in July however, prior to this an electronic copy would be circulated to Members of the Board for feedback.

RESOLVED: That the theme and development of the Public Health Annual Report be noted.

HWB43 POSITIVE BEHAVIOUR SUPPORT SERVICE

The Board considered a report of the Strategic Director, People and Economy, which provided an update on the activity of the positive Behaviour Support Service (PBSS), which had been operational since November 2011. The service was jointly funded by NHS Halton CCG and was a specialist service for children and adults with the primary purpose of improving life quality for those individuals who present with behaviours that challenged services. Eligibility criteria for the service were moderate to severe Learning Disability, including those with a diagnosis of Autistic Spectrum Condition. The service was currently supporting 15 adults and 18 children in the Halton area. In addition, it would also be supporting the return of 6 adults to Halton from out of borough placements in January 2016.

It was noted that the cost of the PBSS to Halton was less than the savings achieved. The report detailed examples of annual savings to the Council.

RESOLVED: That the report be noted and the ongoing work of the PBSS be supported.

Meeting ended at 3.00 p.m.

REPORT TO:	Health Policy & Performance Board
DATE:	21st June 2016
REPORTING OFFICER:	Strategic Director – People & Economy
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Health Policy and Performance Board Annual Report: 2015/16
WARD(S)	Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To present the Health Policy and Performance Board's Annual Report for April 2015 - March 2016.

2.0 **RECOMMENDATION: That the Board:-**

i) note the contents of the report and associated Annual Report (Appendix 1).

3.0 **SUPPORTING INFORMATION**

3.1 During 2015/16, the Health Policy and Performance Board has examined in detail many of Halton's Health and Social Care priorities. Details of the work undertaken by the Board are outlined in the appended Annual Report.

4.0 **POLICY IMPLICATIONS**

4.1 There are no policy implications arising directly from the Annual Report. Any policy implications arising from issues included within the Annual Report will have been identified and addressed throughout the year via the relevant reporting process.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 As with the policy implications, there are no other implications arising directly from the report. Any finance implications arising from issues included within it would have been identified and addressed throughout the year via the relevant reporting process.

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

6.1 **Children & Young People in Halton**
There are no specific implications as a direct result of this report however the health needs of children and young people are an integral part of the Health priority.

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

6.3 **A Healthy Halton**
The remit of the Health Policy and Performance Board is directly linked to this priority.

6.4 **A Safer Halton**
None identified.

6.5 **Halton's Urban Renewal**
None identified.

7.0 **RISK ANALYSIS**

7.1 None associated with this report.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None associated with this report.

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

9.1 None under the meaning of the Act.

Health Policy and Performance Board

Annual Report

April 2015 - March 2016

I have been a member of the Health Policy and Performance Board since 2007, but I am very pleased to report on the work of the Board during 2015/16 in my new capacity as Chair of the Board.

Firstly I would like to acknowledge the work of Councillor Ellen Cargill, the previous Chair of the Board, for her mentorship over the years which has certainly equipped me with the skills in undertaking this challenging role.

In addition to thanking all members of the Board, I would particularly like to take this opportunity to thank my new Vice Chair, Councillor Stan Hill, who has provided valuable support to me over the past 12 months and also Councillor Mark Dennett, Halton's Mental Health Champion, who has worked very hard in driving forward with improvements in Mental Health provision over the past 12 months.

I would also like to acknowledge the work of Simon Banks, Chief Officer and his team at the NHS Halton Clinical Commissioning Group (CCG) and Sue Wallace Bonner, Director of Adult Social Services for all the help and support given to the Board over the past year too.

The remit of the Board is to scrutinise the Health and Social Care Services provided to the residents of the Borough; we also have a responsibility to scrutinise Hospital Services, including Mental Health Services and the Board take these responsibilities very seriously.

One area that has been a particular focus for the Board this year are the issues that have been raised by Halton residents regarding the issuing of Car Parking Fixed Penalty Notices at Halton and Warrington Hospitals.

This has resulted in the Board meeting with representatives from Warrington and Halton Hospitals NHS Foundation Trust on a number of occasions to address and try and resolve residents' concerns.

This year, the Board were extremely pleased to see the opening of two new Urgent Care Centres in Halton providing easier access to urgent care for local residents. Members have taken the opportunity to visit the new Centres in addition to visiting Learning Disability Day Services.

As usual, 2015/16 has proved to have been a very busy, challenging and interesting time for us all and I'm sure 2016/17 will be no different!

Cllr Joan Lowe, Chair

Health Policy and Performance Board Membership and Responsibility

The Board:

Councillor Joan Lowe (Chairman)
Councillor Stan Hill (Vice-Chairman)
Councillor Sandra Baker
Councillor Mark Dennett
Councillor Margaret Horabin
Councillor Charlotte Gerrard
Councillor Shaun Osborne
Councillor Martha Lloyd Jones
Councillor Carol Plumpton Walsh
Councillor Pauline Sinnott
Councillor Pamela Wallace

During 2015/16, Tom Baker was Halton Healthwatch's co-opted representation on the Board and we would like to thank Tom for his valuable contribution.

The Lead Officer for the Board is Sue Wallace-Bonner, Director of Adult Social Services.

Responsibility:

The primary responsibility of the Board is to focus on the work of the Council and its Partners, in seeking to improve health in the Borough. This is achieved by scrutinising progress against the aims and objectives outlined in the Council's Corporate Plan in relation to the Health priority.

The Board have met six times in 2015/16. Minutes of the meetings can be found on the Halton Borough Council website. It should also be noted that the Board, at each of their meetings, receive and scrutinise the minutes from Halton's Health and Wellbeing Board and monitors work/progress within this area.

This report summarises some of the key pieces of work the Board have been involved in during 2015/16.

GOVERNMENT POLICY- NHS AND SOCIAL CARE REFORM

Care Act

Throughout the year the Board have received updates on the implementation of the Care Act; Phase 1 of the Care Act came into force on 1st April 2015 which included elements such as the duty to provide prevention, information and advice services, including independent advocacy and Carers being entitled to an assessment and support, with the same rights as any adult service user.

Significant levels of assurance have been provided to the Board that Halton is fully compliant with its legal obligations and as a result of the implementation of the Act there has been an increase in demand for services and assessments; some of this increase in demand has been managed with improvements in sign posting and prevention services. Significantly more individuals are now provided with information and signposted with positive results.

The Board will continue to watch with interest the development of the work nationally taking place on the cap on care costs and the means test which were due to be introduced in April 2016 and the Department of Health has decided to postpone this until April 2020.

Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards (DoLS) is one aspect of the Mental Capacity Act (2005). The Safeguards are there to ensure that people in care homes and hospitals are cared for in a way that does not inappropriately restrict their freedom, and if necessary restrictions are only applied in a safe and correct way, and that this is only done when it is in the best interests of the person and there is no other way to provide appropriate care.

Following a Supreme Court judgement in 2014, a DoL can occur in a domestic setting where the State is responsible for imposing those arrangements. This will include a placement in a supported living accommodation in the community. Hence, where there is, or is likely to be, a DOL in such placements must be authorised by the Court of Protection.

As such the Board received a report outlining the impact that this ruling has had within Halton; basically within Halton and across the Country there has been a significant increase since April 2014 on the number of DOLs. There has been mounting criticism of DoLS and as a result the Government requested the Law Commission to undertake a review. The Law Commission has subsequently developed proposals to replace DoLS and following consultation will publish its recommendations in 2016 with a view to achieving legislative reform by 2017 – 18.

Closure of the Independent Living Fund

After an independent review in 2007, the Government acknowledged that the Independent Living Fund (ILF) system was inequitable for people and operated outside of care systems operated by the Local Authority. The Government subsequently decided to close the ILF on 30th June 2015 with the ILF users transferring to the management of the local authority. Although the funding of ILF was to transfer to the local authority an attrition rate of 5% was to be applied to the overall costs that the local authority would receive.

The Board received a report on the work undertake by the ILF Project Team which was established to review the 51 ILF recipients in Halton and produce support plans to reflect any changes that may be made once the national eligibility criteria was applied. It was noted by the Board that this option reduced the financial risks to the Council whilst reassuring ILF recipients that their needs will be met once ILF ceased its function. The Board were pleased to hear that all the reviews were completed prior to the transfer date.

SERVICES

Urgent Care Centres

The Board were extremely pleased to see the significant progress made in the development of Halton's Urgent Care Centres, with both the Runcorn and Widnes UCCs opening during 2015, which are on the sites of the old Minor Injuries Unit at Halton Hospital and the Widnes Walk in Centre. Staffed by a team of on-site integrated healthcare professionals and with a range of diagnostic facilities, our UCCs are community-based primary care facilities providing access to urgent care to our local population.

The UCCs in Halton are:-

- Widnes NHS Urgent Care Centre – located at the Health Care Resource Centre, Caldwell Road, Widnes WA8 7GD.
- Runcorn NHS Urgent Care Centre – located at Halton Hospital, Hospital Way, Runcorn WA7 2DA.

The Centres operate from 7am until 10.30pm (accepting patients up until 10pm), 365 days a year. NOTE: Radiology operates from 8am until 10pm, 365 days a year.

In addition to being able to assess/treat minor illnesses and injuries, the Centres are able to provide care to those presenting at the Centres will a range of other conditions, through the development of the necessary competencies of staff teams and agreed pathways of care.

The UCCs can also receive patients from the ambulance service within agreed protocols and pathways of care.

Mental Health

It should be noted that Mental Health services in Halton are under huge pressure. Nationally the wait times and need for Mental Health services have risen to an all-time high. Halton is no different and we have a significant challenge to ensure our services (both preventative and treatment) meet National standards.

As such the Board have received regular reports from Councillor Mark Dennett, Halton's Mental Health Champion, over the past 12 months outlining improvements in Mental Health provision within Halton.

One such improvement is the commissioning of Admiral Nurses for Dementia, which commenced in February 2016. Admiral Nurses provide families with the knowledge to understand the condition and its effects, the skills and tools to improve communication, and provide emotional and psychological support to help family carers carry on caring for their family member.

Men's Health

In January 2016, the Board received an update from Halton's Director of Public Health in respect of Men's Health in Halton.

Local analysis shows that average male life expectancy in Halton is lower than women, a pattern seen regionally and nationally. National research has shown that men seek advice and help from preventative and medical services less than women. Thus whilst it remains vital that we have high quality universal services, we need to understand when it is also appropriate to have targeted services. There are a range of preventative and support services available in the borough which have been developed to provide specific advice and support to men, such as those detailed in the attached report. These should continue to address the needs of men and provide advice and support in a way that appeal to men.

In July 2015 the Centre for Public Scrutiny and the Men's Health Forum produced a guide designed to help scrutiny of local actions to promote men's health and tackle health inequalities. The report presented to the Board outlined the actions taking place in Halton to address the issues raised in the guide and progress to date.

Homeless Service

Councillor Ron Hignett, Executive Board Portfolio Holder for Physical Environment attended the Board to provide an update on developments in respect of Homelessness and the work of the Housing Solutions Team.

Following the full Strategic Review of Homelessness which took place during 2012 which resulted in the development of the current Homelessness Strategy 2013/18, the associated strategic action plan has continued to be implemented. The Strategy provides clear direction for preventing and addressing Homelessness within Halton and reflects the relevant factors known to affect future homelessness.

The Housing Solutions Team play a key role in addressing homelessness in Halton by proactively working with all client groups to reduce and prevent homelessness.

The Board also received information regarding a Supreme Court Judgement in May 2015 which will impact on future homelessness assessments. The case marks an important change to how Authorities assess homeless people's 'vulnerability' when deciding on whether they have a statutory duty to house them. In effect it will require more applicants to be deemed vulnerable and so have a priority need. It will place additional pressure upon homelessness services and place further pressure upon temporary and long term housing accommodation providers. Authorities will have to widen the criteria for deciding who gets housed as a result of the Supreme Court decision.

The Board noted that for Halton this will likely lead to increased homeless acceptances but it was felt that that the temporary accommodation provision in place within Halton is sufficient to meet these potential demands.

Adult Safeguarding

The Board have received regular reports/updates on Adults Safeguarding issues, including DoLs as referenced earlier in this report, throughout the year.

An example of this includes the Adult Safeguarding report presented to the Board in March which provided the Board with details of the Safeguarding Adults Board (SAB) Annual Report for 2014/15. Although Halton have been producing SAB Annual Reports for a number of years now, the Care Act 2014 has now made it a statutory requirement for SABs to produce Annual Reports.

The Annual Report summarises all of the key achievements and priorities the SAB has been working towards over the last twelve months. The report also sets out the national and local developments on safeguarding adults at risk.

The Board heard with interest the work that had taken place which was associated with the four key priorities, as outlined below:

1. Promote awareness of abuse and the right to a safe and dignified life – particularly among the “vulnerable” and “at risk”, but also among staff, volunteers and the wider community
2. Increase the contribution from service users and carers, ensuring their views and experience inform the Board’s work and service developments. Provide individualised services that keep people safe, but permit informed decisions about risk
3. Ensure there is a strong multi-agency approach to the safety, wellbeing and dignity of all adults at risk
4. Equip employees with the necessary tools and training to safeguard adults at risk and ensure their dignity is respected.

The Board also were interested to hear about the work Halton had recently become involved in, with regards to the Anti - Slavery Network, a multi-agency group that is committed to working together to prevent modern slavery and human trafficking. Nationally, it is a very disturbing and complex problem. Breaking the lives of the vulnerable and voiceless, it represents a grave abuse of human rights and basic dignity.

POLICY

Care Management Strategy

In June 2015, the Board received ‘Making a difference: A strategy for transforming Care Management in Halton 2015-2020, which was developed within a range of national and local policies and themes including the Care Act 2014. As referenced earlier in the Annual Report the Act places additional responsibilities on the Council, one of which being the ’wellbeing principle’ and the wider focus on the whole population in need of care rather than just those with eligible needs or who are funded by the state.

The implementation of the Care Act has significant implications for the roles of the Adult Social Care workforce as the way people access the care and support system changes and demand increases for assessments and support plans from self-funders and carers.

The strategy presented sets out a framework to build on Halton’s existing care management model and construct a professional, skilled care management service that is fit for purpose and responsive to this future demand.

Respiratory Strategy for Halton 2015 – 2020

Respiratory disease is one of the key contributing factors to reduced life expectancy in Halton and is the third leading cause of death after circulatory disease and cancer.

There are significant health inequalities in Halton concerning respiratory diseases where the mortality rate in our most deprived areas is double that of Halton as a whole.

During 2015 the Board were pleased to receive the new Respiratory Strategy to address respiratory health for Halton from Halton's Director of Public Health. The Strategy identifies key factors influencing respiratory health and provides recommendations for action to prevent respiratory illness, improve identification, treatments and outcomes and ensure provision of appropriate, high quality, primary, secondary and community health and social care services for all ages.

Service Closure Policies and Procedures

From April 2015 the Care Act required local authorities to help develop a social care market that delivers a wide range of sustainable high-quality care and support services, and places responsibility on local authorities to deliver a duty to ensure that needs are met, including when there is a planned or emergency disruption to services. In particular, the Act is explicit in the local authority's responsibility to use market intelligence to have sound market oversight in order to develop a suitable local care and support market, foresee potential risks to disruption to services (i.e. through business failure, withdrawal from market, regulatory compliance etc.) and undertake preventive action to avoid and/or minimise disruption in the event of a care service closure.

In line with the new requirements on the local authority, the Board were presented with three policies and procedure documents that make up the 'Service Closure Policies':

- **An overarching policy in relation to market oversight:** Intelligence gathering, contract monitoring, identifying risks in service continuity, responding to risks, preventing service closure
- **A policy and procedure for responding to a planned service closure:** Covering domiciliary, residential and supported living services. Planned closures may occur for a number of reasons, including business failure, decommissioning or contract default.
- **A policy and procedure for responding to an unplanned service closure:** Covering domiciliary, residential and supported living services, where there is little of no warning of disruption to, or closure of, a service. This may be due to a number of reasons, including fire, flood, disease outbreak, immediate and significant risk of safety.

It is unfortunate that during 2015 these policies had to be used with the closure of a local home.

NHS Halton Clinical Commissioning Group (CCG): Information Management & Technology (IM&T) Strategy 2015-18

NHS Halton CCG has a clearly stated intention to use transformational technologies to meet the needs of Halton's patient population, users and staff and as such in June 2015 the Board received details of NHS Halton CCG's IM&T Strategy.

The Board was advised that the Strategy had been developed in conjunction with a number of key stakeholders. The Strategy identifies what both local priorities were in relation to IM&T and also the wider healthcare economy priorities which spanned a number of organisations and which were likely to span the life of the strategy.

A number of work streams have been identified within the Strategy which had been based on areas that were not currently being met and then identifying the possible solutions that could meet this need; their potential impact on outcomes and also their ease of implementation had also been mapped. As a result it was reported to Board that a number of detailed project plans were now being developed in collaboration with the relevant stakeholders to progress developments and implementation of the Strategy.

'Top Up' Policy

In January 2016, the Board received information regarding Additional Payments (for accommodation), commonly referred to 'Top ups'. Under the Care Act 2014 an individual can choose care home accommodation best suited to their needs. This may be more expensive than the 'going rate' for the type of accommodation that Halton has negotiated with the provider for a person with such needs. In such cases, a 3rd party, usually a nominated family member, will agree to pay the additional amount the provider is asking. Dealing with these 'additional payments', monitoring them and agreeing liability when the 3rd party can no longer continue to make such payments is what the policy presented to the Board sets out.

Because responsibility for top-ups has historically been between the 3rd party and the provider, Halton has never previously required an Additional Payments policy. However, in the light of the changes stemming from the Care Act and advice from Halton's legal department, this approach was no longer regarded as best practice. It could result in a greater risk of litigation in situations where the 3rd party is no longer able to maintain payments. The Act recommends that each Local Authority should have a level of oversight of the Top-Up payments between 3rd party and provider.

As such it was decided that the most appropriate way to achieve this was to have a policy and a tripartite agreement which clearly states that liability lies with the 3rd party if Top-Up payments can no longer be met. Failure to do so could result in prolonged and expensive legal cases involving not only the provider, but also the 3rd party or the person in need of care.

SCRUTINY REVIEWS

Discharge from Hospital

The Discharge from Hospital scrutiny review focused on the quality of the Discharge planning process and associated pathways to those Halton residents who have been admitted to the local Acute Trusts for both elective or emergency care. It examined the services that are already in place and evaluated their effectiveness in meeting the needs of the local population.

The group sought national and local evidence and undertook a range of site visits to understand best practice in and the systems and issues with ensuring timely, safe and effective discharge of people from hospital. Contributors were made by Hospital Discharge Teams, the voluntary sector, Warrington and Halton Hospitals NHS Foundation Trust, St Helens and Knowsley Teaching Hospitals NHS Trust, Care Home support teams, NHS Halton CCG; 2 local GP's and their surgeries and the North West Ambulance Service.

As a result of the review the Board has made a number of recommendations, including that:-

- The Voluntary Sector need to develop a plan with the Acute Hospitals to map out how they will work collaboratively in respect of supporting people through hospital discharge;
- A Community Care Matron with the capacity and skills to prescribe and undertake medication reviews would enhance the Care Home Support Team;
- A review of patients repeatedly re-admitted for treatment of the same condition should consider coding such re-admissions in a different way such as open access. The use of the urgent care centres to deliver a broader range of treatments should be considered;
- Acute Hospitals should continue to ensure the maximum use of their discharges lounges which support a more timely discharge process; and
- Effective communication and timely access to clinical information is key to ensure safe and effective discharge and systems should continue to develop to improve this.

PERFORMANCE

The Health Policy and Performance Board has a key role in monitoring and scrutinising the performance of the Council in delivering outcomes against its key health priorities. Therefore, in line with the Council's performance framework, during the year the Board has been provided with thematic reports which have included information on progress against key performance indicators, milestones and targets relating to Health.

INFORMATION BRIEFING

During 2015/16 the Board continued to receive an Information Briefing Bulletin in advance of each of the Board meetings.

The Information Briefing is a way of trying to manage the size of the agendas of the Board meetings better. Including information on topics which were previously presented to Board as reports only for the Board's information now into the Information Briefing bulletin allows the Board to focus more on areas where decisions etc. are needed.

Areas that have been included in the Information Briefing over the last 12 months have included:-

- Halton's Learning Disability Nursing Team;
- Care Home Support Team;
- Adult Safeguarding;
- People and Economy Directorate Business Plan 2016/19 - Adult Social Care Key Developments;
- Summary of Care Quality Commission GP Inspection Reports;
- Update on implementation of the Loneliness Strategy; and
- Accident and Emergency Attendances.

WORK TOPICS FOR 2016/17:

The Board recognise and value the essential role that carers play in supporting some of the most vulnerable people in our community and with the introduction of the Care Act 2014, Carers are now recognised in law in the same way as those they care for; this means they have the right to an assessment of their needs. As a consequence, the Act has resulted in an unprecedented focus on Carers and their own health and for the first time sets out a set of national criteria to establish whether the Carer is eligible for support.

As such in March 2016, the Board chose Carers as the scrutiny topic to be examined during 2016/17.

The topic will focus on the type and quality of Carers Services provided in Halton and the associated pathways in place to support Carers' ability to access those Services. It will examine these services and associated pathways, with a view to evaluating their effectiveness in meeting the needs of the local population.

Report prepared by Louise Wilson, Development Manager – Urgent and Integrated Care, Policy & Economy Directorate
Email: louise.wilson@halton.gov.uk Tel: 0151 511 8861

REPORT TO: Health Policy and Performance Board

DATE: 21st June 2016

REPORTING OFFICER: Strategic Director, People & Economy

PORTFOLIO: Health and Wellbeing

SUBJECT: Transforming Care Programme

WARD(S): Boroughwide

1.0 PURPOSE OF REPORT

1.1 To provide the Board with details of the purpose and associated processes of the Government's Transforming Care Programme and the local progress for Halton residents.

2.0 RECOMMENDATIONS: That the Board

i) Note the contents and comment on the report and its associated appendices.

3.0 SUPPORTING INFORMATION

3.1 Background to Transforming Care Programme

3.1.1 Following the publication of the Government's response to Winterbourne View Hospital (2012) a concordat plan of action was developed. By the time of the report by Stephen Bubb (Winterbourne View – *Time for Change, 2014*), it was evident that the intended reduction in the use of inpatient beds had not been achieved.

3.1.2 The Government has now set clear targets for the reduction of inpatient beds and this is to be a 50% reduction nationally over the next three years. A number of 'fast-track areas' have already commenced this Programme.

3.1.3 The Transforming Care Agenda encompasses both Children and Adults with Learning disability and/or Autism and in particular those who display behaviour that challenges. In contrast to the earlier Government policies, Transforming Care looks at the wider set of community services that need to be in place to support the reduction in beds and a more comprehensive response to Children and Adults who challenge. Delivering this, it is suggested, some areas will require significant remodelling of existing services. The key areas of the Transforming Care Programme are:

- **Empowering individuals** – giving people with learning disabilities and/or autism, and their families, more choice and say in their care

- **Right care in the right place** – ensuring that we deliver the best care now, including a new approach to care and treatment reviews, whilst re-designing services for the future, starting with five fast-track sites to accelerate service re-design and share learning

- **Regulation and inspection** – tightening regulation and the inspection of providers to drive up the quality of care

- **Workforce** – developing the skills and capability of the workforce to ensure we provide high quality care

- **Data and information** – making sure the right information is available at the right time for the people that need it, and continuing to track and report progress

3.1.4 It will be seen from the above that these themes are not dissimilar to those referenced in the Valuing People guidance. The National Service Model which underpins Transforming Care can be found at ***Appendix 1***.

3.2 **Where does Halton fit in?**

3.2.1 Halton is part of a mid-Mersey hub comprising Halton, St Helens, Warrington and Knowsley Councils and their equivalent Clinical Commissioning Groups (CCGs). Governance of the hubs lies with Cheshire and Merseyside Transforming Care Board who will oversee the implementation of the programme (Sue Wallace-Bonner, Director of Adult Social Services is a member of this Board). See ***Appendix 2*** for the Governance Structure.

3.2.2 A number of meetings involving the mid-Mersey hub are taking place to develop a joint plan. It is of particular importance to note that the commissioning hub across the mid-Mersey adopted a model of care which saw the closure of eight Assessment and Treatment (A&T) beds at Willis House in 2010. The A&T beds commissioned by NHS Halton CCG are on the Byron Ward at Hollins Park, Warrington. Halton has not utilised any A&T beds in for the last twelve months, although Halton currently has one patient admitted to Byron ward. There is a robust Multi-disciplinary team around this patient to support an appropriate and safe discharge.

3.2.3 Another feature of the Transforming Care Programme of particular importance is that those people who are funded through NHS Specialist Commissioning fall within this. There are four people thus funded who may return to Halton in the future but current indications are that this will not be for at least 12 months. These patients are monitored and reviewed via NHS Specialised Commissioning, including the completion of Care and Treatment Reviews (CTR). Halton's Learning Disability Clinical Lead is aware of these patients.

3.3 **What needs to be done?**

3.3.1 Planning and financial templates have been issued to all hubs and these have been

submitted for Halton. These are initial responses and more work is needed. The final sign off for all plans is scheduled for the June 2016 and these must be signed by Health and Wellbeing Boards. A copy of the latest version of the Mid-Mersey Plan can be found at ***Appendix 3.***

3.3.2 In order to make the process meaningful we need to engage more systematically with self-advocates and families and repopulate the templates with more detailed information, and in particular that related to budgets associated with Children's services. There has been a number of co-production events which Halton self-advocates have attended. There are Confirm and Challenge groups for Self-advocates and families to co-produce the transforming care plan. The Learning Disability Partnership Board should be the board which oversees the delivery of the local Transforming Care plan. The board will need to be widened out to include Children and Young People alongside Adults.

4.0 POLICY IMPLICATIONS

4.1 None identified.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 Those people with behaviours that challenge are particularly vulnerable to inappropriate restrictive practices. Ensuring robust community based services are in place will provide safeguards.

5.2 Remodelling some community based services may require additional investment. A workforce development stream has been established and Halton statutory and commissioned services are undertaking a Learning Needs Analysis to identify any gaps.

5.3 NHS England is also making available a total of £30m nationally, over a three year period to support the programme. The criteria identified by NHS England are those areas that have inpatient beds to close and those who need to expedite the reduction of patients receiving treatment in hospital which could be delivered in a non-hospital setting. As noted in 3.2.2 Halton have already completed this work, so are unlikely to qualify for the funding. For any funding requested match funding will need to be identified. There is inter-dependency with the mid-Mersey hub for some of the priority areas identified.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**

The outcomes of this programme will be the continuation of in-provision for people in times of deteriorating health or crisis and conjunction with the development of high quality services closer to enable people to live independent lives closer to their friends, family and carers.

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

6.3 **A Healthy Halton**
The outcomes of this programme will be the continuation of in-provision for people in times of deteriorating health or crisis and conjunction with the development of high quality services closer to enable people to live independent lives closer to their friends, family and carers.

6.4 **A Safer Halton**
None as a result of this report.

6.5 **Halton's Urban Renewal**
None as a result of this report.

7.0 RISK ANALYSIS

7.1 Failure to deliver the Transforming Care Programme may place at risk some of our particularly vulnerable service users.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None identified.

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

9.1 None under the meaning of the Act.

Appendix 1

The National Service Model

1 People should be supported to have a **good and meaningful everyday life** – through access to activities and services such as early years services, education, employment, social and sports/leisure; and support to develop and maintain good relationships.

2 Care and support should be **person-centred, planned, proactive and coordinated** – with early intervention and preventative support based on sophisticated risk stratification of the local population, person-centred care and support plans, and local care and support navigators/keyworkers to coordinate services set out in the care and support plan.

3 People should have **choice and control** over how their health and care needs are met – with information about care and support in formats people can understand, the expansion of personal budgets, personal health budgets and integrated personal budgets, and strong independent advocacy.

4 People with a learning disability and/or autism should be supported to live in the community with **support from and for their families/carers as well as paid support and care staff** – with training made available for families/carers, support and respite for families/carers, alternative short term accommodation for people to use briefly in a time of crisis, and paid care and support staff trained and experienced in supporting people who display behaviour that challenges.

5 People should have a choice about where and with whom they live – with a choice of **housing** including small-scale supported living, and the offer of settled accommodation.

6 People should get good care and support from **mainstream NHS services,** using NICE guidelines and quality standards – with Annual Health Checks for all those over the age of 14, Health Action Plans, Hospital Passports where appropriate, liaison workers in universal services to help them meet the needs of patients with a learning disability and/or autism, and schemes to ensure universal services are meeting the needs of people with a learning disability and/or autism (such as quality checker schemes and use of the Green Light Toolkit).

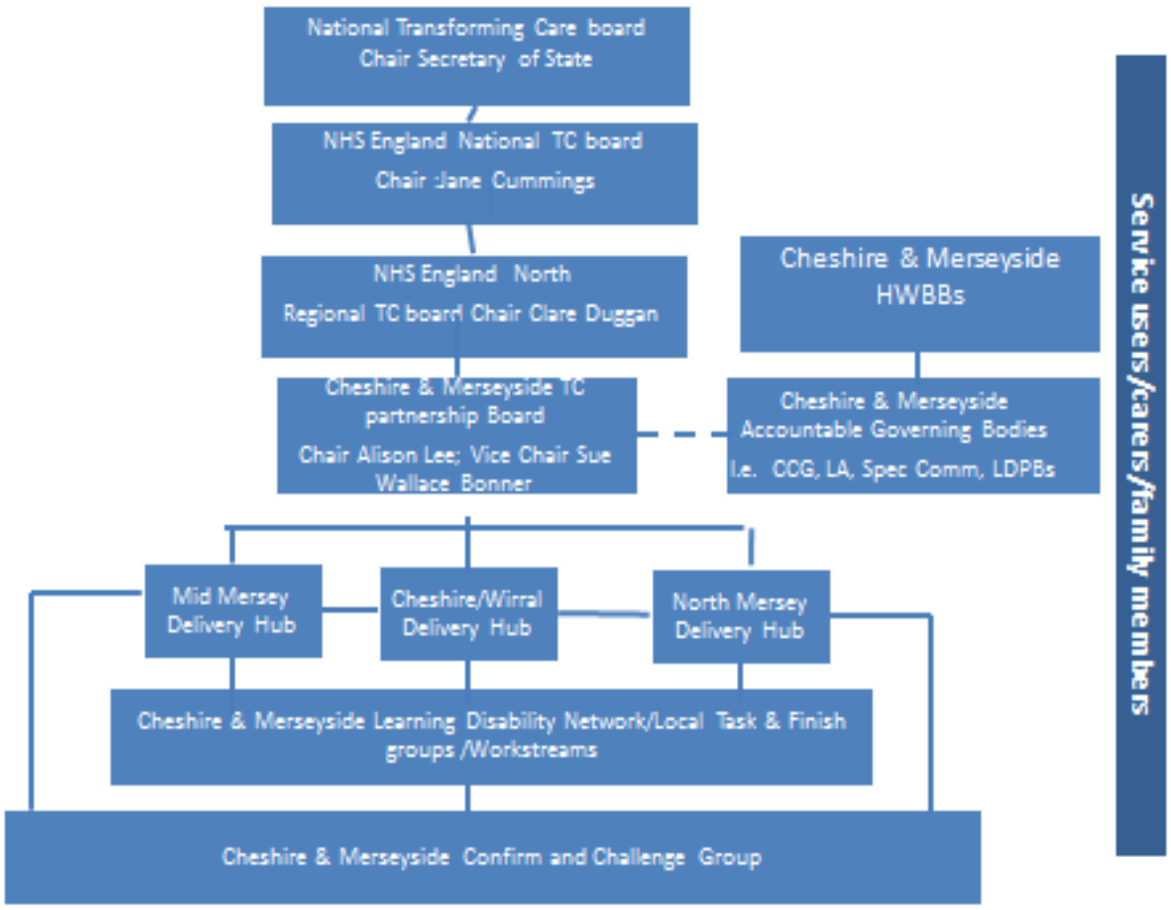
7 People with a learning disability and/or autism should be able to access **specialist health and social care support in the community** – via integrated specialist multi-disciplinary health and social care teams, with that support available on an intensive 24/7 basis when necessary.

8 When necessary, people should be able to get **support to stay out of trouble** – with reasonable adjustments made to universal services aimed at reducing or preventing anti-social or 'offending' behaviour, liaison and diversion schemes in the criminal justice system, and a community forensic health and care function to support people who may pose a risk to others in the community.

9 When necessary, when their health needs cannot be met in the community, they should be able to access high-quality assessment and treatment in a **hospital** setting, staying no longer than they need to, with pre-admission checks to ensure hospital care is the right solution and discharge planning starting from the point of admission or before.

Appendix 2

Governance Structure



Joint transformation planning template

Introduction

- **Purpose**

This document provides the template and key guidance notes for the completion of local plans aimed at transforming services for people of all ages with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition, in line with *Building the Right Support – a national plan to develop community services and close inpatient facilities* (NHS England, LGA, ADASS, 2015). These plans should cover 2016/17, 2017/18 and 2018/19.

- **Aims of the plan**

Plans should demonstrate how areas plan to fully implement the national service model by March 2019 and close inpatient beds, starting with the national planning assumptions set out in *Building the Right Support.* These planning assumptions are that no area should need more inpatient capacity than is necessary at any one time to cater to[1]:

- 10-15 inpatients in CCG-commissioned beds (such as those in assessment and treatment units) per million population
- 20-25 inpatients in NHS England-commissioned beds (such as those in low-, medium- or high-secure units) per million population

These planning assumptions are exactly what the term implies – assumptions for local commissioners to use as they enter into a detailed process of planning. Local planning needs to be creative and ambitious based on a strong understanding of the needs and aspirations of people with a learning disability and/or autism, their families and carers, and on expert advice from clinicians, providers and others. In some local areas, use of beds will be lower than these planning assumptions, but areas are still encouraged to see if they can go still further in supporting people out of hospital settings above and beyond the these initial planning assumptions.

- **National principles**

Transforming care partnerships should tailor their plans to the local system's health and care needs and as such individual plans may vary given provider landscape, demographics and the system-wide health and social care context.

[1]The rates per population will be based on GP registered population aged 18 and over as at 2014/15

However local plans should be consistent with the following principles and actively seek to evidence and reinforce these:

a. **Plans should be consistent** with **Building the right support** and the **national service model** developed by NHS England, the LGA and ADASS, published on Friday 30th October 2015.

b. **This is about a shift in power.** People with a learning disability and/or autism are citizens with rights, who should expect to lead active lives in the community and live in their own homes just as other citizens expect to. We need to build the right community based services to support them to lead those lives, thereby enabling us to close all but the essential inpatient provision.

   To do this people with a learning disability and/or autism and their families/carers should be supported to co-produce transformation plans, and plans should give people more choice as well as control over their own health and care services. An important part of this, is through the expansion of personal budgets, personal health budgets and integrated budgets

c. **Strong stakeholder engagement:** providers of all types (inpatient and community-based; public, private and voluntary sector) should be involved in the development of the plan, and there should be one coherent plan across both providers and commissioners. Stakeholders beyond health and social care should be engaged in the process (e.g. public protection unit, probation, education, and housing) including people with direct experience of using inpatient services.

Summary of the planning template

Planning template

1. Mobilise communities

Governance and stakeholder arrangements

Describe the health and care economy covered by the plan

Current providers are 5BP for inpatient services, commissioned collaboratively across the local footprint (Halton, Warrington, Knowsley and St Helens) via a block contract. Each area commissions Community LD Health Services (e.g. Nursing, Psychology) via in house mechanisms or via 5 Boroughs Partnership NHS Foundation Trust. Care management is provided by each respective Local Authority.
Voluntary sector contracts provide advice guidance and support to children, young people and adults with additional needs
Local social care provision is a mix of in-house and independent sector with strong links.

A number of Local Authorities and CCG's have pooled budget arrangements (LA/CCG) for service users in receipt of either Continuing Healthcare and/or Section 117 funding.

In the context of Warrington. Similar to a number of areas they commission the Independent sector for individuals who require bespoke packages of care, but require a locked rehabilitation environment. Opening in 2016 is an establishment that can meet the needs of a small but complex cohort (ASH House Rehabilitation and resettlement service in Warrington).Warrington are looking to explore with mid Mersey colleagues the potential to use this as a resource to support individuals with complex needs within their own or nearest place of origin. This is focused at optimising outcomes for the individual patients, their Carers and Commissioning organisations.

Describe governance arrangements for this transformation programme *Guidance notes; who are the key partners, what is their involvement*

The Cheshire and Merseyside (C&M) Transforming Care Board brings together the 3 C&M delivery hubs to oversee and support the transformation and delivery of learning disability service provision across the C&M footprint.

The Lead Officer for the 5BP/Mid Mersey delivery Hub is John Edwards (St Helens Integrated Commissioning), with Lisa Birtles Smith (Halton CCG) as the Deputy Lead Officer.

The core hub membership comprises of the following people:

David Pye (St Helens LA/CCG Commissioning Manager)
Jill O Neill (Knowsley LA Commissioning Manager)
Jan Warburton (Commissioning Manager, Knowsley CCG)
Keiron Gibbons (Clinical Co-ordinator Warrington CCG)
Margi Butler (Commissioning Manager, Warrington CCG)
Tom Fairclough (Commissioning Manager, Knowsley CCG)
Sheila McHale (Head of Children and Families Commissioning, Halton CCG)
Lorna Pink (Community LD Team Manager, 5BP)
Alastair Barrowcliff (Consultant Clinical Psychologist, 5BP)

The board is accountable to the NHS England North TC board. The governance structure is attached at Appendix 2.

Key Stakeholders

C&M has a strong history of working in partnership to improve care for people with learning disabilities across the C&M footprint which has enabled many of the key partnerships to be brought together and engage in the development of this plan. Key partners involved in the TC programme and represented at the C&M TC board include;

- Health and Social care commissioners;
- 12 CCGs
- 9 LAs
- NHS England Specialist Commissioning
- Service users, Experts by experience, family members, self-advocates
- NWADASS representing the 9 C&M LAs
- Providers organisations:
- CWP
- Merseycare
- 5BP
- Cheshire & Merseyside Learning Disability Network
- Public Health England
- NHS Health Education North
- Confirm and Challenge Group supported by Pathways/NWTDT

Representation is from senior leaders from each organisation who have the authority to deliver the transformation programme All partners are committed to delivering new models of care and support for people with a learning disability and/or autism. This will be achieved with people with learning disabilities, their families and advocates and will be provided through more detailed co-produced plans.

Describe stakeholder engagement arrangements

Stakeholder day

A local stakeholder event was held on 16 Dec 2016 at Daresbury Park Warrington to understand the local 'ask' of the National Transforming Care programme across the Cheshire & Merseyside footprint.

Over 85 delegates attended the event, with representation from health, local authority, social care, NHS providers, Healthwatch, advocacy, housing, and experts by experience and family members.

An annual self advocacy event coordinated by Pathway's Associates is being delivered in Blackpool on 26th February 2016. This is another opportunity for Self Advocates and Carers to comment on local plans.

Work is also on-going at a local level, examples include Knowsley's "Being Involved Advocacy Group – BIG" who are doing some work around the area.

Members of the National Transforming Care Programme (NHS England and LGA) outlined the national 'ask' and timescales for mobilisation and delivery. As Senior Responsible Officer

for this programme of work, Alison Lee, Accountable Officer, West Cheshire CCG endorsed the progress and work to date in this field across Cheshire & Merseyside, but also acknowledged the challenge ahead.

Moving into their relevant delivery commission hubs, the stakeholders started to work together to:
- Describe the vision for services for people with a Learning disability/autism or behaviours that challenge living in Cheshire & Merseyside?
- Established the strengths and weakness of current LD service provision in their locality
- Identify any key stakeholder that are missing and need to be involved
- Describe what does success look like
- Identify some local quick wins, and
- Begin to prioritise services developments for Years 1, 2 and 3
- Give thought to how the delivery hubs will progress locally

Details from the event have been collated and shared with stakeholders present (Appendix 2). NHSE England will now utilise the detail from the event together with the findings of the retrospective reviews to develop a strategic plan for Cheshire & Merseyside which will be shared with the 3 delivery hubs and relaxant governing bodies.

Describe how the plan has been co-produced with children, young people and adults with a learning disability and/or autism and families/carers

Use of co-production has been undertaken via group work. Each area is slightly different however such forums include, 5BP Autistic Spectrum Conditions Focus group, Autism Service Development Groups; Local discussions with peoples cabinets and at LD partnership boards. Self advocacy representation was facilitated at the NHS England Stakeholder day in December 2015 at Daresbury Park. Plans will also be discussed at the Annual Self Advocates conference (coordinated by Pathways Associates) in late February 2016.

It is recognised by the 5BP Mid Mersey Hub, that further work is required over the next 12 months to engage with Children's Services, to ensure the plans are fit for purpose and reflect the needs of individuals across the entire life cycle. In the first instance Commissioners from the 5BP Hub will engage with Children's Services commissioners in order to mobilise this area of work.

Please go to the 'LD Patient Projections' tab of the Transforming Care Activity and Finance Template (document 5 in the delivery pack) and select the CCG areas covered by your Transforming Care Partnership

Any additional information

Financial Information will be added in due course.

2.Understanding the status quo

Baseline assessment of needs and services

A comprehensive LD/Autism JSNA has been completed by Liverpool John Moore's university.

Learning Disabilities and Autism: A health needs assessment for children and adults in Cheshire and Merseyside

In order to support the plan, a review was also conducted by Colin Vose (Independent Consultant) entitled:

"Transforming Care for people with Learning Disabilities and/or Autism in Cheshire and Merseyside Baseline assessment: A review of learning disabilities service performance across Cheshire and Merseyside 2010-2015 and Model of Care 2016-2018.

Provide detail of the population / demographics

The Four Borough Commissioning Alliance was established in 2010 to co-ordinate commissioning between the then 4 PCTs of Knowsley, Halton, St Helens and Warrington for Mental Health and Learning Disability Provision. The alliance was inclusive of PCTs and Local Authorities.

The Alliance aimed to redesign Learning Disability services by introducing a new Model of Care. This is based on a number of principles, including:

- flexibility and accessibility,
- inclusion,
- quality,
- independence,
- specialist health intervention innovative solutions to behaviour management within the community to support those within their homes/community placements for as long as possible
- admission as an in-patient as a last resort whilst ensuring in- patient admissions are not seen as an alternative to social care provision, for example respite care
- Repatriation of those in out of area placements.

The Alliance, in developing its Model of Care, consulted extensively with Local Learning Disability Partnership Boards, placing service users at the heart of this process. Its Model of Care was published in summer 2011. The principle service provider is 5 Borough Partnership NHS Foundation Trust.

As part of the re-design, a new range of interventions would be available through an enhanced Specialist Intensive Community Support Team. This also included an analysis by the Alliance the admissions data, which found that many of the admissions occurred as a result of tenancy or family breakdowns, often due to difficulties in supporting an individual with challenging behaviours. Since the redesign, each area has commissioned and in some cases decommissioned services relevant to each area. This process will require each member of the TC Hub to identify gaps in provision, to support/promote preventative community level interventions.

The increase in resource and support from the SICST would be provided by closure of one ward, Willis House and transferring that resource to the SICST. The core aim is was to reduce these admissions by working with all those involved and keeping individuals in their own setting and environment for as long as possible. Enclosed is the latest CQC report regarding the 5BP Community Services for people with LD and Autism.

http://www.cqc.org.uk/sites/default/files/new_reports/AAAE1366.pdf

Prior to this redesign the 4 Mid Mersey PCTs utilised 16 beds across two separate units, one in Warrington and one in Whiston, Willis House.

Through the impact of this enhanced community service, the number of Assessment & Treatment beds reduced from 16 to 8, with the delivery of the remaining 8 beds from the most suitable, best and appropriate venue.

It was collectively agreed by the Alliance to utilise the 8 beds from the Byron Unit in Warrington and close the beds at Willis House in Whiston. The site at Whiston was refurbished and used to deliver community learning disability services including colocation with Learning Disability Social Workers from Knowsley.

Prior to the service change the Byron Unit underwent a major refurbishment and was regarded as a high quality, spacious environment. Enclosed is the latest CQC report from the Byron Ward.

https://www.cqc.org.uk/sites/default/files/new_reports/AAAE2027.pdf

Other particulars of the Mid Mersey service re-design included:

- Extension of the hours of work by the SICST from the Traditional 9-5 model to 8am and 6pm, Monday to Friday.
- The adoption of the LD Direct Enhanced Service (LDDES) for delivery of health checks across all primary care practices within the Alliance Geography,
- Adoption of reasonable adjustments across acute hospital sites, Warrington General, Halton General and St Helens & Knowsley hospitals,
- Full compliance with of the Green Light Toolkit by mental health services (national standard for inclusive delivery Mental Health service for those with a Learning Disability).
- Creation of clear service pathways, related service specifications and adoption of Health of the Nation Outcome Scale (Ho-NOS LD) measures across services.
- Adoption of key performance measures which included monthly monitoring of all LD admissions, discharges lengths of stay and delayed discharges.
- Effective transition arrangements between Children and Adult services
- Development of a number clinical pathways relating Learning Disability, Early onset dementia with a Learning Disability, Dysphasia and Challenging Behaviour. The pathways identify what multi-disciplinary assessments the patient will be offered and treatment programmes available.

As a result of the service design (as described above), a retrospective review of occupied bed days over the 5 year period 2011/12 to 2015/16 has demonstrated a reduction in occupied bed days in A&T beds across Mid Mersey in tables 1&2 below.

Further work is required across the areas encompassed in the Mid Mersey Hub to better

understand the demographics of Children's Services, particularly the numbers of Residential Placements and Children placed under the mandate of the Mental Health Act. Commissioners from across the mid Mersey hub will communicate with Children's Services colleagues on a six monthly basis to establish the numbers of people placed in residential school settings and patients detained under the Mental Health Act.

Analysis of inpatient usage by people from Transforming Care Partnership

Table 1: LD in patient activity 2010/11-2015/16, Knowsley, St Helens, Halton

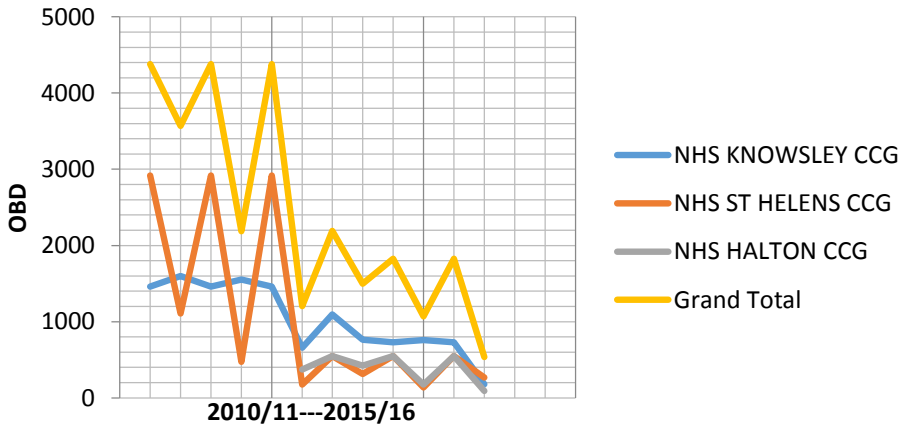
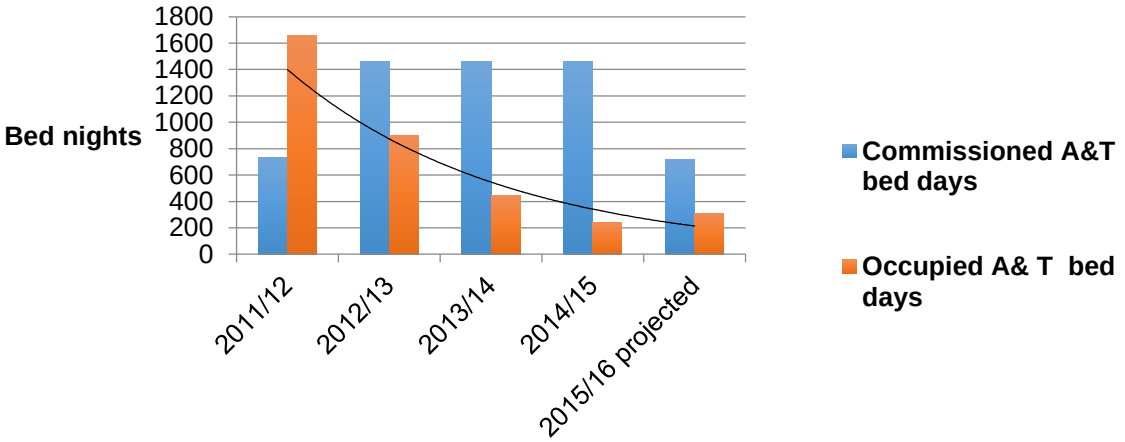


Table 2: Warrington A&T LD Occupied bed activity 2011-2015



Describe the current system

The Four Borough Commissioning Alliance was established in 2010 to co-ordinate commissioning between the then 4 PCTs of Knowsley, Halton, St Helens and Warrington for Mental Health and Learning Disability Provision. The alliance was inclusive of PCTs and Local Authorities.

The Alliance aimed to redesign Learning Disability services by introducing a new Model of Care. This is based on a number of principles, including:

- flexibility and accessibility,
- inclusion,
- quality,
- independence,
- specialist health intervention innovative solutions to behaviour management within the community to support those within their homes/community placements for as long as possible

admission as an in-patient as a last resort whilst ensuring in- patient admissions are not seen as an alternative to social care provision, for example respite care . Adults requiring additional inpatient support are assessed via the Green Light tool kit to sign post to the most appropriate service.

- Repatriation of those in out of area placements.

The Alliance, in developing its Model of Care, consulted extensively with Local Learning Disability Partnership Boards, placing service users at the heart of this process. Its Model of Care was published in summer 2011. The principle service provider is 5 Borough Partnership NHS Foundation Trust.

Across the footprint other current Health and Social Care provision is commissioned through Local Authorities, PBSS Services, Social Care Providers, Social Landlords, Independent Hospital Providers and the Voluntary/Third Sector.

The current model of care in recognises all of the 5 cohorts outlined in the national model, however it is recognised by Halton, Knowsley, Warrington and St Helens that further work is required in terms of redesign, commissioning and transformation to sustain positive performance, reduce where appropriate and to optimise outcomes for people with Learning Disabilities where appropriate.

A key challenge for all areas encompassed within this plan is to effectively capture and support individuals who are vulnerable and have lower level support needs, usually managed within the community with minimal or no Health or Social Care input.

The promotion and development of education, health and social care plans, is in line with the SEND reforms.

Commissioners from the 5BP delivery hub will also work with local in patient providers over the next 12 months to better understand the landscape in terms of in-patients who do not originate from the TCP area. Basic numbers will be ascertained. More robust protocols will also be developed around information sharing when an individual is placed outside of the area of ordinary residence.

What does the current estate look like? What are the key estates challenges, including in relation to housing for individuals?

Across the mid Mersey footprint Housing is provided by registered landlords and individuals have their own tenancies. Further adapted accommodation is being built in some boroughs to support repatriation and provide accessible accommodation to meet specific needs of those with LD and ASC.
Some boroughs have also developed core and cluster/core and flexi style accommodation, which focuses on independence, individualised tenancies in one complex with 24hr oversight from a support provider.
Small residential homes are also commissioned for people with LD.

Each area has existing framework agreements with their Social Providers. Some areas are also reviewing their existing frameworks.

The current understanding of estates and the facilities available is clear. The TCP area uses the Byron Ward at Hollins Park as the Primary Assessment and Treatment facility. The focus over the next twelve months is to sustain the current position, however beyond this further work is required to review the amount of beds required, and to support further repatriation of individuals. Plans need to be developed in conjunction with Housing Strategy colleagues to ensure that there are appropriate housing options within local communities to meet the needs of the complex co-hort of people that need to be repatriated particularly individuals who are transferring from secure settings.

What is the case for change? How can the current model of care be improved?

Developing more individualised budgets and Personal Health Budgets and the local offer to include all the 5 cohorts encompassed in the national model.

Develop a core and cluster model that gives autonomy but also supports independence minimising risk.

There needs to be a proactive approach to build on current successes and to progress further. This includes the enhancement of existing community services to afford more capacity and flexibility in the system. The philosophy of prevention is integral to the plan.

New Services will also need to be commissioned across the footprint to ensure that there is continued progression and to avoid more people being admitted into in-patient facilities.

There is a clear need and focus regarding joint working across the mid Mersey footprint to repatriate individuals from secure settings such as Calderstones, as such patients will be the most difficult cases to repatriate as some cases pose risks and exhibit presentations linked to historical index offences.

The 5BP area of planning recognise that further work is required to support the uptake of personal budgets, as each respective area does not have a relatively huge uptake. To do this, work will be undertaken to understand a baseline of how many service users are in receipt of a personal budget; with realistic targets of how many will be issued between 2016 – 2019. Further work will also need to be undertaken with Health and Social Care Assessors in each respective area to ensure that the message around personal budgets is engrained within organisational structures and everyday practice.

Please complete the 2015/16 (current state) section of the 'Finance and Activity' tab of the Transforming Care Activity and Finance Template (document 5 in the delivery pack)

Any additional information

Financial Information is currently being collated and due to the high volume of specific information required, this will only be completed by 31st March 2016.

3.Develop your vision for the future

Vision, strategy and outcomes

Describe your aspirations for 2018/19.

The outcomes that will change as a result of the transformation programme can be grouped into 4 broad categories;

- Improved quality of care
- Improved quality of life
- Reduced reliance on inpatient services
- Improved service user /family experience

What outcomes will change?	What will change be?	How improvement against each of these domains will be measured
Reduced reliance on inpatient services - Reduced admissions to in patient LD beds where appropriate - Reduced LD inpatient beds in line with national assumptions - Reduced Length of stay - Increased use of IPC - Increased use of personal budgets	50 % reduction in admissions to in patient LD beds *(Jackie we thought the 50% reduction was only across fast track sites???)* Further development, redesign in community teams, and commissioning of some new services in order to enhance resilience and prevent MH admissions.	To monitor reduced reliance on inpatient services, we will use ; - the Assuring Transformation data set - uptake of IPC -
Improved quality of care - Compliance with national CTR policy - Continued year on year improvement in health checks and health action plans - Commissioned LD eye pathway across C&M - Increased uptake in screening programmes including Imm and vacs - Increased use of IPC - Increased use of personal budgets		To monitor quality of care, we are supporting the development of a basket of indicators (see Annex A); exploring how to measure progress in uptake of personal budgets (including direct payments), personal health budgets and, where appropriate, integrated budgets; and strongly support the use by local commissioners of quality checker schemes and Always Events
Improved quality of life - reduction in avoidable and premature deaths - Increased placement stability Development/enhancement of	South Cheshire LD mortality review	Make use of the Health Equality Framework In addition to the HEF the World Health Organisation QOL Assessment

Health facilitation and standardised health checks with GPs re DES to include known health risks for people with specific health conditions e.g. in Cerebral Palsy, Downs Syndrome.		Framework. CIPOLD recommendations, requirements and outcomes.
Improved service user /family experience - SAF feedback - Feedback from service user/family forums - Increase in reasonable adjustments, Co-production service design as a wider view with reasonable adjustments as an example of this. Identification of disability groups within all health and social care coding i.e. LD, ASC, MH. -		SAF monitoring

Describe any principles you are adopting in how you offer care and support to people with a learning disability and/or autism who display behaviour that challenges.

Across the footprint, organisations and Providers are following person centred approaches and promoting positive behavioural support. Even areas that do not have specific PBS Services, the model of PBS is intrinsic to and underpins practice.

Follow principles of the Mental Capacity Act.

Please complete the Year 1, Year 2 and Year 3 sections of the 'Finance and Activity' tab and the 'LD Patient Projections' tab of the Transforming Care Activity and Finance Template (document 5 in the delivery pack)

Any additional information
Is the plan both
Financial Information is currently being collated and due to the high volume of specific information required, this will only be completed by 31st March 2016.

4.Implementation planning

Proposed service changes (incl. pathway redesign *and* resettlement plans for long stay patients)

Overview of your new model of care/ What new services will you commission?

St Helens, Knowsley, Halton and Warrington are working closely and have developed a core set of strategic objectives which are pertinent to each area, some of which can be developed and implemented using a collaborative approach.

The objectives include:

1. **Accommodation & Support** for people from across the mid Mersey footprint (St Helens, Halton, Knowsley, Warrington) with complex presentations and/or linked index offences who currently are placed in secure settings. Warrington has a facility which is due to be opened, which could potentially meet the needs of St Helens, Knowsley, Warrington and Halton patients.

2. **Post Diagnostic Support for ASD /ADHD-** a model for ASD has been proposed by 5 Boroughs Partnership NHS Foundation Trust, which focuses on augmented services and support for people once they have received a diagnosis. This is currently a service gap across St Helens, Halton, Knowsley and Warrington. The development of such services is cited in the "Think Autism" national strategy. The focus of this type of service model is community orientated prevention/integration and to avoid the deterioration of people's Mental Health.

3. **Supporting People's challenging behaviour** –further support for people in their home and for families requiring psycho therapeutic intervention support (to compliment PBS) across the footprint. In the specific context of PBS Halton and Knowsley currently have PBS Services in place commissioned via Halton Borough Council. St Helens does not currently have a dedicated or specialist Positive Behaviour Support (PBS) Practitioner employed within or supporting the local Learning Disability Service offer. Whilst practitioners within existing Community Learning Disability teams may have skills pertinent to the assessment for and delivery of behavioural interventions, this is part of the generic skills mix and no dedicated support is provisioned. It is recognised that a dedicated practitioner role within existing services with a remit to coordinate local resources and professional groups could enhance current delivery of and deployment of a PBS model of working within St Helens. Warrington currently has systems in place via the LD Nursing Team, which is currently adequate and fit for purpose.

4. **Primary Care** health checks / Acute Liaison LD Nurse and/or health facilitators in those boroughs that do not currently have this provision. This is to ensure that the Physical health needs of people with Learning Disabilities are addressed (including the cohort of people with LD/Autism 14-18 in transition requiring Health checks), and to ensure that patient mortality is given the level of priority it deserves. The focus of enhancing such services is to address any health inequalities that people with Learning Disabilities and/or Autism face, to reduce health deteriorations which could potentially contribute to admissions and to improve quality of life to reduce the potential for premature deaths as far as possible.

5. **Peer Advocacy** which includes enhancing capacity into the system. It is important to strengthen and enhance the existing offer, in order for people with Learning Disabilities and Autism to continue to contribute to the respective LD/ASD agenda's across Health and Social Care. Co-production is of paramount importance.

6. **24/7** – crisis response for people for LD/ASD (e.g. Operation Emblem). Street triage services can potentially be developed or redesigned for the LD /ASD population to avoid admissions where appropriate, and to avoid people with LD/ASD entering the Criminal Justice system.

Commissioners will ensure that the objectives are aligned to the national model and also the national SEND reforms.

Some areas have enhanced operations around Clinical Coordination and CTR's to oversee repatriation and ensure timely discharge from inpatient units is achieved moving forward. The role will include coordinating "blue light reviews" as appropriate and post admission CTR's. Each area needs to consider operations around this going forward to enhance efficiency.

Local Authorities and CCG's are working closely around funding arrangements for people who are detained/admitted under the Mental Health Act or at risk of an admission.

The investment of NHSE Transforming Care funding would be integral to the development and support of these initiatives, in order for St Helens, Knowsley, Halton and Warringon to not only current sustainability but continued progression.

What services will you stop commissioning, or commission less of?

1. Less Residential Schooling Placements.

2. Less out of area Hospital and Acute Placements including rehab facilities.

What existing services will change or operate in a different way?

Local services will be required to adopt a more proactive approach utilising the Multi-Disciplinary Team /Care and Treatment Review model and optimise support to individuals who are deemed at risk of an inpatient admissions. Significant work is required with local Health and Social Care Providers at Strategic and Operational Levels with a focus of enhancing resilience and effectiveness ultimately to negate admissions where appropriate and safe to do so.

There needs to be a greater emphasis on delivering more personalised services via Personal Budgets/Personal Health Budgets.

Describe how areas will encourage the uptake of more personalised support packages

- Consideration of those children with EHC plans having personalised integrated budgets.
- Consolidate the use of integrated complex care budgets.
- Enhance the infrastructure in place for integrated budgets.
- *Baseline work to be undertaken to understand the current uptake of Personal Budgets.*
- *Realistic targets for improvement to be developed.*
- *Monitoring of Personal Budget uptake/allocation.*

What will care pathways look like?

MDT/CTR approach to provide clarity of where roles and responsibilities sit.

5BP pathways need to be reviewed to ensure that the pathways are still relevant and efficient. Improvements need to be made where appropriate.

How will people be fully supported to make the transition from children's services to adult services?

Transition strategy and protocols are under review in some areas. Including a more whole of life approach.
Enhancement of MDT/CTR approaches. Some areas have Transitional Operational Groups to discuss individual cases.

Some areas have integrated Departments to there is strategic and operational oversight of transitional processes. For example St Helens have recently integrated Children and Young People's Services and Adult Social Care and Health Departments into a single People's Services Department. This will provide greater consistency moving forward. Other areas also have similar arrangements in place.

How will you commission services differently?

- More pooled budget arrangements.
- Mid Mersey commissioning hub approach.
- Outcomes based Commissioning.
- Ensuring Social Value is intrinsic in the relevant services.
- Greater consistency in terms of costs and charges to Providers.

How will your local estate/housing base need to change?

- Developing accommodation options for people who need to be repatriated from secure settings.
- More efficient Core and Cluster/Core and Flexi support needs to be considered.
- More local community residential support for people with LD/ASD who exhibit more complex challenging behaviours.

Alongside service redesign (e.g. investing in prevention/early intervention/community services), transformation in some areas will involve 'resettling' people who have been in hospital for many years. What will this look like and how will it be managed?

- Use of Dowries where appropriate.
- Repatriation of OOB individuals using barriers tool and MDTs

How does this transformation plan fit with other plans and models to form a collective system response?

- The plan aligns to all Local Authority's approach and commitment to the Care Act particularly around prevention.
- National Autism Strategy, particularly the development of post diagnostic services.
- Mansell Report around supporting people with LD who exhibit complex challenging behaviours.
- Valuing People Strategy and Death by indifference reports, particularly around the area of Health Facilitation.

Any additional information

5.Delivery

What are the programmes of change/work streams needed to implement this plan?

Guidance notes; As a minimum, set out a workforce development plan, an estates plan and a communications and engagement plan

1. Workforce development plan
2. Estates plan
3. Communications and engagement plan
4. Transition group to look at transition protocol and strategy
5. Revised LD/ASD Strategies
6. Revision of any joint commissioning strategies.

Who is leading the delivery of each of these programmes, and what is the supporting team.

Guidance notes; Who are the key enablers to success, what resources have been identified

1. Organisational Development Leads for responsibility for LD.
2. To be determined.
3. Asset management working group – estates.
4. Communication and Engagement Managers/Leads.
5. LD/Autism Operational and Strategic Commissioning Officers/Leads.
6. Commissioning Leads LA's/CCG's

What are the key milestones – including milestones for when particular services will open/close?

Implementation of Joint approach around complex placements for people who are detained in secure settings – Autumn 2016.

What are the risks, assumptions, issues and dependencies?

Guidance notes; Are there any dependencies on organisations not signatory to this plan, or external policies/changes?

A risk register will be developed in due course, with a full risk analysis and mitigation plan.

Key risks include:

1. *The level of financial commitment involved with implementing and delivering the Transforming Care programme. The financial envelope across the TCP is yet to be decided in order to deliver the key initiatives outlined. There is a risk that due to significant financial challenges across the local health and social care economy (due to national pressures) there may not be sufficient resources available to commission adequate levels of service in order to deliver the programme successfully.*

2. *Market risk. There is a risk that the social care market for complex care and support may continue to stay the same; this could result in not enough capacity to repatriate*

the number of individuals encompassed within the plan.

3. *There is a risk that if the local A&T bed base is further reduced, Commissioners may be in a position whereby placements may have to be commissioned on a more reactive spot purchase basis, which predominantly denotes higher costs and also undermines the principles of Transforming Care, which is focused on delivering care closer to home.*

What risk mitigations do you have in place?

Guidance notes; Consider reputational, legal, safety, financial and delivery, contingency plans

A risk register will be developed in due course, with a full risk analysis and mitigation plan.

1. *Financial work to be undertaken to determine what is needed in terms of resources across the collective 5BP hub of planning in order to deliver the programme successfully. Any resource commitments will need to have full endorsement and approval from each respective CCG and LA within the TCP.*

2. *Commissioners will communicate with the market to ensure that the market is clear around expectations of services, in order to meet the needs of the local population.*

3. *Close monitoring and risk analysis of the bed usage of Byron Ward will continue as a collective across the hub of planning.*

Any additional information

6.Finances

Please complete the activity and finance template to set this out (attached as an annex).

End of planning template

Annex A – Developing a basket of quality of care indicators

Over the summer, a review led by the Department of Health was undertaken of existing indicators that areas could use to monitor quality of care and progress in implementing the national service model. These indicators are not mandatory, but have been recommended by a panel of experts drawn from across health and social care. Discussion is ongoing as to how these indicators and others might be used at a national level to monitor quality of care.

This Annex gives the technical description of the indicators recommended for local use to monitor quality of care. The indicators cover hospital and community services. The data is not specific to people in the transforming care cohort.[2]

The table below refers in several places to people with a learning disability or autism in the Mental Health Services Data Set (MHSDS). This should be taken as an abbreviation for people recorded as having activity in the dataset who meet one or more of the following criteria:

2. They are identified by the Protected Characteristics Protocol - Disability as having a response score for PCP-D Question 1 (Do you have any physical or mental health conditions lasting, or expected to last, 12 months or more?) of 1 (Yes – limited a lot) or 2 (Yes – limited a little), and a response score of 1 or 2 (same interpretation) to items PCP-D Question 5 (Do you have difficulty with your memory or ability to concentrate, learn or understand which started before you reached the age of 18?) or PCP-D Question 13 (Autism Spectrum Conditions)
3. They are assigned an ICD10 diagnosis in the groups F70-F99, F84-849, F819
4. They are admitted to hospital with a HES main specialty of psychiatry of learning disabilities
5. They are seen on more than one occasion in outpatients by a consultant in the specialty psychiatry of learning disabilities (do not include autism diagnostic assessments unless they give rise to a relevant diagnosis)
6. They are looked after by a clinical team categorised as Learning Disability Service (C01), Autistic Spectrum Disorder Service (C02)

[2] Please refer to the original source to understand the extent to which people with autism are categorised in the data collection

Indicator No.	Indicator	Source	Measurement[3]
1	Proportion of inpatient population with learning a disability or autism who have a person-centred care plan, updated in the last 12 months, and local care co-ordinator	Mental Health Services Data Set (MHSDS)	Average census calculation applied to: • Denominator: inpatient person-days for patients identified as having a learning disability or autism. • Numerator: person days in denominator where the following two characteristics are met: (1). Face to face contact event with a staff member flagged as the current Care Co-ordinator (MHD_CareCoordinator_Flag) in preceding 28 days; and 2. Care review (Event record with MHD_EventType 'Review') within the preceding 12 months.
2	Proportion of people receiving social care primarily because of a learning disability who receive direct payments (fully or in part) or a personal managed budget (Not possible to include people with autism but not learning disability in this indicator)	Short and Long Term Support statistics	This indicator can only be produced for upper tier local authority geography. Denominator: Sum of clients accessing long term support, community services only funded by full or part direct payments, managed personal budget or commissioned support only. Numerator: all those in the denominator excluding those on commissioned support only. Recommended threshold: This figure should be greater than 60%.
3	Proportion of people with a learning disability or autism readmitted within a specified period of discharge from hospital	Hospital Episodes Statistics (HES) and Assuring Transformation datasets. Readmission following discharge with HES main specialty -	HES is the longest established and most reliable indicator of the fact of admission and readmission. • Denominator: discharges (not including transfers or deaths) from inpatient care where the person is identified as having a learning disability or autism • Numerator: admissions to psychiatric inpatient care within specified period

[3] Except where specified, all indicators are presumed to be for CCG areas, with patients allocated as for ordinary secondary care funding responsibility.

		Psychiatry of Learning Disabilities or diagnosis of a learning disability or autism.	The consultation took 90 days as the specified period for readmission. We would recommend that this period should be reviewed in light of emerging readmission patterns. Particular attention should be paid to whether a distinct group of rapid readmissions is apparent. NHS England is undertaking an exercise to reconcile HES and Assuring Transformation data sets, to understand any differences between the two. At present NHS England will use Assuring Transformation data as its main source of information, and will be monitoring 28-day and 12-month readmission.
4	Proportion of people with a learning disability receiving an annual health check. (People with autism but not learning disability are not included in this scheme)	Calculating Quality Reporting Service, the mechanism used for monitoring **GP** Enhanced Services including the learning disability annual health check.	Two figures should be presented here. • Denominator: In both cases the denominator is the number of people in the CCG area who are on their GP's learning disability register • Numerator 1. The first (which is the key variable) takes as numerator the number of those on their GPs learning disability register who have had an annual health check in the most recent year for which data are available • Numerator 2. The second indicator has as its numerator the number of people with a learning disability on their GPs learning disability health check register. This will identify the extent to which GPs in an area are participating in the scheme
5	Waiting times for new psychiatric referral for people with a learning disability or autism	MHSDS. New referrals are recorded in the Referrals table of the MHSDS.	• Denominator: Referrals to specialist mental health services of individuals identified in this or prior episodes of care as having a learning disability or autism • Numerator: Referrals where interval between referral request and first subsequent clinical contact is within 18 weeks

6	Proportion of looked after people with learning disability or autism for whom there is a crisis plan	MHSDS. (This is identifiable in MHMDS returns from the fields CRISISCREATE and CRISISUPDATE)	Method – average census. • Denominator: person-days for patients in current spell of care with a specialist mental health care provider who are identified as having a learning disability or autism or with a responsible clinician assignment of a person with specialty Psychiatry of Learning Disabilities • Numerator: person days in denominator where there is a current crisis plan

REPORT TO: Health Policy and Performance Board

DATE: 21st June 2016

REPORTING OFFICER: Director of Adult Social Services

PORTFOLIO: Health & Wellbeing

SUBJECT: Social Work Caseload Management

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To appraise the Board of Adult Social Care's approach to caseload management.

2.0 **RECOMMENDATION: That:**

i) The report be noted
ii) Members comments received.
iii) Members are invited to attend a social work matters forum

3.0 **SUPPORTING INFORMATION**

3.1 **Caseload Management**

Caseload management is an important part of overall workload management, in our care management services, particularly in ensuring that social workers have a manageable workload, that they have a good mix of cases and that peaks and troughs with individual workers are co-ordinated effectively across the whole team. Social Workers have a workload average of 25 cases. However, it is important to note, some staff may have a significantly smaller case load, this may be indicative that they are working with highly complex cases that require more time consuming case management interventions. Some social workers may have somewhat higher caseloads, which is likely to be indicative that they have some inactive cases that they need to close off their systems.

3.2 Therefore we start off with a solid grounding that workloads are manageable. We have good staff retention, of permanent social workers, hold no vacancies and have negligible reliance on agencies workers. We operate with a new progression route policy for social work staff, we hold a good mix of experience staff and newly qualified staff and offer regular placements for social work students.

3.3 We are operating within, the National Employer Standards for Social Workers, which were published by the Local Government Association (LGA) May 2014 which, "set out the shared core expectations of employers which will enable

social workers in all employment settings to work effectively". The purpose of the Standards is to sustain high quality outcomes for service users and their families, carers and communities.

3.4 The Employer Standards are split into three main areas, as shown in the diagram below:

Within the framework there is a specific standard on "Safe Workloads and Case Allocation" that states: - Employers should ensure social workers have safe and manageable workloads.

3.5 <u>The approach in Halton</u>

There is an established Professional Capability Forum, chaired by the Principal social Worker, (within Halton this is the Divisional Manager Care Management Services), and its members include, team managers, social workers and policy professionals. We examined the Employee Standards and developed an overarching action plan.

3.6 As a part of this work a new Caseload Management Framework for Adult Social Care teams has been developed and a revised Supervision Policy, Procedure and Practice, launched in March 2016). It impresses that within adult care management services; caseload management is seen as an important aspect of maintaining workforce skills and experience, managing workload capacity and being able to offer effective services. From using the Framework managers are aware of the types of caseloads that each individual has and this enables them to allocate new cases appropriately, making sure that all workers have the opportunity to have a range and variety of cases. There is also a new requirement for managers to Audit supervisions.

3.7 Within the framework a caseload weighting tool was developed with managers alongside social work practitioners. We worked on the basis that caseload management can be operated as a system or scheme that is put in place to record the types and volume of work undertaken by each worker. This enables an accurate assessment of the workload for individual workers. This is normally

carried out using some sort of weighting of the types of cases the worker has using points for certain criteria. Such a system generally focusses on the complexity of the case and the risk value of the case. This information is then combined with other factors (such as the experience of the worker) to calculate an overall "score" which can then be used to assess how appropriate the workers' caseload is for them. We trialled some caseload weighting tools from other authorities with some social workers and sort their views on them.

3.8 A workshop was held to offer dedicated time to discuss existing caseload weighting models. The group had the opportunity to talk those we trialled and other additional models and agreed to develop our own approach in Halton, a an example from the Social Care Institute of Excellence (SCIE) model, in addition to the group's own ideas. This took into account the problems encountered with points-based models and instead opting to use a traffic light system. This model uses the headings of Activity; Risk and Travel with three options under each. Each option is classed as Red, Amber or Green to ascertain the most complex cases. Prior to supervision, each worker can rate their own cases, in preparation for discussion at supervision where the manager can then confirm the rating and note down the total number of cases in each category - red, amber and green.

3.9 Evaluation - As with all new frameworks and systems, to ensure they are working effectively a review needs to take place. In terms of this framework, it has been agreed to undertake a two-stage review at the three-month period and six-month period (June 2016 and November 2016). Analysis will be completed by Principal Managers to evaluate the framework and its effectiveness.

3.10 In conjunction with the development of the Caseload Weighting Framework, the Supervision Policy, Procedure and Practice have been revised. The revision includes the following main changes:

- Inclusion of a Continuing Professional Development (CPD) table for social care workers/occupational therapists to use to record and evidence their own CPD in-line with the requirements of their relevant professional bodies;
- Updated the Supervision Record to include the new caseload weighting information.
- A Supervision Audit tool for managers

3.11 <u>Areas for Improvements</u>

- We are working with our performance team to develop more in-depth intelligence and reporting on social work activity, including cross comparisons across teams.
- Following the implementation of the Progression Route Policy for Social Work an opportunity has arisen for the development of two new "Advanced Social Work posts". This should help support the larger integrated field work teams with direct practice support advice and expertise and supervisions.

- We are shortly sending out a workforce survey called "The Organisational Health Check", which is recommended by the Local Government Association (LGA) as part of assessing performance against the framework described under The Standards for Employers of Social Workers. This is an important tool in supporting and delivering effective social work. It assesses practice conditions in five areas :-

1. Effective workload management
2. Pro-active workflow management
3. Having the right tools to do the job
4. A healthy workplace
5. Effective service delivery

This will check that the working environment of the organisation's social work workforce is safe, effective, caring, responsive and well-led.

3.12 <u>Additional professional support infrastructure for Social Workers</u>

- A Social Work Matters Forum has been established since, February 2015. The Principal Social Worker meets quarterly. with social workers to look at and discuss professional and topical issues for social work. The Forum aims to:

  - Elevate the voice of the social work
  - Promote professional debate on key social work issues
  - Share and update on upcoming social work agendas

There is a national Chief Social Worker for Adults, Lyn Romeo, who works from Government Office, her role is to:

- Provide an expert voice for social work in government, providing advice and guidance on social work and social work matters in relation to policy and legislation.
- Continue the reform of social work education, training and practice.
- Improve the wider public's perceptions and understanding of the role and value of social work in improving people's lives.

The Chief Social Worker will be visiting the Forum to meet with social workers in Halton.

- Action Learning Sets – Social Workers meet on a monthly basis to discuss case work, research articles etc to promote reflective practice and support the professional capability portfolio.

4.0 **POLICY IMPLICATIONS**

4.1 None Applicable

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 There are no financial implications at this time.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

None Applicable

6.2 Employment, Learning & Skills in Halton

None Applicable

6.3 A Healthy Halton

None Applicable

6.4 A Safer Halton

None Applicable

6.5 Halton's Urban Renewal

None Applicable

7.0 RISK ANALYSIS

7.1 Need to ensure Caseload Management Framework is monitored and reviewed. No risks involved at present.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None identified.

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

Document	Place of Inspection	Contact Officer
Caseload Management Framework for Adult Social Care	Municipal Building	Marie Lynch Divisional Manager

REPORT TO:	Health Policy & Performance Board (PPB)
DATE:	21st June 2016
REPORTING OFFICER:	Strategic Director, People & Economy
PORTFOLIO:	Health & Wellbeing
SUBJECT:	One Halton - Health & Wellbeing Operational Plan 2016/17
WARD(S)	Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To inform the Health PPB of the initial operational plan for 2016/17 submitted to NHS England (NHSE) as part of the annual planning round and to identify further work that will be undertaken to develop the priorities for the five year Sustainability and Transformation Plan and the Financial Recovery Plan, with the clear actions to be delivered during the year.

2.0 RECOMMENDATION: That the Board:

i) Note the contents of report and associated appendix; and
ii) Support the commissioning team(s) in identifying the priorities and delivering the subsequent actions.

3.0 SUPPORTING INFORMATION

3.1 Introduction

NHSE issued their Five Year Forward View planning guidance in October 2014, with a set of priorities for the NHS up to 2020, and the direction of travel for new models of care and the improvement of care, quality and financial efficiencies.

In October of the first year of the Five Year plan, NHSE published its revised planning guidance, 'Delivering the Forward View', that extended the planning period to 2021, with a continuation of the existing direction of travel but with a number of new challenges.

The greatest change to the previous processes since Clinical Commissioning Group (CCGs) have been created has been the requirement set by NHSE for the planning footprint to be greater than a single CCG and to be based on the natural geographic health economies. It is on this footprint that NHSE expects to receive a single integrated and consolidated Sustainability and Transformational Plan (STP).

With this in mind all of the CCGs, Local Authorities and Provider Trusts within Cheshire and Merseyside have agreed to work collaboratively on the STP, to

develop a governance structure and to manage any allocations received from the national transformation fund.

Although NHSE want a single STP across an economy footprint, they still require every organisation to provide a series of planning returns describing the level of activity being planned for, the contractual arrangements and the achievement of the key constitutional standards. For 2016-17 NHSE issued all CCGs with a level of activity they expected each CCG to be purchasing and required an explanation of why any CCG has deviated from their forecasts. This Operational Plan (see attached) acts as Halton's response to NHSE, with details of the assumptions and trajectories to evidence the values submitted.

NHSE has, over the last few weeks of the planning cycle, been putting CCGs under increased pressure to increase the levels of activity within their submitted plans, above their own original forecasts, without regard for local strategies or for affordability. NHS Halton CCG has rejected these additional requests and has defended and evidenced the agreed plans and these have now been accepted by NHSE as providing a robust approach.

3.2 **Halton's Planning Process**

NHS Halton CCG has adopted an integrated Borough wide approach to planning with Halton Borough Council and a series of stakeholders, called "One Halton". The "One Halton" consultation and Steering Group identified 6 areas of focus and their executive leads, as follows:

- Mental Health and Learning Difficulties – Dave Sweeney
- Older People – Sue Wallace Bonner
- Long Term Conditions – Jan Snoddon
- Children and Families – Ann McIntyre
- General Well – Eileen O'Meara
- Strategic and Operational Enablers – Leigh Thompson

The process for these areas to identify their service priorities and develop their work plans and delivery timescales for the five years of the STP is still continuing with their task and finish groups. The finalised priority work will be completed and presented to NHS Halton CCG Governing Body in June 2016 and will then be shared with the respective committees and groups for wider circulation in the Local Delivery System (LDS) for inclusion in the STP.

3.3 **Financial Recovery Plan**

NHS Halton CCG is currently forecasting a £8.5m deficit at the end of the current year, while having a statutory duty to break even and a business requirement to deliver a 1% surplus, hold a 1% non-recurrent reserve and a 0.5% contingency. Without the technical requirements the service pressures are closer to £4m.

In order to turn around the deficit and bring the budget on to a sustainable surplus position and financial recovery plan is being enacted, led by the Chief Officer and a newly appointed Head of Recovery. This financial recovery plan will work in parallel

and in collaboration with the Areas of Focus, the LDS and the STP.

To deliver the transformational requirements and to allow a lead time to the delivery of increased efficiencies it is anticipated that the financial position will remain static or even deteriorate in the first instance, before a trajectory of improvement is seen. It is therefore expected that the CCG may not be able to report a breakeven position by the end of the current financial year and that it may take 2 to 3 years, depending on the whole scale system change that will be part of the STP transformational plan.

A series of diagnostic and review processes are being finalised, plus there will be the creation of a clinical taskforce and a management action team undertake the key work streams. A number of early opportunities have been identified and are already being targeted for commencement.

3.4 **Improvement and Assessment Framework**

NHSE has issued the new Improvement and Assessment Framework for 2016-17 on 31st March, which replaces the former assurance process and is aimed to be aligned with the Forward View and the delivery of the STP.

The framework is constructed with four domains, expanding on the “Triple Aim”:-

1. Better Health: this section looks at how the CCG is contributing towards improving the health and wellbeing of its population, and bending the demand curve;
2. Better Care: this principally focuses on care redesign, performance of constitutional standards, and outcomes, including in important clinical areas;
3. Sustainability: this section looks at how the CCG is remaining in financial balance, and is securing good value for patients and the public from the money it spends; and
4. Leadership: this domain assesses the quality of the CCG’s leadership, the quality of its plans, how the CCG works with its partners, and the governance arrangements that the CCG has in place to ensure it acts with probity, for example in managing conflicts of interest.

And the framework has six key clinical priority areas, which are already identified within the One Halton Areas of Focus:-

- Mental health
- Dementia
- Learning disabilities
- Cancer
- Diabetes
- Maternity

Many of the key metrics within the framework will require an integrated response with Public Health towards the preventative strategies and their desired outcomes. The process to undertake the assessment monitoring and review with NHSE is still being confirmed, but should be finalised by the end of the first quarter.

3.5 **Governance, Conclusion and Recommendations**

With the on-going work that is still taking place, it is anticipated that the Operational Plan presented today is the first iteration and that the plan will be refined over time during the first half of the year and evolve into the detailed rolling Operational Plan to manage the strategic 5 year plan.

It is expected that the next few years will be financially taxing and there will be significant difficulties across the economy to deliver the constitutional standards. This is the starting phase for a programme of system wide transformation that will rationalise the configuration of service provision across the provider sector and the foundation for the developments of new models of care with a focus on out of hospital provision.

NHS Halton CCG is going to have to adopt the mentality from a decade ago for "QIPP and GRIP" to identify the opportunities and to ensure there is control and delivery of the plans and schemes through a robust programme management approach. The Borough will need to develop a culture of improvement within its functions and preach a culture of prevention and self-care with its population to reduce the unnecessary demand for health and social care interventions.

The suggested reporting arrangements for this plan are that the commissioning manager's report progress via a Programme Management Office and escalate any concerns to their respective Directors. A consolidated performance report will be sent to NHS Halton CCG's Performance and Finance Committee on a bi-monthly basis with a line of sight through to HBC committees with a quarterly update to the Governing Body.

Work will continue with the portfolio directors on the areas of focus and will be aligned to the Health and Wellbeing strategy and the Joint Strategic Needs Assessment.

It is proposed that this Operational Plan for 2016/17 will be presented to the Health and Wellbeing Board in July.

4.0 **POLICY IMPLICATIONS**

4.1 The Operation Plan is a response to NHS England's priorities planning guidance "Five Year Forward View – October 2014" and "Delivering the Forward View – October 2015".

4.2 The attached Operational Plan will form the first year of the five year Halton Health and Wellbeing Sustainability and Transformation Plan, which will be the framework for the commissioning priorities for both NHS Halton CCG and Halton Borough Council Social Care and Public Health Services.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 There will be Financial and other implications in delivering the plan but allocations received by all of the bodies have been included within the Plan.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

The Operational Plan will support the priority to improve the health and wellbeing of children and young people in the Borough.

6.2 Employment, Learning & Skills in Halton

The Operational Plan will help to support maintaining a healthy workforce.

6.3 A Healthy Halton

All issues outlined in this report and Operational Plan focus directly on this priority.

6.4 A Safer Halton

None identified.

6.5 Halton's Urban Renewal

None identified.

7.0 RISK ANALYSIS

7.1 The main risk identified at this stage is that the Operational Plan may not be delivered due to availability of resources or destabilisation from the LDS or STP.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 The implementation of the Operational Plan will take full account of the Public Sector Equality Duty and the statutory responsibilities of NHS Halton CCG and other partners under the Equality Act 2010.

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

9.1 None under the meaning of the Act.

Halton Clinical Commissioning Group

One Halton Health and Wellbeing Operational Plan

2016-17

Contents

One Halton Health and Wellbeing Operational Plan 2016-2017

1. Introduction

1.1.1. In October 2014, NHS England published its Five Year Forward View[1], which describes how the future of the NHS needed to become more sustainable in order to survive the challenges which the system was anticipated to face over the next five years. The guidance called for a new approach to delivering health and social care services in an integrated manner with a focus on out of hospital care to allow them to focus on genuine acute care needs.

1.1.2. In response, NHS Halton CCG developed a five year strategy and two year operational plan in collaboration with Halton Borough Council and Public Health to work together to improve the health and social care of Halton. To date there have been a number of successes which will be celebrated later in this document.

1.1.3. Building on this, in December 2015, NHS England published further guidance called "Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21[2]. This guidance comprehensively sets out a number of aims, must do's and elements which NHS organisations must deliver against to enable them to become sustainable and transformational organisations by 2021. The required response was the same as the previous year, with the production of two separate but connected plans:

- a five year Sustainability and Transformational Plan (STP), place based and driving the Five Year Forward View; and
- a one year Operational Plan for 2016/17, organised but consistent with the emerging STP.

1.1.4. But with a radical change on previous years guidance with a requirement to develop the longer term strategy on a wider planning footprint than a single CCG and in collaboration with all of the key stakeholders in that economy.

1.1.5. The wider STP needs to ensure that all organisations are working in collaboration to deliver the triple aim of improving care, quality and financial stability in order to continue to provide the best possible healthcare system to the population it serves.

[1] https://www.england.nhs.uk/ourwork/futurenhs/
[2] https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

2. NHS Halton CCG Operational Plan 2016/17

2.1.1. This Operational Plan sets the framework for the place based commissioning of health and wellbeing services in Halton, with a particular emphasis on prevention and early intervention. Integration is key to our strategic approach with all partners working together to deliver joint commissioning, culture change through community development, training for all staff in how to deliver health messages so every contact counts, development of multi-disciplinary teams and joint advocacy and policy work.

2.1.2. A set of action plans are being developed to meet the key priorities through focus area task and finish groups with multi organisational and disciplinary input. Halton also has an integrated approach for engagement and consultation with the public and patients to ensure all commissioning decisions are co-developed and addressing the real needs of those living in the borough.

2.1.3. Ultimate responsibility for the implementation of the healthcare plan, agreed outcomes and key performance indicators lies with the NHS Halton CCGs Governing Body. The Governing Body will utilise the Wellbeing Areas, based on the existing Area Forum boundaries, to deliver its vision at a community level. The aim of Wellbeing Areas is to work alongside local communities to identify issues specific to that particular area and wherever possible, tailor services to meet the needs of that community. This approach is complemented by the development of the Community Wellbeing Practice model, a commissioned initiative reflecting their commissioning intentions to focus provision around local communities. Community Wellbeing Practices are described further in section 8.3.

2.1.4. 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 identifies areas of unmet need and those where the health of the public is below the expected level and need additional support. 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 this plan and deciding on our priorities we have consulted with key partners, local people, including children and young people and community groups, to gain their views on the key health and wellbeing priorities for Halton.

2.1.5. Together with the national priority areas, the local health and social needs will be consolidated into a joint commissioning intentions strategy and a deliverable work plan covering the planning period.

2.1.6. NHS Halton CCG and Halton Borough Council are working in collaboration to deliver a single long term strategy for health, social care and public health services and will present the final strategy to the Halton Health and Wellbeing Board for challenge and agreement.

3. The Five Year Sustainability and Transformational Plan

3.1.1. Within Cheshire and Merseyside, a decision was taken in January 2016, by all of the CCGs, Local Authorities and the provider Hospitals, that the geographical footprint for the local STP would encompass the whole of Cheshire and Merseyside. This footprint encompasses approximately 2.5 million people, 12 CCGs and local authority areas, 9 acute trusts, 5 specialist trusts and 6 community and mental health providers.

3.1.2. The STP will work to deliver the high level strategic transformational change areas, rationalising wider service provision and driving the major network programmes, such as the Urgent and Emergency Care Network, the Crisis Concordat and the Women and Children's Vanguard.

3.1.3. The STP has 5 Local Delivery Systems operating at a level 2 status, each of which will focus on the transformation and collaboration of the local health economies. The priorities and change requirements from the LDSs will feed upward in to the STP as part of the final strategy and submission.

3.1.4. Halton is a member of the Alliance LDS, together with Warrington. St Helens, Knowsley, West Lancashire and Southport and Formby CCGs. This LDS is the single largest LDS within the STP with a population of approximately one million people. The LDS incorporates the acute trusts of Warrington and Halton, St Helens and Knowsley and Southport and Ormskirk, plus 5 Boroughs Partnership NHS Foundation Trust and Bridgewater Community Healthcare NHS Foundation Trust.

3.1.5. There are recognised cross boundary issues with the natural flow of patients into other areas and the wider catchments of the providers, particularly 5 Boroughs Partnership NHS Foundation Trust and Bridgewater Community Healthcare NHS Foundation Trust.

3.1.6. In terms of the formulation of plans, in addition to the Cheshire and Merseyside STP and the Alliance LDS plans, Halton will produce its own Sustainability and Transformational Plan setting of the key priorities and actions for the five years to 2021. It will be a fully integrated Health and Wellbeing Strategic Plan focussing solely on the delivery of services to the local population and the financial sustainability of the borough.

3.1.7. This Operational Plan delivers the first year of the wider five year local plan, and is a direct response to NHS England's requirements for change within 2016-17. In this 12 month period the requirement is primarily related to the healthcare element and the drive to achieve the constitutional standards and the delivery of a financially balance economy.

4. Halton Review of 2015/16

4.1. Progress and successes

4.1.1. In 2015-16 the CCG celebrated the opening of the two Urgent Care Centres in Runcorn and Widnes, significantly expanding the capacity of services available locally to Halton patients requiring urgent and emergency care. The two units have continued to work expanding the care pathways that can be managed outside of the hospital setting, and at the end of the year agreed the inclusion of care for children with croup or wheezy respiratory.

4.1.2. Halton also saw the completion of the Community Wellbeing Practices pilot and its successful evaluation and consolidation. The musculoskeletal project has been undertaking a practice based pilot and will continue to provide evidence of its improvements in care. The procurement of the Child and Adolescent Mental Health Service (CAMHS) was completed and successfully mobilised by the new provider 5 Boroughs Partnership NHS Foundation Trust, who also continue to provide and improve the delivery of the Improving Access to Psychological Therapies (IAPT) programme.

4.1.3. The Countess of Chester was awarded the diabetes education contract for Type 2 patients, cleared the backlog and embedded the new service ahead of schedule. A Type 1 diabetes education programme has been agreed with Warrington and Halton Hospitals NHS Foundation Trust and will commence at the beginning of this financial year.

4.1.4. The CCG also experienced it first full year as having delegated authority for the contracting for general medical primary care services and the awarding and delivery of the work schemes within the Prime Ministers Challenge Fund. This included delivering extended access to primary care medical services in the evening and at the weekend, medical and medicines management support to care homes and the piloting of a diabetic preventative screening programme.

4.1.5. Financially, the CCG has had a challenging year with pressures in the acute sector, prescribing and out of area placements, but it has been successful in delivering its statutory requirements and NHS England's Business Rules of a 1% surplus.

4.1.6. Across its performance indicators the CCG has performed well and with the exception of the delivery of the 4 hour waits in A&E, ambulance turnaround at A&E and the 62 day cancer waiting times standard, the CCG has achieved its requirements.

4.2. Challenges

4.2.1. As mentioned directly above the CCG and the two acute Trusts that serve the CCG have continually struggled to meet the 4 hour A&E waiting time target throughout 2015-16, and with this the associated ambulance turnaround times.

4.2.2. Overall the number of patients attending A&E had not materially risen, and the Urgent Care Centres have diverted non-emergency cases out of the main sites, but the complexity of the patients attending has increased.

4.2.3. This complexity of patients has required a higher level of admission to wards, increased in length of stay and a difficulty to discharge after the acute care is completed. This has resulted in a slowing down of the flow of patients through the hospitals and the difficulties that therefore arise in A&E.

4.2.4. Both hospitals have initiated a number of change programmes to relieve the burden, speed up the handovers of care and the assessment of need. This has been highly successful in preventing the situation deteriorating to a catastrophic position, but has not been able to bring the trusts back above the standard.

4.2.5. For the cancer 62 day standard, the CCG has continued to breach the national standard as a few patients with either complex pathways or from their choice have been seen outside of the 62 day window. It is not evidenced that these delays in care have impacted the patients care plans or outcomes from treatment but there is a continued effort to push for this group of patients to be treated in a timelier manner.

4.3. Financial summary 2015/16

4.3.1. The CCG had an annualised budget of £208 million, in 2015-16, and has achieved it statutory duty to break even and has also delivered against the NHS England Business Rules to report a 1% financial surplus.

4.3.2. The year-end accounts show a level of variation across the both the running and programme costs and across the individual service lines within the programme areas. The CCG has seen an underspend on its overall running cost, largely due to a windfall allocation for the quality premium, but has seen a cumulative pressure on the programme budgets with overspends in mental health and prescribing.

4.3.3. It is recognised that there are a number of recurrent pressures that have been managed with non-recurrent resources that will require addressing within the budget planning and recovery plan in 2016-17.

5. Halton strategic overview

5.1.1. 2015/16 was another year of intense activity within NHS Halton CCG, with the pressures on the NHS increasing as the national system continues to go through a period of austerity. This requires the health economy to find ways to change and transform in an effort to become more efficient, without affecting quality.

5.1.2. Life expectancy is extending, however if these added years are burdened by a longer period of ill health, then there will be no gain to the benefit of this longevity. So there is a need to be healthier for longer. For Halton the life expectancy for women is 83 but their healthy life expectancy is 64 and for males this is 79 and 63, which is slightly below the national position. This means that Halton residents are living 16 to 20 years with a level of ill health that needs the care and support of the health and social care systems.

5.1.3. Working in collaboration with local partners and providers, the CCG is leading a placed based transformational change programme called "**One Halton**".

5.1.4. One Halton is a way of working that involves joining up all the services that deliver care and wellbeing to the people of Halton ensuring that they have the right care and support, at the right time, in the right place to provide the best possible outcomes for everyone.

5.1.5. It is recognised that there are increasing demands on all services. The difference that One Halton will make is to place the people at the centre of their care and well-being. The ethos is simply *'tell your story once, get seen quicker and stay well longer'.*

5.1.6. By joining resources and working together across the Halton Borough, One Halton aims to simplify the current system that patients, families and carers often find complex and difficult to navigate, especially if care and treatment is being delivered by more than one organisation.

5.2. One Halton Objectives:

- To work better together regardless of discipline;
- To find or identify those 'hidden' people who don't access care;
- To treat and care for people at the right time, in the right place by the right people;
- To help people stay healthy and keep generally well;
- To provide the very best in care, now and in the future.
- Provide a programme of ill-health preventative strategies.

5.3. Local Areas of Focus

5.3.1. One Halton is concentrating on six local Areas of Focus which were consolidated from seven priorities previously identified by the Health and Wellbeing Board.

5.3.2. The Areas of Focus have been agreed by all local partners and are backed by a strong evidence base considering the local JSNA, Right Care benchmarks and performance against the range of national and local targets. They are:

- Older people;
- People with Long Term Conditions (LTC);
- People with mental health and learning difficulties;
- Families and children (inc Women's services),
- The generally well, and;
- Operational and Strategic enablers.

5.3.3. The commissioning intentions for these 6 Areas of Focus will be described in detail in our five-year STP, and agreed with the stakeholder bodies and authorised by the Health and Wellbeing Board in July of this year.

5.3.4. These areas will develop wok programmes against their service priorities to deliver the national mandates, the local health needs and the improvements in the triple aim.

5.3.5. The key service priorities at present are

- Frailty
- Care Home Care Planning Approach
- Acute Discharge Management
- Cardiovascular Disease – leading with respiratory services
- Cancer
- Diabetes
- Mental Health
- Learning Disabilities
- Children – with a focus on preschool
- Prevention and tackling the causes of ill health

6. Evidence for Change

6.1.1. Transformational change is required to help meet the challenges of the ageing population, increasing co-morbidity, growing numbers of the population with dementia, increasing costs of care provision, rising readmission rates, and the challenge of transforming care to reduce costs.

6.1.2. However, before Halton can plan and commission its services, it must understand the local landscape and draw on relevant evidence to help to inform its decision making.

6.1.3. For its Operational Plan, evidence and drivers from both local and national sources have been utilised. These include:

- Halton Joint Strategic Needs Assessment;
- Right Care Commissioning for Value Pack
- NHS Atlas of Variation
- NHS England CCG Assessment Framework

6.2. Halton Joint Strategic Needs Assessment (JSNA)

6.2.1. The JSNA are assessments of the current and future health and care needs of the Halton population. It takes into account wider social factors that may have an impact on people's health and wellbeing such as employment, housing and poverty and also has a focus on behaviours which may affect health. From all this information and evidence, priorities are identified which are unique to Halton and they are pulled together into a Health and Wellbeing Strategy.

6.2.2. Before the strategy can be written, the identified priority areas must be consulted upon with stakeholders and members of public before being ratified by the Health and Wellbeing Board and the JSNA is completed and published.

6.2.3. Halton's JSNA's for 2016 are being reviewed and will be published in the coming months.

6.3. Right Care Commissioning for Value Pack

6.3.1. This is a tool provided by the NHS England and Public Health England, which identifies opportunities to improve outcomes in healthcare for key conditions across the whole of their pathway. The tool analyses national registry and activity data to determine the local clinical outcomes, financial effectiveness and patient experiences and benchmarked this data against

similar CCGs (by population and similar demographics) to produce potential opportunities.

6.3.2. These opportunities are not definitive for the delivery of improved care, quality or financial outcomes, but used in conjunction with other metrics provides a robust signpost to the areas that need further investigation.

6.3.3. The CCG has made an early start on reviewing the evidence from the Commissioning for Value pack for Halton. A number of these have been previously identified by the CCG and work has commenced to address these. There is an opportunity to use the programme to look at a whole pathway approach to ensure the best outcomes and efficiencies are gained and details of these are noted in appendix 2.

6.3.4. Halton will be part of wave 2 of the RightCare programme, receiving national support in autumn 2016. Whilst the support will be mainly analytical in nature, the team can help the CCG to focus on the areas of the highest priority.

6.4. The Atlas of Variation

6.4.1. The RightCare programme mentioned above is part of the overall Atlas of Variation, and used in combination with the specific registry dataset identifies the health needs and requirements of the borough, in comparison to comparable economies.

6.4.2. In reviewing the Cardio Vascular Disease (CVD) registry data pack for Halton it identifies similar issues to the RightCare pack, but provides extra granularity in pointing toward obesity, blood pressure and specific disease prevalence within the population.

6.4.3. As a result of the known prevalence the CCG is initiating a programme of atrial fibrillation screening that will identify a cohort of patient with a higher risk of suffering from a stroke and direct them into a diagnostic and preventative pathway to reduce their risk.

6.5. NHS England CCG Assessment Framework

6.5.1. NHS England has now published the 'CCG Improvement and Assessment Framework 2016/17'[3]. This framework provides a number of key performance metrics that have been identified as national priorities.

[3] https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/03/ccg-iaf-mar16.pdf

6.5.2. The metrics that CCGs will be monitored on are wide ranging and outside of the core remit of a CCG. This further demonstrates the need for collaborative working, particularly with public health teams, to address the key causes of ill-health and provide preventative strategies and supportive self-care solutions to acute ill-health interventions.

7. The nine ‘must dos’ for 2016/17 for every local system

7.1.1. Whilst developing long term plans for 2020/21, NHS Halton CCG has developed a clear set of plans and priorities for 2016/17 that will form the basis of this Operational Plan. These plans and priorities are based on the nine must do’s from the recent planning guidance.

7.1.2. This section will detail each of the nine must do’s and demonstrate how NHS Halton CCG intend to respond to each of them.

7.2. Develop a high quality and agreed STP, and subsequently achieve what you determine your most locally critical milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the Forward View.

7.2.1. There is a requirement for local health and care system to come together to create its own ambitious local blueprint for implementing the Forward View.

7.2.2. The One Halton programme has defined several footprints for health and care dependent upon the level of delivery required. It is working collectively with all stakeholders as a health and social care system to identify the priority areas of focus for Halton for the next five years. This is illustrated on the ‘plan on a page’ which is included as Appendix 1.

7.2.3. On a wider scale, as previously noted, Halton is working in collaboration with the other organisations within the Alliance LDS on a sub-regional plan which will in turn support the wider STP of Cheshire & Merseyside.

7.2.4. The governance and system leadership framework has been agreed within the STP and LDS and a programme management office has been appointed to support the production and management of the strategic plans.

7.3. Return the system to aggregate financial balance. This includes secondary care providers delivering efficiency savings through actively engaging with the Lord Carter provider productivity work programme and complying with the maximum total agency spend and hourly rates set out by NHS Improvement. CCGs will additionally be expected to delivering saving by tackling unwanted variation in demand by implementing the RightCare programme in every locality.

7.3.1. Overall the CCG is meeting its statutory duty to breakeven and also the business rules to deliver a 1% surplus.

7.3.2. Going into 2016-17 the CCG still has a requirement to achieve a 1% surplus, plus a 1% non-recurrent reserve to contribute toward the national transformation fund, which with the service pressures will require a QIPP plan of approximately £9m. To deliver this recovery the CCG will require robust cash releasing cost improvement plans to bring the CCGs accounts into balance.

7.3.3. Halton Borough Council has seen reductions in its allocations for social care and public health and will need to put plans into place to provide the greatest outcomes and value for money. It is also anticipated that there will be further reductions in the coming years.

7.3.4. The financial positions for the neighbouring CCGs and provider organisations in the Alliance Health Economy are currently reported to be similar that of Halton.

7.3.5. Both St Helens & Knowsley Teaching Hospitals NHS Trust and Warrington and Halton Hospitals NHS Foundation Trust which serve Halton are due to receive transitional support during 2016-17. This is to support their sustainability and to allow a one year breathing space for radical transformation to be agreed to ensure that services are sustainable over the long term.

7.3.6. With the difficult financial position that the health and social care sector is currently facing, the key national priorities are for the delivery of significant financial reforms, a focus on the transfer of care ‘up stream’ and out of hospitals to reduce the costs in the system at the point at which they are incurred.

7.3.7. Within Halton the ageing population and the growing expectations and demands on health and social care, mirror the anticipated growing deficit forecast by Lord Carter in the 2015 review 'Operational Productivity and Performance in English NHS Acute Hospitals: Unwarranted variations'[4]. The review sets out how the NHS can reduce unwarranted variation in productivity and efficiency.

Financial forecast

7.3.8. The table below gives an outline of the total funding available to Halton for health and social care for the 2016/17 compared to the funding for 2015/16.

7.3.9. Overall the increase available to Halton in 2016/17 is 2.4% however there are marked differences in how this money has been allocated.

Table 3 2016/17 funding

£000,s	2015/16	2016/17
Adult Social Care	38,867	36,434
Children's Social Care	18,730	20,053
Public Health	10,966	10,718
CCG	185,657	191,317
Primary Medical	17,012	17,619
Specialised commissioning	31,180	33,395
Total	302,412	309,536
% change		+2.4%

7.3.10. NHS Halton CCG is better placed than most CCGs due to its close working relationship with Halton Borough Council and Public Health. Some members of staff are funded jointly across the organisations and there is an existing pooled budget arrangement in excess of £41 million, which includes a Better Care Fund pool of £10.5 million. It is expected that this total pooled budget may increase to around £43 million for 2016/17.

7.3.11. The CCG is formulating its cost improvement plan and is still to receive the full details of the business rules and the potential top slice which may be

[4] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf

taken to fund the national reserve. In order to deliver the local transformation it is recognised there will be a need to invest to save and to dual run a number of schemes until the pathways have been fully transferred.

7.3.12. It is therefore expected that in the short term the financial position will deteriorate before an improvement is seen and a medium/long term financial recovery plan is being developed for approval by the CCGs Governing Body.

Tackling unwarranted variation

7.3.13. NHS Halton CCG have analysed the Commissioning for Value (CfV) pack produced by RightCare which allows CCGs to identify where unwarranted variation may lie. The performance of NHS Halton CCG is compared to that of the 10 most similar CCGs and any variations which exist are highlighted. The statistical relevance of that variation and the potential costs, (both financial and non-financial) associated with that variation are given in detail.

7.3.14. Following its analysis of the Commissioning for Value, NHS Halton CCG realised a number of potential areas and have produced actions they will undertake to reduce the variations. An example of the headline potentials and actions for NHS Halton in 16/17 are:

Area	Potential	Action/s
Cancer	To save 22 lives per year should the CCG perform to the average of the 10 most similar CCGs	The CCG have a number of targeted approaches to increase screening for lung, bowel and breast cancers. Additionally, promotional work on the signs and symptoms of lung cancer has been undertaken and will continue in 2016/17.
Respiratory	Saving of £523,000 on non-elective admissions to average of similar 10 CCGs	The excessive number of non-elective admissions was investigated and acted upon by the CCG in 2015/16, by undertaking targeted work on the over 75's to help reduce the non-elective admissions. This work is continuing for 2016/17. The CCG is working in partnership with the community respiratory team to re-commission the service to meet the changing nature of the care needs.
Respiratory (Respiratory Prescribing)	Saving of £419,000 on prescribing to average of similar 10 CCGs	The CCG intends to: Ensure step down in asthma, rationalising inhaler choice, adherence to guidance, patient

		review and cost effective inhaler choice; Look at COPD rescue pack use, undertaking work as result of the national asthma deaths review and reviewing this with high use of relievers and on inappropriate treatment; Commission pharmacies to do COPD reviews with a focus on inhaler technique. This has a potential to include asthma reviews in the future (depending on funding) As part of the re-commissioning of the community service it is intended that all known patients have a medicines management review to ensure they are receiving optimum care.
Trauma & Injuries	Improvements in injuries due to falls in people aged 65+	The Integrated Frailty Action Plan has an initiative to target patients with a high risk of a fall to prevent the incident. The CCG is specifically targeting non-elective admissions in the over 75's through a number of schemes developed with general practice. The MSK pilot is tackling patients with orthopaedic needs that may be a cause of falls.
Maternity & Reproductive Health	Childhood obesity rates are above the England average.	The Families and Children's Focus Area has a Healthy Start and Staying Safe programme that is aiming to address the main causes of childhood obesity in children under 5 with an aim for overall school readiness. Cheshire and Merseyside Women's and Children's Partnership (Vanguard) is promoting 'Health as a Social Movement' and has innovatively partnered with Widnes Vikings Rugby League as part of a 'game changer' programme to work with local schools to tackle obesity, diabetes and emotional

		wellbeing in school children.

7.3.15. A full and detailed list of the actions is available in appendix 2.

7.4. Develop and implement a local plan to address the sustainability and quality of general practice, including workforce and workload issues

7.4.1. NHS Halton CCG has developed the "Strategy for General Practice services in Halton - Creating sustainable out of hospital care for the people of Halton"[5]

7.4.2. This strategy recognises the challenges which General Practice services face but also seeks to address them within Halton by building upon the foundations of good work that is already in place.

7.4.3. This strategy looks at how we can continue to improve the quality, capability and productivity of our General Practice services through a collaborative approach with key stakeholders and, most importantly, with our wider population.

7.4.4. The future model of service outlined in this strategy, 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 stakeholders and organisations.

7.4.5. The emerging themes and care model from the General Practice strategy have led to a broader borough-wide partnership approach. This embraces the MCP approach and provides a greater focus on the wider Out of Hospital approach across Halton.

7.4.6. The strategy will require General Practices to work more in partnership, ensuring that every resident of Halton has access to the same high quality and standardised services. This will involve harnessing the skills, experience and knowledge of the professionals in Halton. This will require work at six levels – borough plus, borough wide, town wide, across community hubs of

[5] strategy for General Practice services in Halton - Creating sustainable out of hospital care for the people of Halton 2014/15 – 2019/20

more than one practice and at individual practice level, ensuring the focus remains on people (patient) putting them at the heart of all we do.

7.4.7. The advent of community hubs will ensure we are focussing on local communities and we will engage with those local communities as services are developed.

7.4.8. Data sourced from the Health and Social Care Information Centre[6] demonstrates that as of 30th September 2013, Halton had the following number of GPs (excluding Registrars and Retainers):

7.4.9. Full Time Equivalent

<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

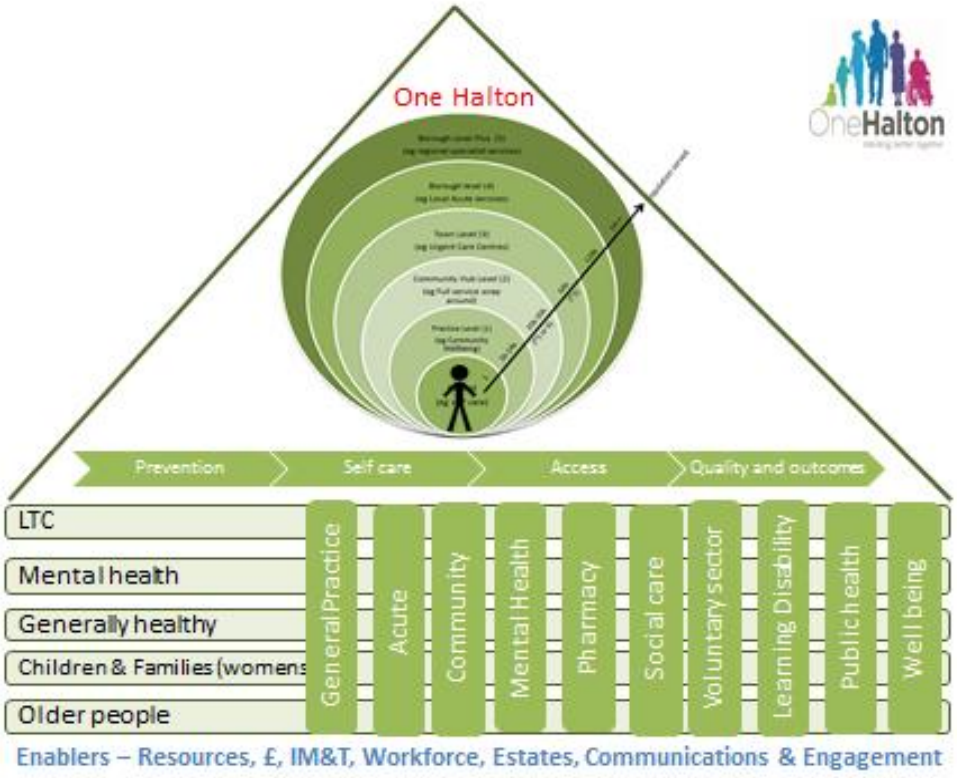
7.4.10. This demonstrates that 27.1% of current practitioners in Halton are 55 and over.

7.4.11. Furthermore, according to the Seventh National GP Work life Survey[7], an increasing number of GPs (nationally) are considering their 'Intention to Quit' within the next five years.

7.4.12. Our future model of care is about multispecialty community provision, working with a range of providers including General Practice. NHS Halton CCG believes this, the One Halton vision, will provide the best opportunity to harness the integrated approach and way of working, as well as maintaining a community focus and building on the existing strengths of General Practice and our existing providers, as well as harnessing new opportunities for community engagement in health and care provision in out of hospital settings.

7.4.13. Our future model of care will be established with services being centred around people in the community.

[6] Health and Social Care Information Centre (2014) [Online]. Available: http://www.hscic.gov.uk/workforce
[7] Institute of Population Health (August 2013), Seventh National GP Worklife Survey. Available: http://www.population-health.manchester.ac.uk/healtheconomics/research/FinalReportofthe7thNationalGPWorklifeSurvey.pdf



7.5. Get back on track with access standards for A&E and ambulance waits ensuring more than 95 percent of patients wait no more than four hours in A&E, and that all ambulance trusts respond to 75 percent of Category A calls within eight minutes, including through making progress in implementing the urgent and emergency care review and associated ambulance standard pilots

7.5.1. Halton is in a unique position as it has no acute hospitals within its Borough, therefore residents must cross boundaries into neighbouring boroughs to attend an Accident & Emergency Departments at either St Helens & Knowsley Teaching Hospitals NHS Trust (Whiston site) or Warrington & Halton Hospitals NHS Foundation Trust (Warrington site).

7.5.2. Public awareness campaigns and pressures on accessing primary care has seen an increase in the number of patients presenting at urgent and emergency care centres.

7.5.3. To help mitigate this and aimed at delivering better quality of service and care locally to its residents, Halton has invested in 2 new Urgent Care

Centre's, by converting both the previous minor injuries unit in Runcorn and the walk in centre in Widnes. Both sites have the same service configuration and delivery model and both are kite marked to receive ambulance transfers.

7.5.4. In the period that the UCCs have been open, patient presentation at A&E and avoidable admissions to hospital has seen a material reduction. A publicity campaign has commenced and will continue to be reiterated to signpost the public to the venues for routine and urgent and emergency care.

Four hour A&E waiting time standard

7.5.5. During 2015/16 both main local acute providers, St Helens & Knowsley Teaching Hospitals NHS Trust and Warrington & Halton Hospitals NHS Foundation Trust have struggled to deliver the 4 hour A&E waiting time standard due to pressures on the service during the year. Both Trusts have agreed their recovery trajectories with NHS Improvements and their lead commissioners. This should result in St Helens & Knowsley reaching the standard by the end of March 2017, whilst Warrington & Halton will make a 3% improvement but remaining unable deliver the constitutional standard during 2016-17.

7.5.6. The Governing Body of the CCG has agreed to continue to monitor and hold to account the acute providers to the NHS Constitutional Standard of 95% throughout 2016/17. They will support the providers to achieve this standard though local initiatives which support the high risk and frequent flyer patients and provide additional opportunities to utilise the UCCs.

Category A ambulance response times

7.5.7. Category A ambulance response times are those emergencies which are deemed life threatening, such as respiratory or cardiac arrest. North West Ambulance Service (NWAS) provide the ambulance service for Halton and have two stations that serve the borough one in Widnes and one in Runcorn.

7.5.8. Performance during 2015/16 was a mixed picture for Halton with a seasonal element to performance very much in evidence showing an above target performance during spring and summer and below target performance during autumn and winter.

7.5.9. NWAS are expected to achieve the 75% Red 1 category calls within an 8 minute response times during 2016/17. Additional capacity has been built into the contract with the service to allow the Trust to achieve the target, cumulatively, regionally and within the borough.

7.5.10. As providers for Halton's emergency ambulance service NWAS have shared their draft Commissioning Intentions for 2016/17. These Intentions will help to address some of the issues identified during 2015/16 particularly around

ambulance response times and handover delays; therefore, NHS Halton CCG supports these Intentions. A copy of the NWAS Commissioning Intentions is available at appendix 3.

Cheshire & Merseyside Urgent & Emergency Care Network (UECN)

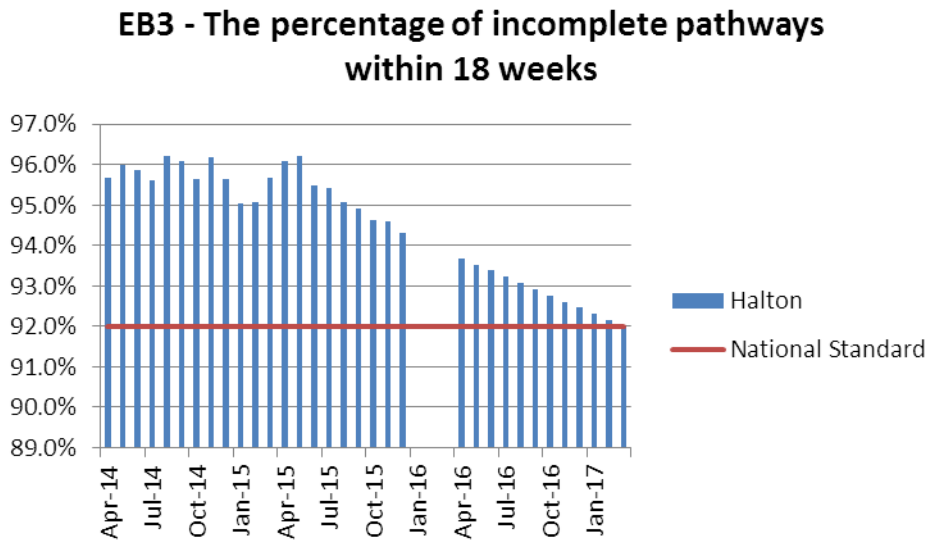
7.5.11. Dr Cliff Richards, Chair of NHS Halton CCG has also been appointed as joint Chair of the Cheshire and Merseyside Urgent & Emergency Care Network (UECN), which was established following the publication of the Keogh Urgent & Emergency Care Review 2015.

7.5.12. The aim of the UECN is to provide strategic oversight of urgent and emergency care over the Cheshire and Merseyside major trauma network area and progress the aims from the Keogh Urgent and Emergency Care Review. The network incorporates all providers and commissioners within the Cheshire and Merseyside STP footprint.

7.6. Improvement against and maintenance of the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment, including offering patient choice

7.6.1. Halton patients have consistently been treated within the 18 week referral to treatment (RTT) standard. The national standard is set at 92% and Halton has achieved between 95% and 96%.

7.6.2. However, as part of the NHS Improvement agreed delivery trajectories the trusts are anticipating a slight drop in the overall performance, but there will be a continued delivery of the standard.



7.7. Deliver the NHS Constitution 62 day cancer waiting standard, including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and make progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.

7.7.1. Halton as a borough has a high prevalence and high cancer mortality, in comparison to similar CCGs, especially from lung cancer. Although the CCG achieves the 2 week target, it has had a problem in meeting the 62 day standard.

7.7.2. The issue is heightened in that both local acute trusts are achieving the standard which NHS Halton CCG has consistently failed to meet due to the granularity of the monitoring. Both Trusts have actions plans to address this and by doing so should bring the CCG performance above the required standard.

7.7.3. NHS Halton CCG is collaborating with neighbouring CCGs to evaluate and implement the recommendations in 'Achieving World-Class Cancer

Outcomes: A Strategy for England 2015-2020'[8] and are committed to working together to improve outcomes for people diagnosed with cancer.

Delivering the 62 day cancer waiting standard

7.7.4. In summer 2015, Monitor, NHS England and the National Trust Development Authority as part of the National Cancer Programme, published a document called Improving & Sustaining Cancer Performance. The focus of the document was on 62 day cancer waits and as such it set out 8 keys targets set and each of the NHS Trusts were tasked with developing an action plan against those targets.

7.7.5. NHS Halton CCG has made steady progress with the key targets resulting in improvements being made towards the standard.

7.7.6. Halton Public Health are supporting the training of frontline primary care staff around early diagnosis and spotting early signs of cancer. They are also delivering a small pilot project where they work with GP Practices to provide follow up phone calls to patients

7.7.7. Additional to this, Public Health England are piloting a GP reminder letter scheme for non-responders of cancer screening to improve the screening uptake. Halton GP's have already undertaken a similar initiative to stress the importance of attending screening and diagnostic appointments and are seeing a steady improvement in attendance rates.

Securing adequate diagnostic capacity

7.7.8. The access to and the capacity of diagnostic equipment within the economy is a not considered a particular issue in Halton. That said, the service is reviewing its current and anticipated activity levels for endoscopic diagnostics.

7.7.9. The CCG has funded an additional x-ray machine and supplementary pathology services at the Widnes Urgent Care Centre. Whilst these additional diagnostics will not be used for potential cancer diagnosis they do free up capacity at the acute provider sites which can then be utilised for diagnostic purposes.

7.7.10. However patients presenting with symptoms, where is it not anticipated to be cancer, may be picked up at the UCC using the onsite diagnostic equipment and rapidly referred on to the cancer pathway.

[8] http://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf

Delivery of 2 week waiting times

7.7.11. The CCG has been working closely with Halton GP practices to increase the percentage of patients who attend their first appointment with a consultant within two weeks of referral. This includes educating patients on the importance of keeping these initial appointments.

7.7.12. The CCG has seen an improvement in compliance during 2015/16 and will continue to have a focus on this during 2016/17.

Delivery of 31 day cancer standard

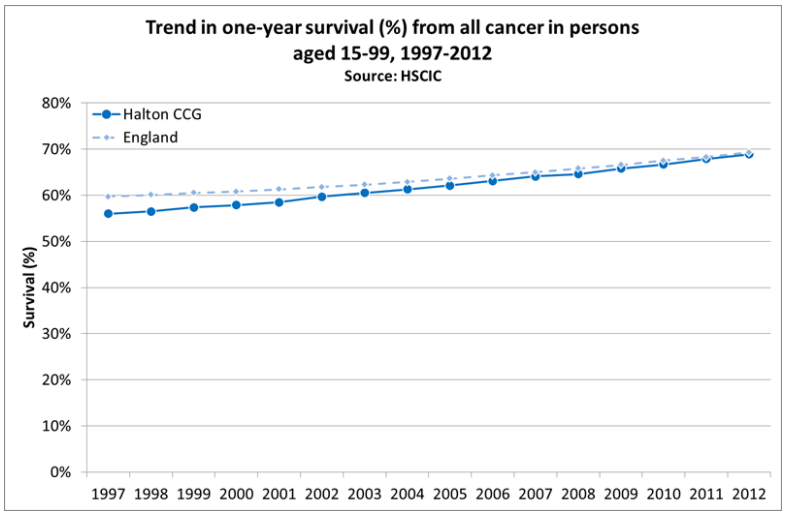
7.7.13. Halton performs very well with regard to patients receiving treatment within 31 days of diagnosis. No breaches have been reported for chemotherapy or radiotherapy treatments and very few for surgery.

7.7.14. The CCG are not anticipating a breach in this cancer standard for 2015/16 and is expecting to continue to report good performance during 2016/17.

Progress in improving one-year survival rates

7.7.15. Halton has made considerable progress in one-year survival rates not only in terms of an absolute increase, but in closing of the gap to the national average.

7.7.16. Of similar CCGs, NHS Halton CCG is ranked amongst the best with a survival rate of almost 70% [9] which is comparable to the national average.



CCG[10]	Survival (%)
Stoke on Trent	65.5%
Telford and Wrekin	65.7%
Mansfield and Ashfield	66.5%
Barnsley	67.7%
Corby	67.9%
Hartlepool and Stockton-on-Tees	68.0%
Rotherham	68.2%
South Sefton	68.5%
Tameside and Glossop	68.7%
Halton	68.9%
St Helens	70.4%
England	69.3%

7.7.17. The CCG is not anticipating any reduction in survival rates. It has, however, identified that additional lives can still be saved by working closely with

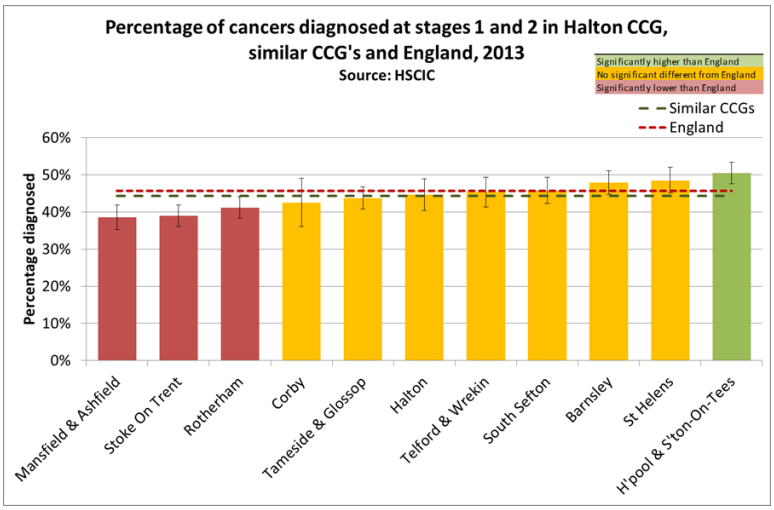
[9] Source: HSCIC
[10] Halton CCG and similar CCGs, 2012 diagnoses

Halton Public Health, GP's and acute providers. Collectively they will focus on the early identification and prompt treatment through better patient education, simplified pathways and a better understanding of the reasons behind cancer waiting time breaches.

Year on year improvement in cancers diagnosed at stage one & two

7.7.18. The most recent available data[11] shows that 44.6% of cancers were diagnosed as stage 1 or 2 in 2013. This is an increase from 43.1% in the previous year and closes the gap to the national average of 45.7%.

7.7.19. Halton Public Health are continuing to deliver screening campaigns, which will encourage patients to attend the two week consultant appointments and contribute to the CCG meeting this standard.



CCG	Percentage
Mansfield & Ashfield	38.5%
Stoke On Trent	39.0%
Rotherham	41.1%
Corby	42.5%
Tameside & Glossop	43.7%
Halton	44.6%
Telford & Wrekin	45.3%
South Sefton	45.8%
Barnsley	47.9%
St Helens	48.5%
H'pool & S'ton-On-Tees	50.5%
Similar CCGs average	44.4%
England average	45.7%

[11] Source: HSCIC 2013

Reducing the proportion of cancers diagnosed following an emergency admission

7.7.20. Halton is slightly higher than the England average for emergency presentations for cancers[12]

	Halton diagnosed following emergency presentation	England diagnosed following emergency presentation
Breast Cancer	6.2%	4.6%
Colorectal Cancer	27.0%	25.1%
Lung Cancer	37.9%	38.4%
Prostate Cancer	10.6%	9.4%

7.7.21. Working together on early detection and referrals, NHS Halton CCG and Halton Public Health aim to reduce the number of cancers identified following an emergency presentation to bring Halton closer to the England average.

7.7.22. Halton will continue to support and promote the nation public awareness campaigns as they are released.

7.8. Achieve and maintain two new mental health access standards: more than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral; 75 percent of people with common mental health conditions referred to the Improved Access to Psychological therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks. Continue to meet a dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia.

7.8.1. NHS Halton CCG commissions its mental health services from 5 Boroughs Partnership NHS Foundation Trust (5BP). Through close partnership

[12] Source: NCIN cancer diagnoses by route of diagnosis, 2006-2010

working, good progress has been made in all areas of mental health provision in Halton.

7.8.2. A complete review of mental health services across the 5BP area of Halton, Warrington, Knowsley, St Helens & Wigan was undertaken in 2015 and the report was published in early 2016. Many of the recommendations from the report compliment the 9 'must do's' and together ensure that the future of mental health services in Halton are transformed and sustainable.

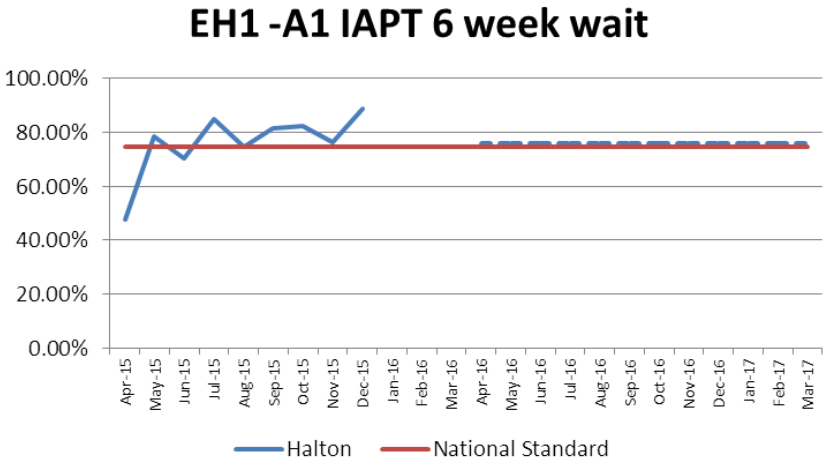
50% of people experiencing 1st episode of psychosis commence treatment in two weeks

7.8.3. Halton will work with the provider to understand the capacity/skill set required and internal data collection systems to facilitate access to the First Episode of Psychosis Service within the time frame. The CCG have committed investment to increase capacity within the service to help meet additional demand.

75% of people with common mental health conditions referred to Improving Access to Psychological Therapies (IAPT) treated in 6 weeks

7.8.4. Halton, for the most part, achieves the 6 week access performance standard with in excess of 80% of patients waiting less than 6 weeks from referral to their treatment beginning. The average monthly figure during 2015/16 was 76% which exceeds the national standard set at 75%.

7.8.5. NHS Halton CCG intends to carry on with its on-going work with IAPT pathways and continue to exceed the national standard for 2016/17. Earmarked resources have been made available to support the delivery of the standards.

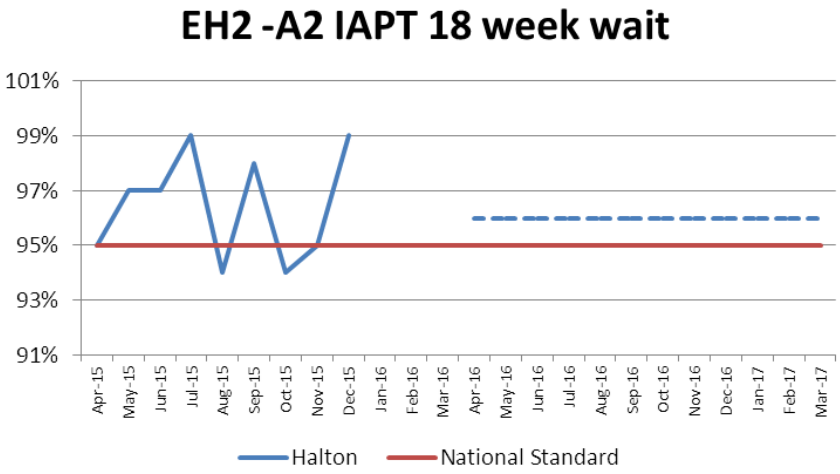


7.8.6. There are some outstanding data discrepancies between data submitted by 5BP to the CCG and the data reported by the Hospital and Social Care

Information Centre (HSCIC) for Halton. Halton is currently in the process of resolving these differences, however based on similar discrepancies seen in 2014/15 it is likely that the 5BP figures reported to the CCG are correct.

95% of people referred to IAPT treated in 18 weeks

7.8.7. Despite a few dips, Halton also achieves the standard of 95% of patients receiving treatment within 18 weeks of referral. The average during 2015/16 was 96%. NHS Halton CCG plans to maintain this level of performance during 2016/17.



7.8.8. As with the 6 week waiting time standard, there is a discrepancy between the data provided by 5BP and that reported by HSCIC. Based on similar discrepancies seen in 2014/15 it is likely that the 5BP figures reported to the CCG are correct.

7.8.9. Additional investment on both a non-recurrent and recurrent basis has been made in the IAPT service to meet the access targets. 5BP has also invested in a bespoke IT system to provide accurate and timely data collection to ensure that the service is delivering efficiently. Individual staff members can be monitored for their performance. Any additional capacity realised from this will be reinvested to increase through put of the service and meet the target regarding treatment completed within 18 weeks.

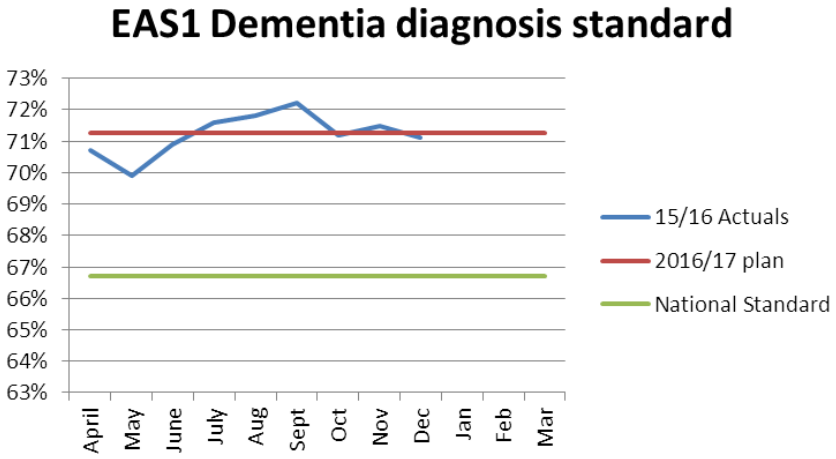
7.8.10. Halton has performed well with the access target but it is recognised that there is further work still require to deliver the recovery target.

Continue to meet dementia diagnosis rate of at least 66.7%

7.8.11. 2015/16 saw a change in the definition for the calculation of dementia diagnosis so that only people aged 65 or over were included in the calculation. Halton did particularly well in identifying dementia in younger

adults so the exclusion of these people from the official calculation led to a reduction of around 2% in the total.

7.8.12. Overall 2015/16 saw Halton exceed the national standard of 66.7% with an average of 71.2% but as at the end of December 2015 there was a short fall of its local stretch target of 75%



7.8.13. The 2016/17 target has been set to continue to exceed the national standard and maintain the level of performance seen in 2015/16.

7.8.14. During 2015/16 and into 2016/17 the CCG will continue to work with General Practice in identifying and supporting those practices with a low diagnosis rate. The CCG are also working closer with care homes and sheltered accommodation in 2016/17 as this may identify further undiagnosed dementia patients. This will be supported by the Care Home Liaison Service.

7.9. Deliver actions set out in local plans to transform care for people with learning disabilities, including implanting enhance community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy.

Implementing enhanced community provision

7.9.1. As part of the Mid Mersey Hub, Halton with St Helens, Knowsley and Warrington CCGs are working with the Cheshire and Mersey Strategic Board. Together they have submitted a high level plan to NHS England and are working on a more detailed submission which will be delivered in line with the national timetable. The CCGs are currently working to identify areas of focus which include transition and supported housing.

Reducing inpatient capacity

7.9.2. NHS Halton CCG has already worked with 5BP and reduced the number of inpatient beds to just 8 covering the whole of the 5BP footprint over the last 5 years. Following a review of cases with specialised commissioning there are no Halton patients in secure inpatient beds who are appropriate for step down into low secure or step down beds within the community at this time. Halton has just 4 patients funded through specialised commissioning in this way and will continue to work with specialised commissioning regarding these individuals with a view to step down into the community when and if this becomes appropriate.

Rolling out care & treatment reviews

7.9.3. NHS Halton CCG has already begun to implement Care and Treatment reviews for people with Learning Disabilities and have utilised the Blue Light protocol. Part of the plan for the future is to develop multi-disciplinary reviews of all clients with LD.

7.10. Develop and implement an affordable plan to make improvements in quality, particularly for organisations in special measures. In addition, providers are required to participate in the annual publication of avoidable mortality rates by individual trusts.

Develop & implement affordable plan to make improvements in quality

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

7.10.2. The CCG is looking to deliver improvements in care planning for smoking, obesity and hypertension through the health improvement team and through primary care which will over time support the reduction in avoidable mortality and morbidity.

Ensure annual publication of avoidable mortality rates by individual trusts

7.10.3. This is a requirement for the acute trusts. NHS Halton CCG would expect the rates to be published via the Summary Hospital-level Mortality Indicator (SHMI) register. The CCG and NHS England would then review these reports as part of their Clinical Quality Forums.

8. Halton Transformational Work in 16/17

8.1. Well North

8.1.1. Well North is a collaborative programme with Public Health England and local communities which is developing, testing and piloting a set of linked interventions to improve the health of the poorest, fastest, in some of the most deprived areas of the North of England.

8.1.2. Well North presented the opportunity to do something different. By providing expertise, skills and resources and working in partnership to improve the health of the poorest communities of the most deprived areas.

8.1.3. In June 2015, the CCG, Public Health and Halton Borough Council came together to consider how it could generate the maximum benefit for individuals within Halton communities using the Well North ethos and concept.

8.1.4. Well North is an incredibly well timed opportunity to rapidly implement part of the overall One Halton vision. It will aligns with the development of a new innovative model, placing services and clinical expertise in the community by changing Children's Centres to Intergenerational [Wellness] Family Centres. They will reach into the community, be a part of the community as family networks and older peoples support and be somewhere easily accessible and local.

8.1.5. Existing local services will work in a more connected way, joining up around older people and families with the introduction of care navigators. This will include the local Well Being services, Social Care in Practice (SCIP) services, the Health Improvement Teams, GPs, Paediatricians, social workers, youth workers, health visitors, voluntary sector organisations and a range of other providers working as a Multidisciplinary Team. They will offer joined up services in the Centres themselves and will also provide out-reach services, going out into the communities, finding and working with families and individuals most at need and enabling them to improve their own and their communities health. Supporting the development and evolution of community networks will better enable the sustainability of the programme.

8.2. Healthy New Towns

8.2.1. In the Five Year Forward View, a clear commitment was made to dramatically improve population health, and integrate health and care services, as new places are built and take shape. This commitment

recognised the need to build over 200,000 more homes in England every year, and invited Expressions of Interest from developments across the country.

8.2.2. Halton was successful in its bid and is now one of the 10 demonstrator sites. The New Communities Programme will help achieve the needs based priorities of the Health and Wellbeing for the people of Halton, which include:

- Prevention and early detection of cancer, e.g. reducing levels of bowel cancer via increased exercise;
- Improved child development, e.g. developing opportunities to explore the natural world, links with growing food and health, reduced obesity through outdoor exercise;
- Reduction in the number of falls in adults using opportunities for increase strength exercises and close to home activities, encouragement of outdoor utilisation and increased vitamin D and bone strength; and
- Prevention and early detection of mental health conditions by encouraging socialisation and community engagement through shared space and 'in built' social spaces, green space and physical activity.

8.2.3. In addition, Halton Borough Council's Core Strategy Local Plan[13] provides the overarching plan for the future development of the borough and sets out the vision for the borough. It identifies why change is needed and where, when and how it will be delivered. By adopting its Core Strategy, Halton has already applied a place-led, spatial planning approach to achieving a vision for Halton in 2028 that will see Halton as;

"*a thriving and vibrant borough where people can learn and develop their skills, enjoy a good quality of life with good health; a high quality, modern urban environment; the opportunity for all to fulfil their potential; greater wealth and equality; sustained by a thriving business community; and within safer, stronger and more attractive neighbourhoods"*.

8.3. Community Wellbeing Practices

8.3.1. In 2012 NHS Halton CCG commissioned Community Wellbeing Practices as a health initiative to fully integrate community wellbeing approaches with all 17 GP practices in the borough.

8.3.2. The scheme aims to support patients in primary care to better access support to address the social problems in their lives that we have found are

[13] http://www4.halton.gov.uk/Pages/planning/policyguidance/pdf/CoreStrategy.pdf

often a causal or contributory factor to poor health, and consequently leads to their attendance at GP and Acute services. It has resulted in the development of a comprehensive range of psychosocial support programmes which have health promotion principles at their core, for example, community navigation services, social prescribing programmes, community resilience events and asset based community development projects.

8.3.3. Community Wellbeing Officers (CWO), based within general practice, provide support to patients whose needs are predominantly social in origin, or where social problems are an exacerbatory factor of a patient's poor physical health or where social circumstances are a contributory factor, for example isolation or depression. The initiative sparked the formation of an integrated sustainable community network which consists of community resources; voluntary, community and social enterprise provision alongside less formal support such as self-help groups. The CWOs work with practice teams, clinicians, patients, and stakeholders to develop practice-specific action plans that address local needs, priorities and opportunities.

8.3.4. The CWOs also provide training and support to enable practitioners to identify and respond to the psychosocial needs of patients. This is done in a number of ways which include:

8.3.5. Wellbeing Reviews aim to get to the root cause of a patient's social problems and understand the patient's skills and capabilities. These form part of a structured plan of support for the patient to move forward. This also includes a community brokerage service that supports patients to navigate their way through the wide range of community support services, included those offered by the VCSE sector.

8.3.6. Psychosocial support, including the provision of community asset based social prescribing groups (linking patients to non-medical sources of support) including a mindfulness programme, community resilience and confidence events and a wide range of community wellbeing projects (e.g. community gardens, musical groups like the ukulele and volunteering opportunities). An evidence based life-skills course based on cognitive behavioural principles is also offered – this has provided an alternative for GPs when considering referring patients to similar Cognitive Behavioural Therapy (CBT) services that have longer waiting lists.

8.3.7. An entrepreneurship programme based on models of co-production to foster a culture of creativity and innovation and capitalise on the skills and talents of patients, clinicians and stakeholders. For example the 'Doctorpreneurs' project that has included activities such as Nordic Walking,

tango dancing, practice makeovers, community gardens and the creation of a ‘dementia passport’.

8.3.8. Community Wellbeing Practices have been re-commissioned therefore services will continue through 2016/17.

8.4. Cultural Manifesto

8.4.1. The NHS Halton CCG Annual General Meeting (AGM) was a visual art exhibition held at the Brindley Theatre entitled “Creative Conversations” within which the CCG premiered the AGM film “A Conversation about Health and Well Being”. Building on this, the CCG has initiated conversations which have led to the evolution of a Cultural Manifesto.

8.4.2. The Cultural Manifesto will cover themes such as Sport, The Arts, The Environment and Social Value and aims to bring an understanding of the real value of the wealth of cultural activities across the Halton borough.

8.4.3. The CCG have entered into a number of strategic partnerships that will help to develop and build alliances and bring the possibility of engaging communities in new, interesting and different ways to increase physical exercise, creativity, reduce isolation and positively engage in healthier activities.

8.4.4. NHS Halton CCG plan to deliver this Cultural Manifesto in 2016/17.

8.5. One Halton Sustainability Development Plan

8.5.1. Sustainable development is ‘development that meets the needs of the present, without compromising the ability of future generations to meet their own needs’. It is about balancing the environmental, social and economic decisions so that no one area outweighs another.

8.5.2. In the past, economic factors have often taken precedence in decision making – leading to situations we face today such as global warming (where the environment has not been considered highly enough in the decision making process), or poverty and inequality (where social factors have not been considered highly enough in the decision making process).

8.5.3. Although in today’s society this still occurs, we are learning on a national, and even global, scale that this imbalance is what is causing many of the problems we see today. By redressing the balance we can build a future for today and for tomorrow.

8.5.4. For health and care the precedent is even higher. Quite simply, social and environmental factors impact on a person's health and wellbeing. By limiting negative impacts, or promoting positive ones, we can actually reduce the need for the treatment of health conditions and care needs; and in turn, the pressure on the health service as a whole – leading to a more sustainable healthcare system.

8.5.5. This approach is set out clearly in the National Sustainability Strategy for Health and Care[14] which sets out the requirements on the health and care system to incorporate sustainable development into its ethos. It describes a sustainable health and care system being achieved by 'delivering high quality care and improved public health without exhausting natural resources or causing severe ecological damage'.

8.5.6. In Autumn 2015, NHS Halton CCG worked with sustainability experts to undertake a gap analysis of the organisation in readiness for the 2016 requirement for all NHS Clinical Commissioning Group to have a Sustainability Plan detailing their proposals for CO^2 reductions, efficient energy use and climate change.

8.5.7. Following the gap analysis the One Halton Sustainable Development Plan 2016-2019 was prepared. The plan describes how NHS Halton CCG and its partners can help achieve a sustainable Halton and future proof against risk (e.g. climate change), requirement (e.g. future legislation) and expectation (e.g. benchmarking against peers outside of the Borough) by identifying and prioritising:

8.5.8. Best practice across the partnership and providing opportunities to share and learn;

- Improvement areas for:
- Cost and CO^2 reduction;
- Potential savings by scale energy provision;
- Social and Cultural Value; and
- Removing duplication and expanding partnership working.
- Identifying where legislation, compliance and national requirements are not yet being met and suggesting steps to rectify this

8.5.9. As there are requirements that must be adhered to and met as an individual organisation and others which can be better met by working in partnership and sharing responsibilities. Therefore the plan was divided into two halves;

[14] Sustainable, Resilient, Healthy People and Places – A Sustainable Development Strategy for the NHS, Public Health and Social Care System'

part one sets out actions that the CCG must meet and part two tackles the areas that were agreed with partners during the gap analysis exercise as shared priorities and action plans against them.

8.5.10. The internal plan will ensure that as a CCG, we will focus on the elements that we have direct control over and includes:

- Having a clear governance structure and accountability;
- Showing a strong leadership in sustainable development;
- Measuring and reducing our resource impact;
- Designing and re-designing services that encourage sustainable care pathways;
- Influencing sustainable development through our supply chain; and
- Evaluating and reporting in line with national standards.

8.5.11. The wider plan has a slightly different emphasis as it supports the collective focus for all the partners. Common priorities were identified during the gap analysis and grouped into themes which support all the individual and collective sustainable development objectives for the CCG and its partners. The plan has already stimulated Halton Borough Council to produce an Affordable Warmth Strategy.

8.5.12. While the outcomes for both plans are expected to be delivered over a three-year time line, the action plans have 2016/17 targets. The plans themselves will be reviewed on an annual basis to update and ensure that the best course of action for the coming year is taken.

8.6. Medicines Management

8.6.1. NHS Halton CCG has identified that the high expenditure associated with medicines is an area where significant challenges exist. Medicines are the most common healthcare intervention that a patient is likely to receive and within Halton approximately 2.8 million items are likely to have been prescribed during 2015/16; at a total cost of over £23 million (excluding any medication which may be been supplied by secondary care).

8.6.2. Effective medicines management within both health and social care is a significant cross cutting theme that needs to be factored into all project developments. The overall cost of medicines to the NHS is increasing year on year and treatments must be safe, evidence based and cost-effective.

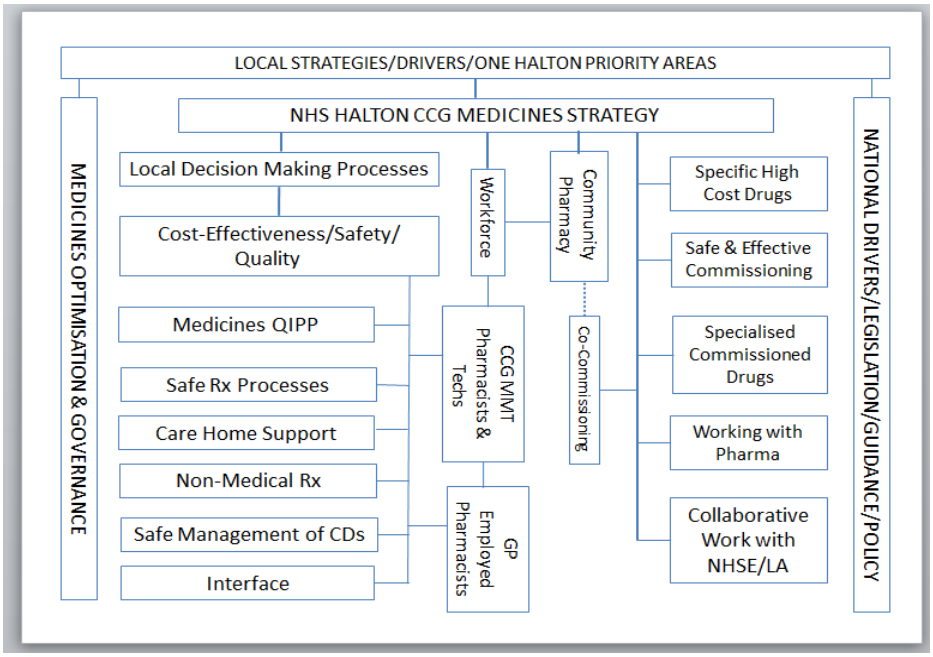
8.6.3. Additionally there is the increasing complexity of available treatments and as such the potential risks to patients if medicines are not used or administered correctly increases. This has a significant cost to the NHS with regards to additional activity such as drug monitoring, routine GP or hospital

appointments and emergency hospital admissions as well as having a socioeconomic impact; therefore effective medicines optimisation is vital to ensuring better outcomes, minimising harm and improving quality of life for patients.

8.6.4. To support this work the CCGs Medicines Management Team will be developing an overarching Medicines Strategy that will incorporate all the key elements of medicines management, medicines optimisation and pharmacy. The table below provides an overview of the Medicines Management Strategy areas.

8.6.5. Through this strategy all the key elements and themes will be joined up to show how they interlink and interact with each other and with other key CCG Strategies and priorities. This will include the following areas:

- Community Pharmacy;
- Medicines Optimisation, at both a GP practice and CCG commissioned service level and including medicines use in the care home setting;
- Specific High Cost Drugs;
- Specialised Drugs;
- Safe Management of Controlled Drugs
- Non-Medical Prescribing
- Working with the Pharmaceutical Industry



8.7. Workforce & Estates

Workforce

8.7.1. A third of babies born this year will see their 100th birthday in contrast to 1948 when 50% died before age 45. This evidences the significant improvements seen in healthcare over the last 60 years however it poses a significant risk to our workforce in managing this increased demand. We are 'promised' nationally, an additional 5000 GPs to support these workforce issues however the reality is that less trainees are choosing general practices when they qualify and more GPs are choosing to retire earlier than normal retirement age. The gender balance between male and female doctors is also changing which is also impacting on workforce availability.

8.7.2. NHS England has produced a 10 point action plan – Building the workforce, a new deal for GPs to support addressing these workforce issues however, as this is a national document and targeted at the most under-doctored areas first, it is essential that NHS Halton CCG has its own strategy which is compliant with the national action plan.

8.7.3. The current silo working of practices is also unsustainable as we move more and more to delivery of equitable services and increased services closer to home. Significant progress is now being made and we plan to have a fit for purpose work force plan for 16/17 and beyond.

Estates

8.7.4. Estates are a key enabler for the implantation of the Five Year Forward View. Whilst new models of care are changing the way healthcare is delivered, the point at which it is delivered must also be taken in consideration.

8.7.5. NHS Halton CCG has delegated responsibility for the primary care estate in Halton and as such needs to work to align its estate to complement the future CCG plans.

8.7.6. In 2015, the Halton Strategic Estates Plan was produced which reviewed the Halton primary care estate and identified estate rationalisation opportunities which will deliver both clinical and financial benefits. By understanding its estate function, NHS Halton CCG can maximise the use of high quality buildings and dispose of unwanted costly buildings.

8.7.7. A Primary Care Estates Working Group (PCEWG) was set up to deliver the recommendations of the Strategic Estates Plan and produce a Primary Care Estates Development Plan which will support any applications for estates enabling funds.

8.7.8. On wider, Borough wide footprint, NHS Halton CCG is working with all its estates colleagues to collectively achieve efficient use of buildings across the public, private and voluntary sectors – but especially health and social care. By working in partnership and looking at the estate as assets of the community, they will ensure that there is an integrated approach to sharing premises or acquiring assets, when it is in the best interests of the partnership to do so.

8.7.9. The partnership is also aligning the assets with the digital healthcare plans across the borough to ensure the estate is 'technology-proof' so that it can enable future plans.

8.8. Information Management & Technology (IM&T)

8.8.1. In line with the NHS Halton CCG IM&T strategy and the development of the Mersey wide Digital Roadmap, the operational priorities for 16/17 is to continue to build the necessary infrastructure to deliver the strategic aims; paper free at the point of care and interoperability. This will be focused on a number of key deliverables within 16/17.

Development and implementation of EMIS clinical services into intermediate and urgent care settings.

8.8.2. In addition to both the primary care systems and the recently implemented EMIS system within Halton Haven hospice, this will instantly provide interoperability across a significant proportion of our health economy within 16/17 and will provide a solid foundation from both a governance and technical perspective to build on longer term as per the digital roadmap implementation.

Phase 1 interoperability solution between health and social care

8.8.3. Implementation of an electronic record patient viewer to allow social care access to the GP record. 16/17 will see the development of the necessary infrastructure to allow social care view access to the GP record. The second phase of this project will then allow two-way data sharing between health and social care and also the creation of a virtual care plan that can be accessed and populated as an integrated document.

8.8.4. These local deliverables in collaboration with wider system partners will ensure we are progressing against are strategic aims but also delivering tangible improvements for patients and frontline staff.

8.9. Governance

8.9.1. NHS Halton CCG will monitor and manage delivery of this Operational Plan via a combination of internal CCG committees and external contract meetings.

8.9.2. Internally, the Governing Body will receive regular reports on progress against all targets and standards and assume overall responsibility for delivery. More detailed assessment, review and management of all elements will take place in the Finance and Performance Committee; which then provides reports to the Governing Body.

8.9.3. Externally and where required, the CCG will ensure all relevant targets, standards and performance issues are raised, monitored and addressed with both the lead commissioner and provider of the respective service. To monitor progress against any issues, the Finance and Performance committee will receive regular reports and, where required, ensure appropriate actions are taken.

9. Conclusion

9.1.1. NHS Halton CCG will address the nine ‘must do’s’; improve access to services 7 days a week; develop, agree and make progress on a sustainability and transformation plan; return the system to aggregate financial balance and develop and implement an affordable plan to make quality improvements. There will be further development and implementation of local plans which will address the sustainability and quality of general practice. Work will continue to maintain and improve performance against constitutional standards specifically those relating to and including, ambulance waiting times, A&E, cancer and mental health; transform care for those with learning disabilities.

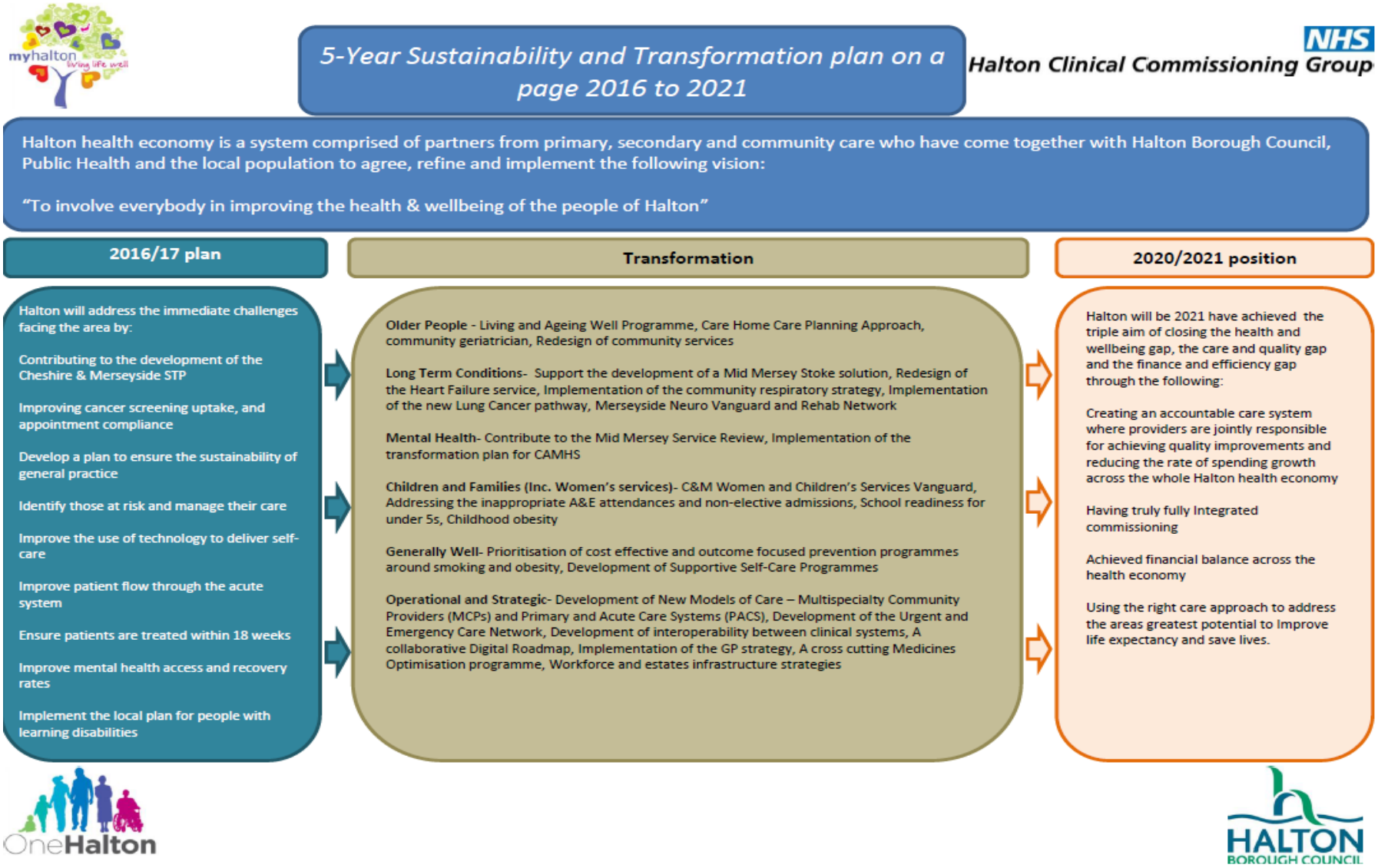
9.1.2. Our priorities as seen within this operational plan will see improvements in (this list is not exhaustive);

- Tackling self-care, prevention and early intervention,
- Reduction in childhood obesity,
- Improvement in diabetes prevention,
- Improvements in tackling smoking, alcohol and physical inactivity
- Reduction in avoidable admissions
- A step change in patient activation and self-care
- An expansion of integrated health budgets and choice
- Improvements in the health of our employees
- Improved resilience in general practice
- Achievement of the constitutional standards
- 7 day working
- Technological advancements with full interoperability and access to digital health records.
- New models of care
- Implementation of the two new mental health waiting time standards
- Close the gap on LD and autism
- Improve maternity services

9.1.3. The CCG has produced a placed based operational plan that is fully integrated, working closely with our partners in social care, public health, other local government services, NHS providers, voluntary sector organisations and members of the local community. It is this plan that will deliver a sustainable system for the future care of our population.

9.1.4. In conclusion NHS Halton CCG is committed to delivering the five year forward view and to continuously strive to deliver against the ***triple aim – better health, transformed quality of care delivery, and sustainable finances,*** harnessing the energies of clinicians, patients, carers, citizens and local partners.

Appendix 1 – plan on a page



Appendix 2 – RightCare Commissioning for Value: potentials & actions

Cancer

Potential	Actions
• There is potential to save 22 lives per year should the CCG perform to the average of the 10 most similar CCGs. • The CCG could potentially save £202,000 on elective admissions for cancer treatment should the CCG perform at the average of the 10 most similar CCGs there is a potential further saving of £319,000 if the CCG could perform at the average of the best 5 similar CCGs • improvements are possible in Females 50-70 screened for breast cancer in last 36 months • improvements are possible in Bowel cancer screening – approximately 10% lower than the average of the 10 most similar CCGs with huge variation between practices, ranging from 33.9% uptake to 67.4% uptake in 2014 • improvements are possible in <75 mortality from Lung Cancer – approximately 40% higher than the average for 10 most similar CCGs but confidence interval is large so could be between 18% worse and 58% worse • Uptake of breast screening is below marginally below national target, with an 18% variation between the highest and lowest uptake practices. • Uptake of cervical screening is below on average 4% below national target, with a 10% variation between the highest and lowest uptake practices.	• Work has been done recently to increase the accessibility of the mobile breast screening unit with the Borough to encourage participation, and Health and Wellness Services within Public Health are engaging with practices prior to call and recall rounds to engage women directly and encourage participation. • Public Health have signed a collaborative agreement with public health across Cheshire and Merseyside to address bowel screening uptake and promote this in a coherent approach across the sub region. In addition, local Health and Wellbeing Services are directly working with practices to develop new initiative to increase participation in bowel screening • A coordinated approach is required to encourage uptake amongst eligible women and PHE must be accountable for providing support to primary care through engagement and training on additional to providing coordinated and focussed public facing activities in poorer performing areas (across all screening programmes). • Considerable work has been undertaken locally to promote the signs and symptoms for lung cancer and promote early interventions, which has seen increases in early stage diagnosis. However, as a key cause of early mortality, consideration must be made to adopt an ACE lung screening approach locally to increase the proportion of stage I and II diagnosis and reduce diagnosis through emergency presentations by development of symptom specific and straight to diagnostic pathways.

Gastro Intestinal

Potential	Actions
• The CCG could potentially save £653,000 on elective admissions for gastro intestinal treatment should the CCG perform at the average of 10 most similar CCGs • Potential saving of £534,000 on non-elective admissions to average of similar 10 CCGs • Potential saving £300,000 on prescribing to average of similar 10 CCGs	• This was investigated and acted on by the CCG in 2015/16 by undertaking targeted work on the over 75's to help reduce NEL admissions, this is continuing in 2016/17 • The CCG will work with Public health to investigate the main presenting conditions, including what co-morbidities are linked, including links to alcohol and the link between the above average number of non-elective admissions for Gastro Intestinal conditions and the high mortality from Gastro intestinal Cancer.

Genito Urinary

Potential	Actions
• The CCG could potentially save £207,000 on elective admissions for Genito urinary patients should the CCG perform at the average of the 10 most similar CCGs • Potential saving of £345,000 on non-elective admissions to average of similar 10 CCGs • Potential saving £176,000 on prescribing to average of similar 10 CCGs • Improvements are possible in Patients on CKD register with a BP of 140/85 or less • Improvements are possible in Creatine ratio test used in last 12 months	• The CCG intends to remodel the community continence service including revision of the continence pathway and a formulary. • The excess number of non-elective admissions was investigated and acted on by the CCG in 2015/16 by undertaking targeted work on the over 75's to help reduce NEL admissions, this is continuing in 2016/17 • The increase in prescribing costs may be due to Emergency department prescribing, some high costs brands being used first line rather than generic sildenafil so we are revisiting this with GP practices to see if there is the possibility of a switch. Also have identified small amounts of off label use being recommended by urologists but possibly not many patients even though it is always the brands they recommend. Also some high use of costly Over Active Bladder drugs – some possibly coming from secondary care but also primary care

	probably feel quite comfortable stepping up to alternative brands once first line choices tried. • NHS Halton CCG under delegated commissioning arrangements will develop a general practice performance report to monitor and highlight QOF performance including CKD patients with high BP and Creatine ratio testing. • The CCG and Public Health will work together to review the coding behind secondary care activity, particularly in urgent care.

Endocrine, Nutritional & Metabolic

Potential	Actions
• potential saving of £72,000 on non-elective admissions to average of similar 10 CCGs • prescribing – potential saving £649,000 • improvements are possible in % diabetes patients cholesterol < 5 mmol/l • improvements are possible in % diabetes patients HbA1c is 64 mmol/l • improvements are possible in % diabetes patients whose BP <150/90 • improvements are possible in Retinal screening • Improvements are possible in Non-elective spend on diabetes – approximately 30% worse (between 10% and 50%) • Risk of MI in people with diabetes – approximately 160% worse (between 20% and 300%) • Risk of heart failure in people with diabetes – approximately 100% worse (between 20 and 180%) • Non elective spend on renal pathway –	• there have been numerous new antidiabetic drugs which are increasing in use but the CCG are also quite high on prescribing of Gliptins which we have been trying to review over a number of years but it is quite slow progress and difficult • The CCG has a plan for 2016/17 to work with dietetics to review the all the supplements in relation to sip feeds, however capacity is an issue but it is a potential invest to save area for 2016/17 • NHS Halton CCG under delegated commissioning arrangements will develop a general practice performance report to monitor and highlight practice performance including cholesterol, HbA1c and blood pressure • The CCG and Public Health will work together in 2016/17 to further review the potential for improvement.

approximately 30% higher (between 15% and 45%)	

Neurological

Potential	Actions
• Potential saving of £968,000 on non-elective admissions to average of similar 10 CCGs • Neurological prescribing – potential saving £546,000	• Implementation of the neurology vanguard (the neuro network) • Prescribing spend is linked to prescribing for Pregabalin (for neuropathic pain) in the main. The CCG have done some work to optimise the doses used as there is a flat pricing structure but it needs constant review • The CCG have also tried to look at switching to alternatives but this has not been very successful. Opioids and migraine treatments is also a high spend area for the CCG, especially transdermal and oxycodone plus large amounts of expensive milder opioids such as co-codamol • The CCG are looking at oxycodone and will be trying to revisit transdermal opioids again in 16/17. The CCG have done some work to reduce costs and improve quality in this area already but will be done in 2016/17

Respiratory

Potential	Actions
• Potential saving of £523,000 on non-elective admissions to average of similar 10 CCGs • Respiratory prescribing– potential saving £419,000 on prescribing to average of similar 10 CCGs	• Halton is developing a new adult rapid response respiratory specification with a launch in April 2016 • The excess number of non-elective admissions was investigated and acted on by the CCG in 2015/16 by undertaking targeted work on the over 75's to help reduce

• improvements are possible in % asthma patients with a review • Improvements are possible in Emergency admission rate for children with asthma, 0-18 yrs. – approximately 40% (between 15% and 65%) • Improvements are possible in % of COPD patients with record of FEV1 – approximately 5% (between 4% and 6%)	NEL admissions, this is continuing in 2016/17 • Respiratory prescribing makes about 10% of the total prescribing budget. The CCG has scope to do more to ensure step down in asthma, rationalising inhaler choice, adherence to guidance, patient review and cost effective inhaler choice. The CCG are looking at COPD rescue pack use, doing some work as a result of the national asthma deaths review and so reviewing this with a high use of relievers and on inappropriate treatment. Also commissioned pharmacy to do COPD reviews with a focus on inhaler technique – which is a huge issue. Potential for roll out to include asthma in the future depending on funding. • NHS Halton CCG under delegated commissioning arrangements will develop a general practice performance report to monitor and highlight practice performance.

Trauma & Injuries

Potential	Actions
• Potential saving of £524,000 on non-elective admissions to average of similar 10 CCGs - approximately 20% higher (between 15% and 25%) • Improvements are possible in Injuries due to falls in people aged 65+ - approximately 45% worse (between 35% and 55%) • Improvements are possible in Unintentional & deliberate injury admissions 0-24 years – approximately 25% worse (between 15% and 35%)	• In 2015/16 The CCG invested heavily in the development of two urgent care centres in Halton, these two sites have already begun making an impact on the number of non-elective admissions and in 2016/17 further developments including additional paediatric pathways will ensure that the UCC's continue to have an impact • The CCG is specifically targeting non-elective admissions in the over 75's through a number of schemes developed in general practice • Public Health are investing in a mindfulness scheme in schools to reduce the number of children self-harming, leading to injury admissions.

Circulation

Potential	Actions
• Circulation prescribing – potential saving £142,000 on prescribing to average of similar 10 CCGs • improvements are possible in Patients with CHD whose last measured cholesterol is 5mmol/l or less • improvements are possible in % hypertension patients whose BP <150/90 • improvements are possible in % stroke patients whose BP <150/90 • Improvements are possible in <75 mortality from acute MI – approximately 40% worse (between 5% and 75%) • Improvements are possible in TIA cases treated within 24 hours – approximately 35% worse (between 10% and 60%)	• The CCG is developing an innovative scheme to identify people with Atrial Fibrillation in the community and also to ensure that patients diagnosed with AF are on the appropriate NICE treatment, this may increase the spend on anticoagulation therapies in the short-term but will have savings elsewhere in the system by prevention of strokes. • NHS Halton CCG under delegated commissioning arrangements will develop a general practice performance report to monitor and highlight practice performance • Public Health are conducting an audit of hypertension with the intention of improving care, it's possible that prescribing costs will increase but hospital admissions / deaths/ disability reduce. Some investment in primary care may be required to encourage the audit process since this can then be applied to Respiratory, Diabetes and other conditions showing variation The data obtained will provide even deeper granularity than the Right Care packs and will also indicate where prevention rather than clinical spend will be beneficial

Maternity & reproductive health

Potential	Actions
• Flu vaccinations to pregnant women are below national target • Breastfeeding rates are low • Improvements are possible in % receiving of children receiving 2 doses of MMR by 5 years of age	• Halton has continued to increase the uptake of flu vaccinations to pregnant women and is amongst the highest performing CCG in Cheshire and Merseyside but improvements are still possible. Uptake still remains 23% below national target. Additional support from PHE and NHS England is required to ensure maternity services are key deliverers and local work will continue to engage and

• Improvements are possible to reduce practice variation in childhood immunisations, including primary vaccinations by age 2 • Improvements are possible in A&E attendance rate for <5's • Emergency admission rates for <5's – approximately 15% worse (between 10% and 20%) • Childhood obesity rates are above the England average • Improvements are possible in Mean number of decayed, filled or missing teeth in children aged 5 yrs	promote mechanisms to improve vaccination of pregnant women in primary care • Rates of breastfeeding initiation have shown some improvements in Halton, but remain low. Improvements are possible, aiming to in increase by 2% each year. Change is slow as it requires whole system change • A coordinated approach between local public health, primary care and PHE is needed to ensure MMR vaccination achieves 95%. • Despite annual fluctuations Halton has slowed the year on year rise in childhood obesity, but the levels of children aged 4-5 who are overweight or obese remains worse than the England average, and therefore can be improved • The CCG and public health are review the evidence base behind a paediatrician in the community scheme which could impact on childhood accidents and admissions to hospital

Mental Health

Potential	Actions
• Improvements are possible in Emergency hospital admissions for self-harm • Improvements are possible in Access to IAPT services – approximately 35% worse (between 30% and 40%) • Improvements are possible in IAPT referrals with a wait <28 days – approximately 90% worse (between 85% and 95%) • Improvements are possible in Service users on CPA – approximately 30% worse	• Public Health are investing in a mindfulness scheme in schools to reduce the number of children self-harming, leading to injury admissions. • Halton CCG have worked with 5 Boroughs Partnership NHS Foundation Trust to improve the IPAT Access rate and in 2015/16 now exceed the national standard, however further improvement needs to be made with regard to the IAPT recovery rate in 2016/17 and an action plan is in place between the CCG and the Trust.

Appendix 3 – North West Ambulance Service Commissioning Intentions 2016/17

Paramedic emergency service commissioning intentions 2016/17 (NWAS)
Contract for April 2016 to be agreed to enable delivery of mandated national Speed of Response Targets, and progression of the Modernisation and Transformation initiatives, in line with what is outlined here
Development of new Payment Model which seeks to incentivise the right behaviours along the Urgent and Emergency Care pathway
Aligning of the Commissioning arrangements for 999 and 111, including CQUIN schemes
NWAS to work with Health Economies in the North West for the Sustainability and Transformation plans
Revisit the Handover and Turnaround Action Plan, from the Event in July 2015. Seek to agree a place to have oversight and responsibility for its delivery;
Take forward aligning the Front-End Triage System for 999 and 111 Integration;
Further development of the Clinical Hub, linking to local arrangements and working with the Urgent & emergency care networks developing the specification(s) for the Integrated Urgent Care Service
Work with CCGs, Local Authorities and Providers to further develop Direct Referral Protocols and Pathways - The first area of focus to be 'Falls' building on the outputs of the 'Falls Summit' in October 2015;
Work with Commissioners and Providers to develop Protocols for NWAS to have the ability to activate non-NWAS resource
Develop a Public Communication and Engagement Plan, for what can be expected from the Urgent and Emergency Ambulance Service in the NW
Access to Information and in particular Summary Care Records
Further work to support ability to measure Outcome data, including obtaining NHS Number
Better use of Technology to develop Interoperability for improved access to patient and service information
A focus on Workforce: what is needed for the new model.

Appendix 4 – 2016/17 Metrics

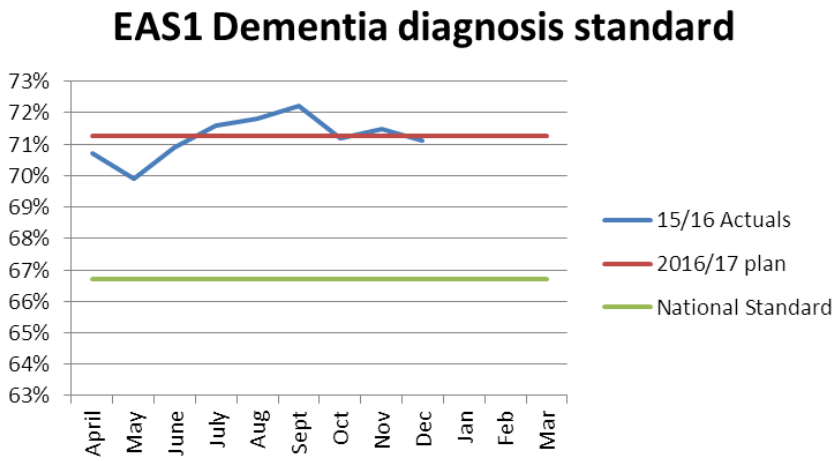
EAS 1 Dementia Diagnosis

2015/16 saw a change in the definition for the calculation of dementia diagnosis so that only people aged 65 or over were included in the calculation, Halton did particularly well in identifying dementia in younger adults so the exclusion of these people from the official calculation led to a reduction of around 2% in the total.

During 2015/16 and into 2016/17 the CCG are working with General Practice in identifying and supporting those practices with a low diagnosis rate. The CCG are also working closer with care homes and sheltered accommodation in 2016/17 and this may identify further undiagnosed dementia patients.

Overall 2015/16 saw Halton exceed the national standard of 66.7% with an average of 71.2% but as at the end of December 2015 fall short of its local stretch target of 75%

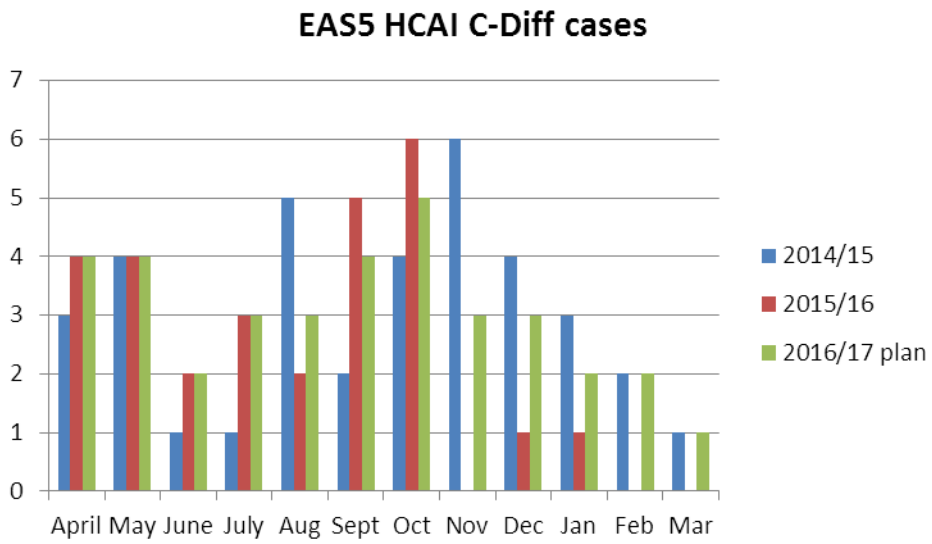
The 2016/17 target has been set to continue to exceed the national standard and to maintain the level of performance seen in 2015/16



EAS5 C-diff

Halton has had relatively stable numbers of Health care Acquired infections (HCAI) for C-diff in both 2014/15 and 2015/16 to December 2015. 36 cases were reported in 2014/15 and the current forecast is for there to be 33 cases in 2015/16.

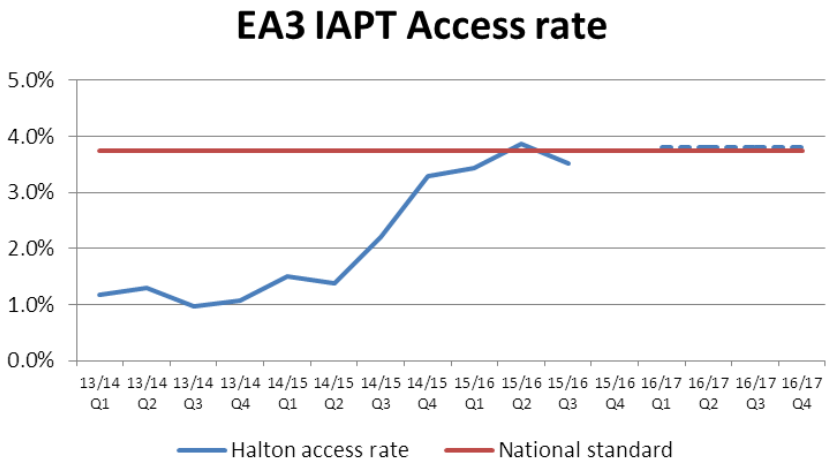
The operational standard has been set for the CCG for C-Diff HCAI at the same rate as the previous year, therefore the plan for 16/17 is based on a total of 36 cases.



EA3 IAPT Access

NHS Halton CCG has worked closely with 5 Boroughs partnership (5BP) to improve both access rates and recording practice, this has been seen during 2015/16 with an increasing access rate. For 16/17 Halton aims to continue working with 5BP to maintain this improved level of performance and to exceed the national standard.

NHS Halton has increased the denominator for this performance measure to take into account the increasing population. For 2016/17 the estimated number of people living with anxiety or depression amenable to IAPT treatment has been increased from 16,420 to 16,453 as a result the number of people to be treated each quarter has increased to 617 in order to achieve the national standard of 3.75%



EAS2 IAPT Recovery rate

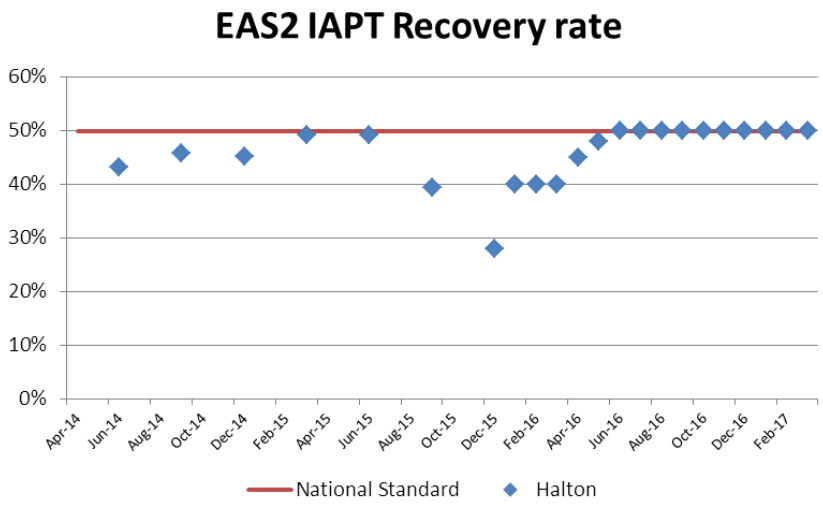
Historically Halton has found it challenging to achieve the national standard of a 50% recovery rate for people completing at least two IAPT sessions. This continued in 2015/16 and Halton has now agreed an action plan with 5BP to increase the recovery to rate to at least the national standard by June 2016.

Performance is planned to increase to 40% in January 2016, increasing to 45% in April and reaching 50% in June 2016. Some of the work being done with 5 Boroughs Partnership NHS Foundation Trust to achieve this improvement include;

1) Reduce attrition rates - to keep people in service to achieve recovery (too many drop out after two treatments)

2) Increase uptake of self-referral model to ensure only those engaged with the process will enter treatment and achieve recovery.

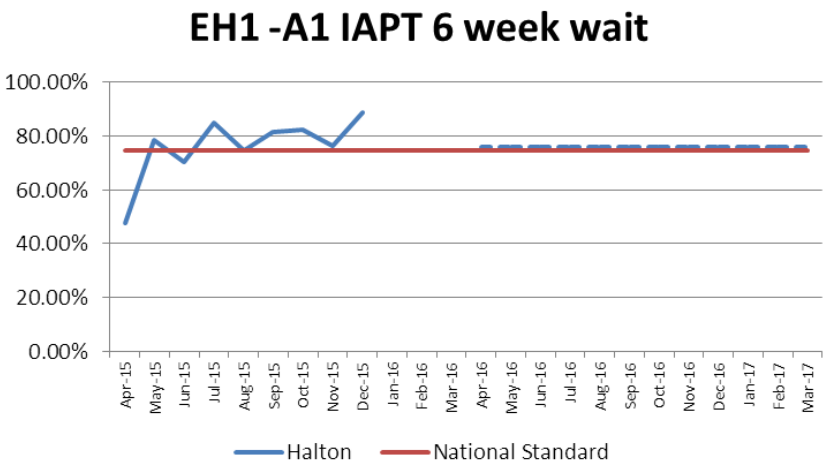
3) Implementation of 'group' based therapies



EH1 – A1 Mental Health 6 week access

Halton, for the most part, achieves the 6 week access performance standard with in excess of 80% of patients waiting less than 6 weeks from referral to their treatment beginning, the average monthly figure during 2015/16 was 76% this exceeds the national standard set at 75% and Halton intends on continuing to exceed the national standard for 2016/17

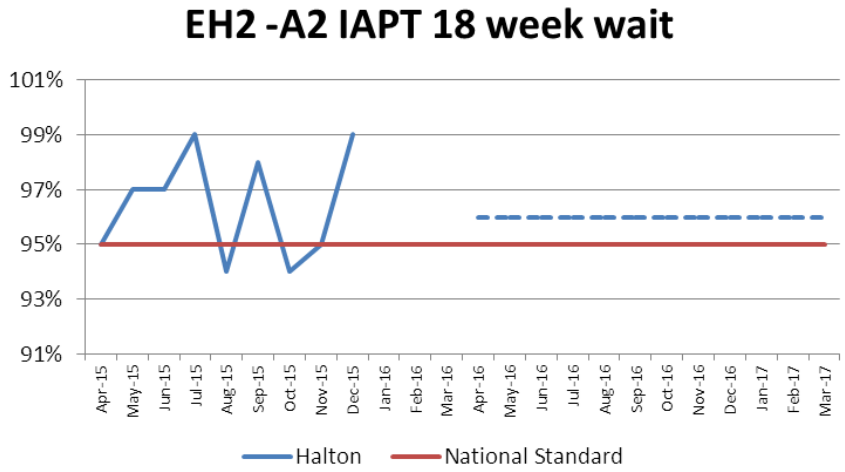
There are some outstanding data discrepancies between data submitted by 5BP to the CCG and the data reported by the HSCIC for Halton, Halton is currently in the process of resolving these differences however based on similar discrepancies seen in 2014/15 it is likely that the 5BP figures reported to the CCG and reported here are correct.



EH2 – A2 Mental Health 18 week access

Halton, for the most part, achieves the 18 week waiting standard of 95% of patients receiving treatment within 18 weeks of referral. The average during 2015/16 was 96%, NHS Halton CCG plans to maintain this level of performance during 2016/17.

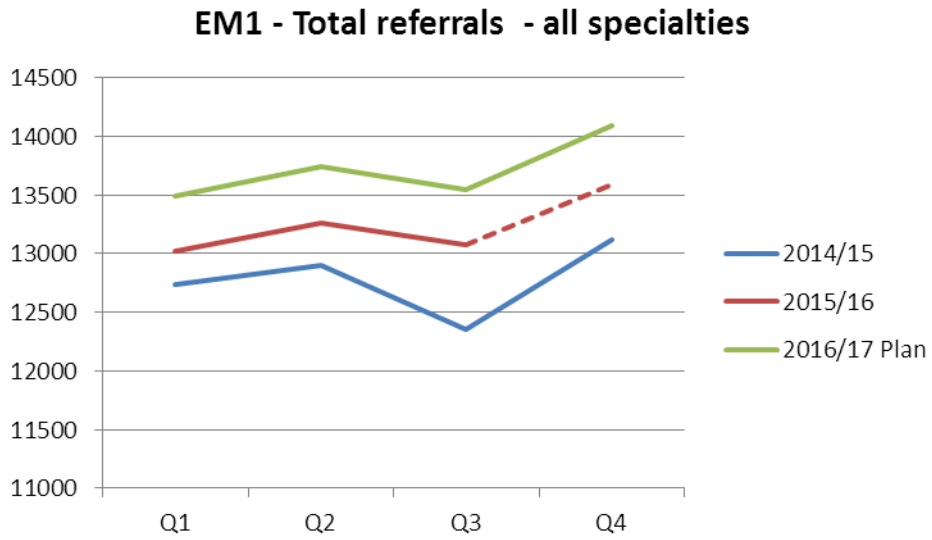
As with the 6 week waiting time standard there is a discrepancy between the data provided to the CCG from 5BP and that reported by HSCIC, based on similar discrepancies seen in 2014/15 it is likely that the 5BP figures reported here are correct.



EM1 – Total referrals – all specialties

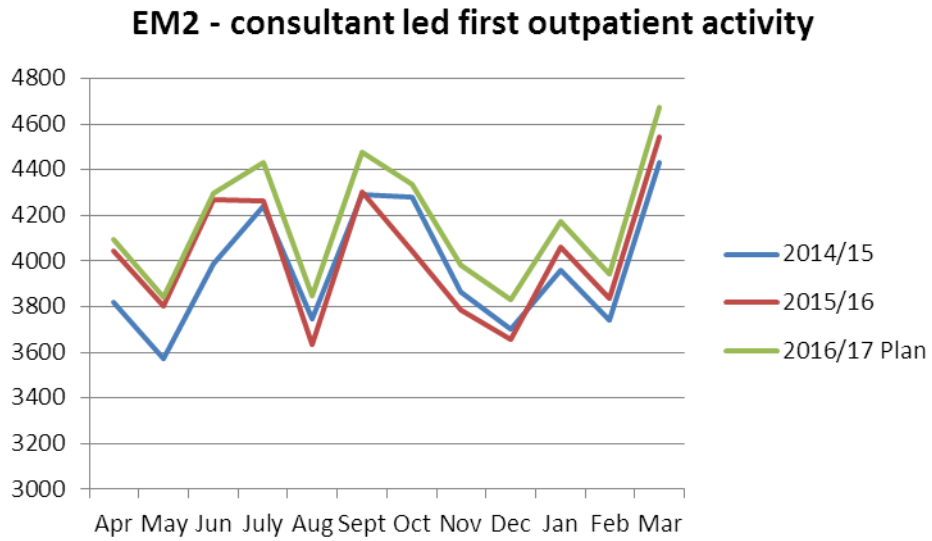
NHS Halton CCG witnessed an increase of 3.6% (1851 Num) in the total number of referrals for all specialties between 2014/15 and 2015/16 this increase was made up of an underlying increase in demand of 2.7% and a demographic growth increase of 0.9%. The population growth is the same for 2016/17 and the CCG expects the demand

growth in 2016/17 to remain the same. The overall impact of demand and demographics means an estimated 1918 more referrals (+3.6%) for 2016/17



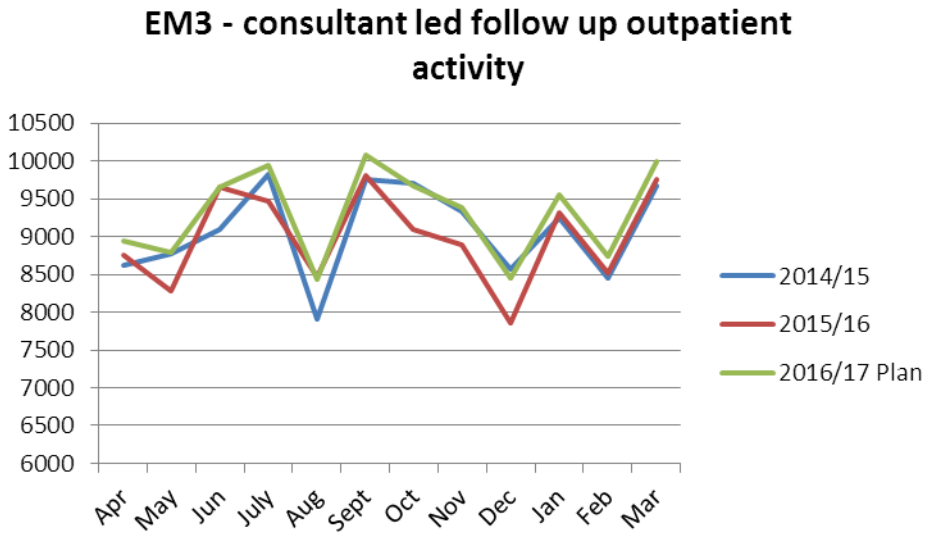
EM2 Consultant led first outpatient attendances (total activity)

NHS Halton CCG witnessed an increase of 1.3% (617 num) in the total number of consultant led first outpatient attendances between 2014/15 and 2015/16 this increase was made up of an underlying increase in demand of 0.4% and a demographic growth increase of 0.9%. The population growth is the same for 2016/17 however the Indicative Hospital Activity Modelling tool (IHAM) suggests non-demographic growth of 2.6%, therefore a total growth of 3.5% has been planned for. The overall impact of demand and demographics means an estimated 1689 more outpatient attendances for 2016/17



EM3 Consultant led follow up outpatient activity attendance (Total Activity)

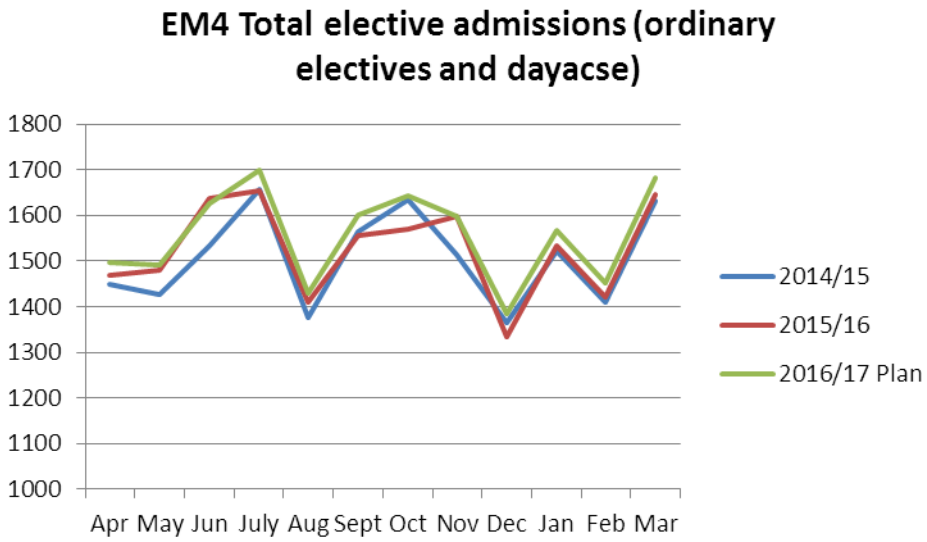
NHS Halton CCG witnessed a reduction of -1.0% (-1060 Num) in the total number of consultant led follow up outpatient attendances between 2014/15 and 2015/16 this reduction was made up of an underlying reduction in demand of -1.9% and a demographic growth increase of 0.9%. The population growth is the same for 2016/17 The IHAM non-demographic growth figure of 2.6% has been used. The overall impact of demand and demographics means an estimated 3775 more outpatient attendances (+3.5%) for 2016/17



EM4 Total elective admissions (ordinary electives + daycases) total activity

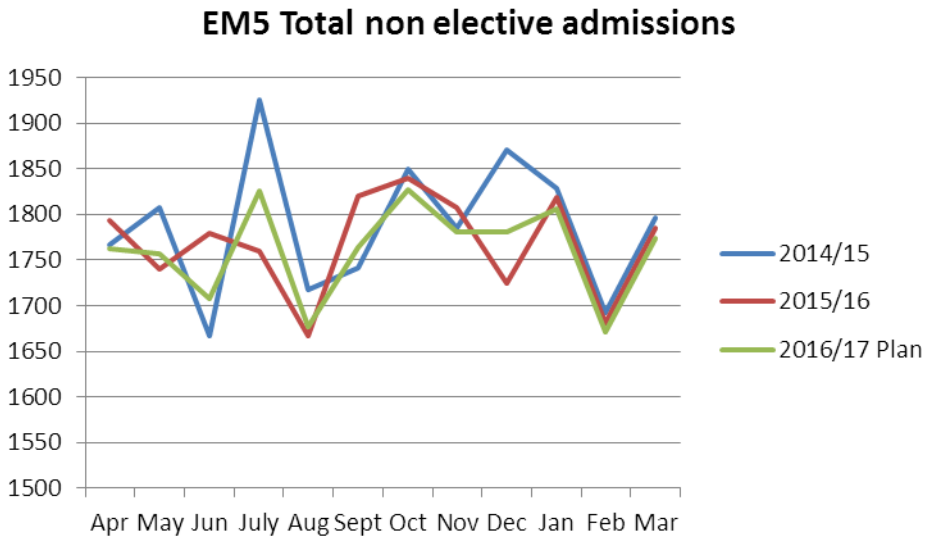
NHS Halton CCG witnessed an increase of 1.3% (231 num) in the total number of elective admissions between 2014/15 and 2015/16 this increase was made up of an underlying increase in demand of 0.4% and a demographic growth increase of 0.9%. The population growth is the same for 2016/17 The level of observed non-demographic growth is greater than that predicted by the IHAM tool (1.1% v 0.8%) therefore the CCG has prudently planned for the larger of the two figures.

The overall impact of demand and demographics means an estimated 2.0% (361) increase in elective admissions for 2016/17



EM5 Total non-elective admissions (total activity)

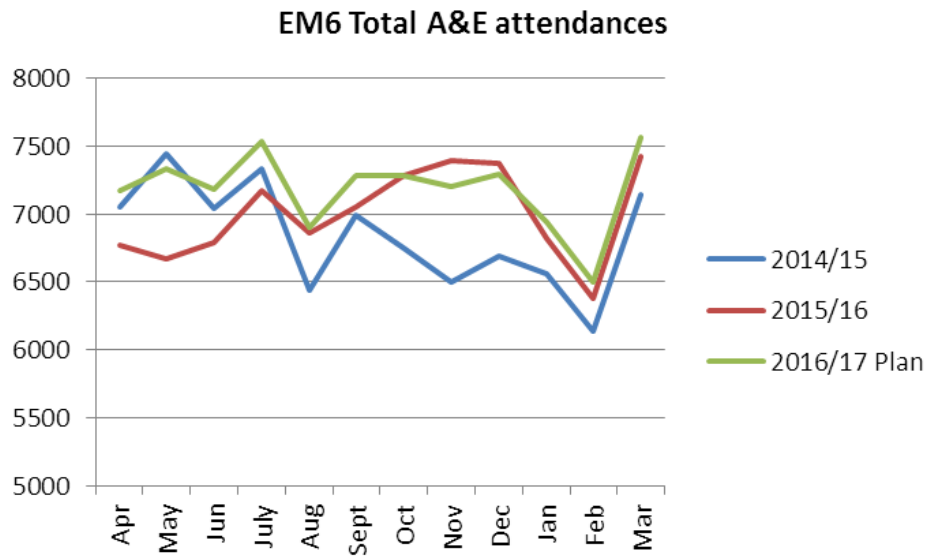
NHS Halton CCG witnessed an reduction of -1.1% (-235 num) in the total number of non-elective admissions between 2014/15 and 2015/16 this decrease was made up of an underlying decrease in demand of -2.0% and a demographic growth increase of 0.9%. The population growth is the same for 2016/17. There are a number of schemes due to be in place in 2016/17 which will reduce the number of non-elective admissions including reductions based on the full year impact of the opening of the Widnes Urgent Care Centre, new pathways of care being introduced at the urgent care centres and a Public Health scheme introducing mindfulness in schools to reduce self-harm. The impact of the reductions is forecast to be -2.1% (-444) however predicted increased in demand is expected to be +0.8% for IHAM non-demographic growth and +0.9% for demographic population growth, the net impact of the changes is a forecast reduction of -0.4% (-83)



EM6 Total A&E attendances

NHS Halton CCG witnessed an increase of 2.3% (1923 num) in the total number of A&E attendances between 2014/15 and 2015/16 this increase was made up of an underlying increase in demand of 1.4% and a demographic growth increase of 0.9%. The population growth is the same for 2016/17. Significant reductions in type 1 A&E activity at Warrington were witnessed, offset by increases in type 3 activity at the Runcorn urgent care centre.

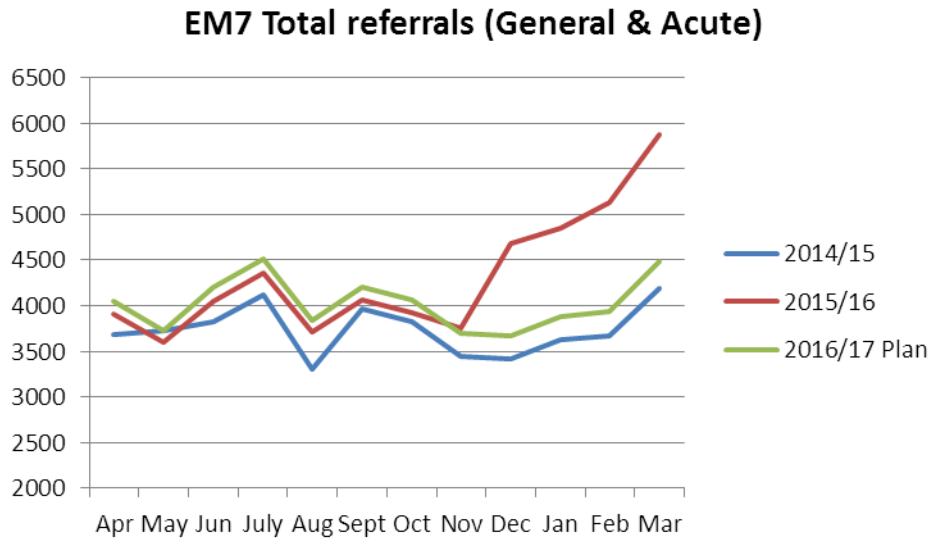
There are a number of schemes due to be in place in 2016/17 which will continue to reduce Type 1 A&E attendances including reductions based on the £5 per head scheme for older people which although primarily aimed at preventing non-elective admissions will also impact on A&E attendances and a Public Health scheme introducing mindfulness in schools to reduce self-harm. The overall impact of these reductions is expected to be around -0.5% however the CCG expects to see considerable movement from type 1 to type 3 urgent care centre activity. The impact of demand and demographics means an estimated 2181 more A&E attendances +2.6%) for 2016/17



EM7 Total referrals (General & Acute only)

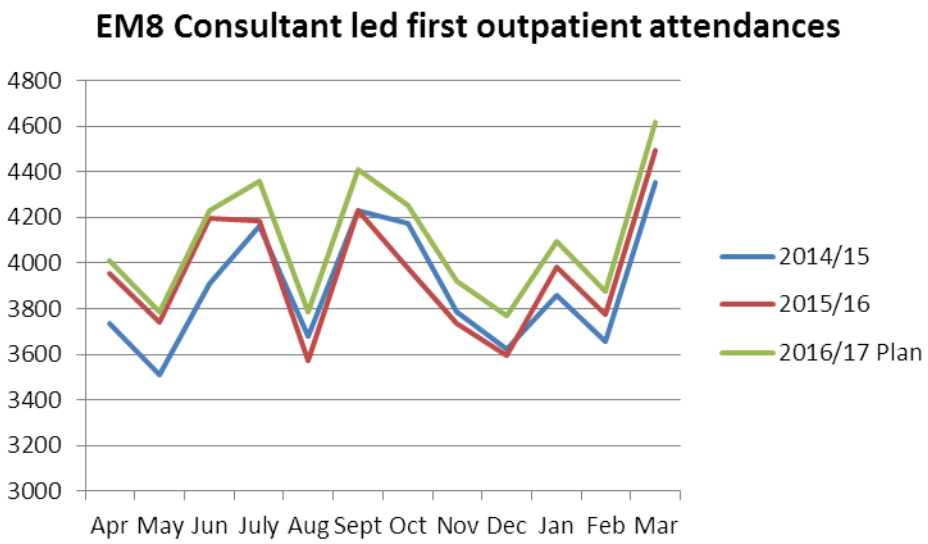
NHS Halton CCG witnessed an increase of 15.8% (7085 num) in the total number of referrals for general & acute specialties between 2014/15 and 2015/16 The majority of this increase is attributed to the introduction of the Lorenzo system at Warrington & Halton Hospitals NHS Foundation Trust, which has had led to significantly different uploaded data. Prior to the introduction of Lorenzo the increase seen was in the region of 4.6% however in December and January the size of the increase seen at Warrington was more than 70% These figures have been provided to the CCG by NHS England

and are what the CCG is required to plan against. Following discussion with Warrington CCG it is still unclear if Warrington & Halton Hospitals NHS Foundation Trust was previously under-reporting or if the new system is considerably over-reporting, this will be resolved in 2016/17 however for planning consistency a 3.6% increase has been planned for to keep in line with the increase planned for total referrals for all specialities (EM1)



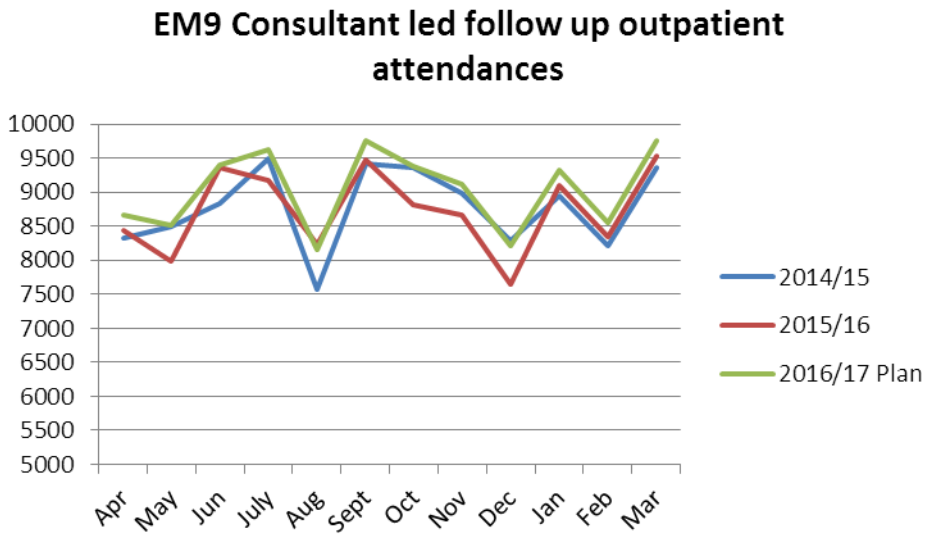
EM8 Consultant led first outpatient attendances (Specific acute)

NHS Halton CCG witnessed an increase of 1.6% (769 num) in the total number of consultant led first outpatient attendances (Specific acute) between 2014/15 and 2015/16 this increase was made up of an underlying increase in demand of 0.7% and a demographic growth increase of 0.9%. The population growth is the same for 2016/17 non-demographic demand growth in 2016/17 has been profiled using the indicative hospital activity model as +2.6%, this is higher than the non-demographic growth witnessed in 15/16 however the CCG has conservatively planned for this higher rate of growth. The overall impact of demand and demographics means an estimated 1660 more outpatient attendances (+3.5%) for 2016/17.



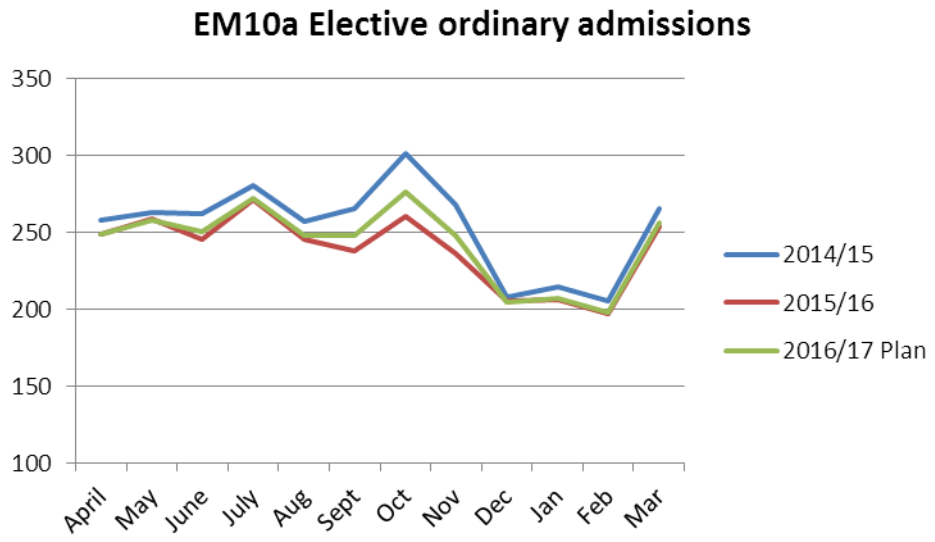
EM9 Consultant led follow up outpatient attendances (specific acute)

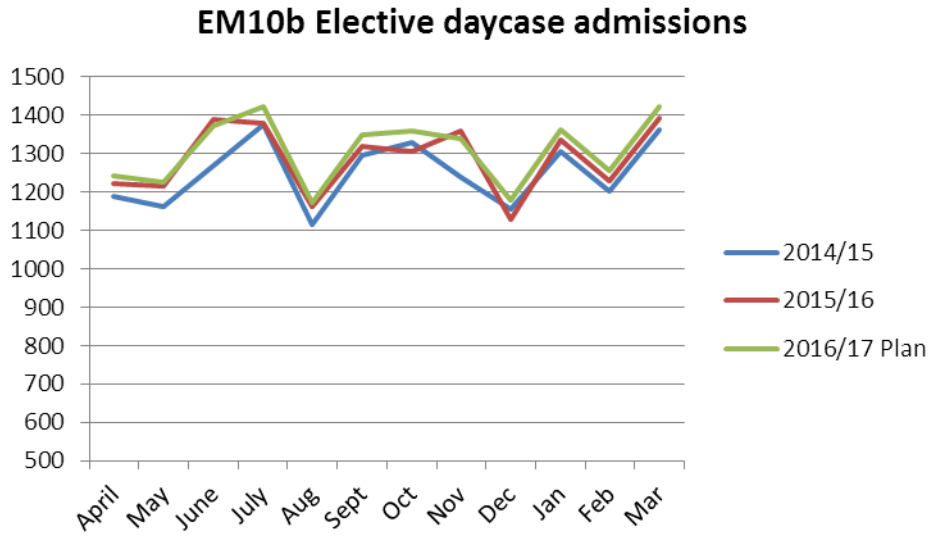
NHS Halton CCG witnessed a reduction of 0.5% (528 num) in the total number of consultant led follow up outpatient attendances between 2014/15 and 2015/16 this reduction was made up of an underlying reduction in demand of -0.4% and a demographic growth increase of 0.9%. The population growth is the same for 2016/17 non-demographic demand growth for 16/17 has been profiled using the IHAM value of +2.6%, this is higher than the growth witnessed in 15/16 however the CCG has conservatively planned for this higher level of growth. The overall impact of demand and demographics means an estimated 3667 more outpatient attendances (+3.5%) for 2016/17



EM10 Total elective admissions (specific acute) (Ordinary electives + Daycases)

NHS Halton CCG witnessed an increase of 2.8% (508 num) in the total number of elective admissions between 2014/15 and 2015/16 this increase was made up of an underlying increase in demand of 1.9% and a demographic growth increase of 0.9%. The population growth is the same for 2016/17 The IHAM non-demographic demand forecast of +0.8% has been used. The overall impact of demand and demographics means an estimated 311 more elective admissions (+1.7%) for 2016/17

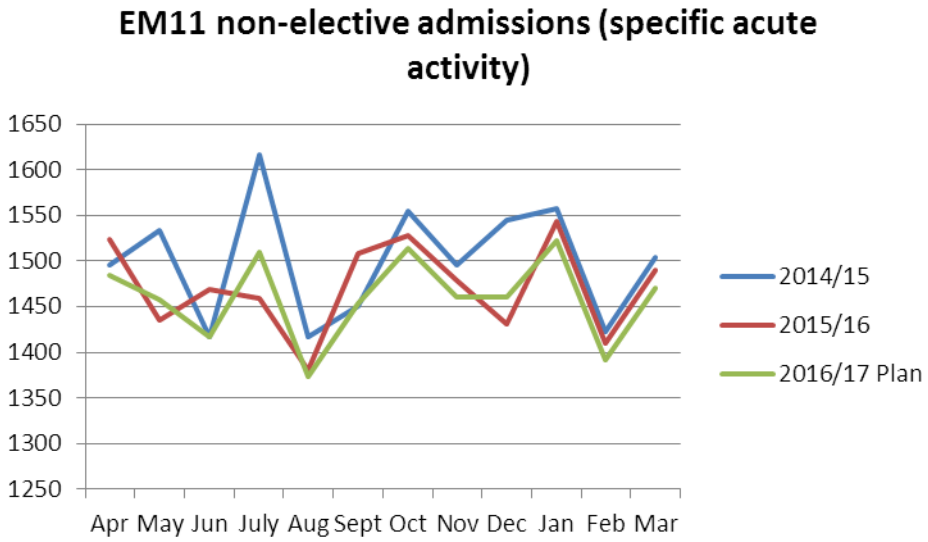




EM11 Total non-elective admissions (specific acute)

NHS Halton CCG witnessed an reduction of -2% (-271 Num) in the total number of non-elective admissions between 2014/15 and 2015/16 this decrease was made up of an underlying decrease in demand of -2.9% and a demographic growth increase of 0.9%.

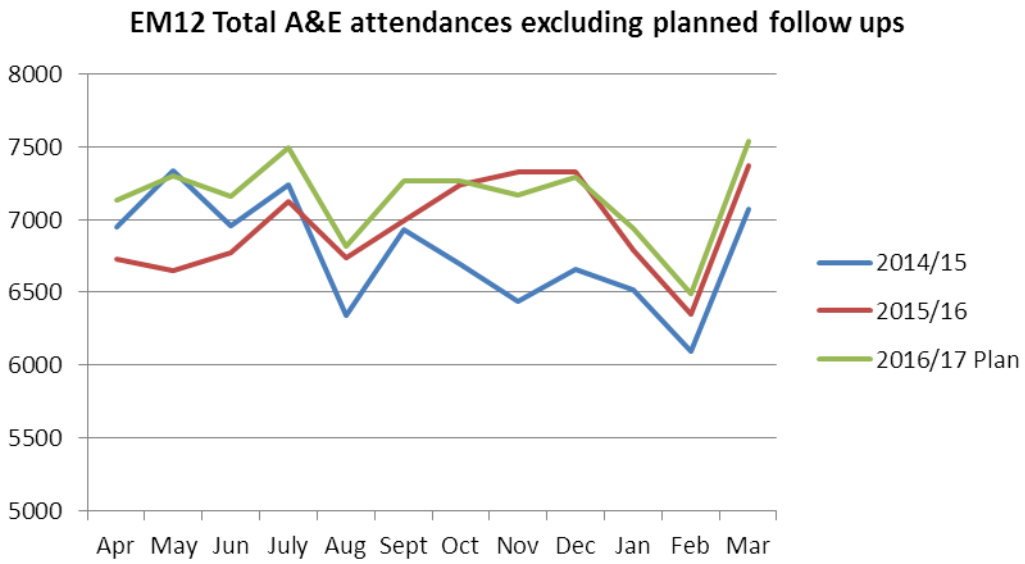
The population growth is the same for 2016/17. There are a number of schemes due to be in place in 2016/17 which will continue this reduction in non-elective activity including reductions based on the full year impact of the opening of the Widnes Urgent Care Centre, new pathways of care being introduced at the urgent care centres and a Public Health scheme introducing mindfulness in schools to reduce self-harm. The overall impact of demand and demographics means an estimated 144 fewer non-elective admissions (-0.8%) for 2016/17



EM12 Total A&E attendances excluding planned follow ups

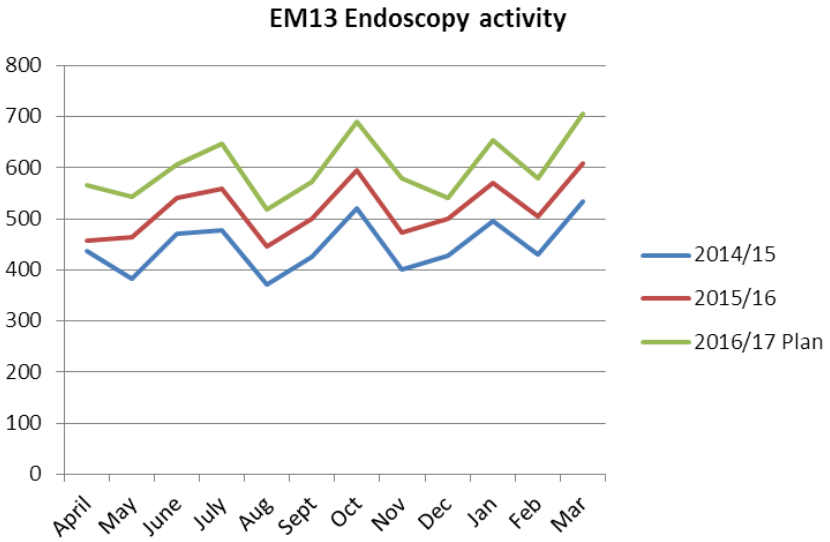
NHS Halton CCG witnessed an increase of 2.7% (+2,182 Num) in the total number of A&E attendances excluding planned follow ups between 2014/15 and 2015/16 this increase was made up of an underlying increase in demand of +1.8% and a demographic growth increase of 0.9%. The population growth is the same for 2016/17. Significant reductions in type 1 A&E activity at Warrington were witnessed, offset by increases in type 3 activity at the Runcorn urgent care centre.

There are a number of schemes due to be in place in 2016/17 which will continue this reduction in A&E attendances including reductions based on the £5 per head scheme for older people which although primarily aimed at preventing non-elective admissions will also impact on A&E attendances and a Public Health scheme introducing mindfulness in schools to reduce self-harm. The overall impact of demand and demographics means an estimated increase of 2.9% (2,456) in the number of A&E attendances for 2016/17



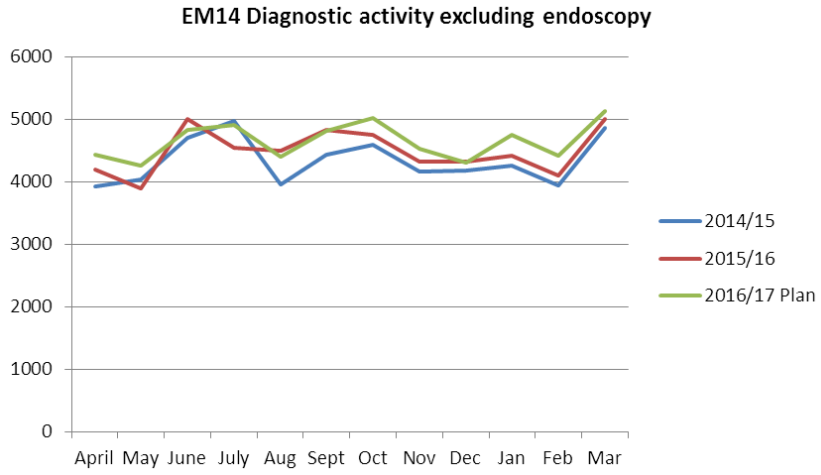
EM13 Endoscopy activity

NHS Halton CCG witnessed an increase of 15.8% (847 num) in endoscopic activity between 2014/15 and 2015/16 this increase was made up of an underlying increase in demand of 14.9% and a demographic growth increase of 0.9%. The population growth is the same for 2016/17 This level of demand growth exceeds the levels of growth witnessed both in the number of GP referrals and the number of outpatient attendances and is not fully understood. Until the reasons behind this high level of growth are understood it is prudent to plan for a similar level of increase demand growth in 2016/17. The overall impact of demand and demographics means an estimated 980 more endoscope activities (+15.8%) for 2016/17



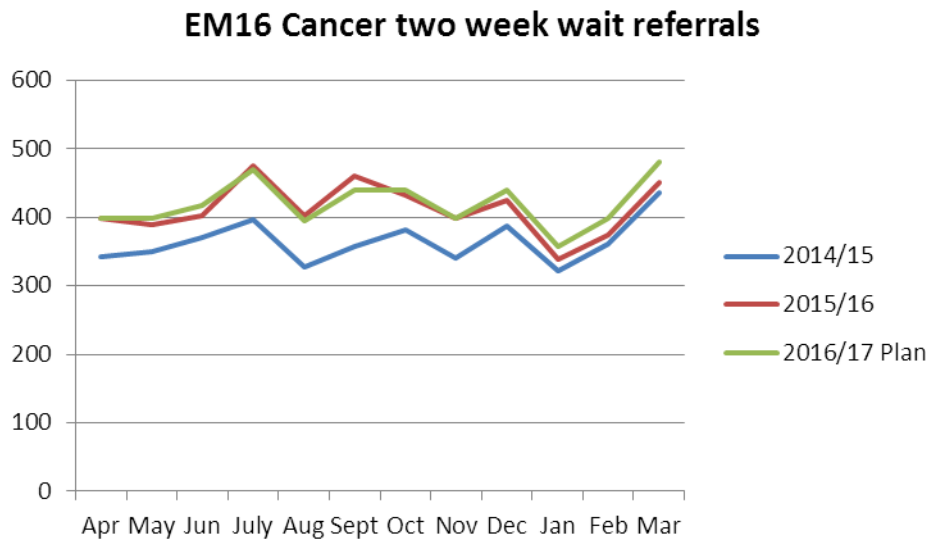
EM14 Diagnostic activity excluding endoscopy

NHS Halton CCG witnessed an increase of 3.6% (1870 num) in the number diagnostic activities carried out (excluding endoscopy) between 2014/15 and 2015/16 this increase was made up of an underlying increase in demand of 2.7% and a demographic growth increase of 0.9%. The population growth is the same for 2016/17 and there are no actions that will impact on the demand growth in 2016/17 therefore this has also remained unchanged. The overall impact of demand and demographics means an estimated 522 more diagnostic activity (excluding endoscopy) (+3.6%) for 2016/17



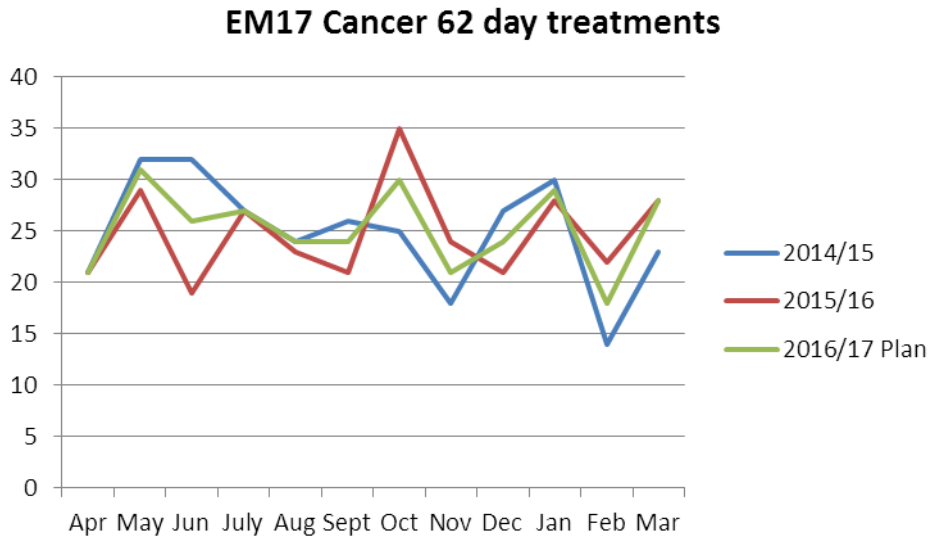
EM16 Cancer Two week wait referrals

NHS Halton CCG witnessed an increase of 13.1% (572 num) in the number of two week wait referrals between 2014/15 and 2015/16 this increase was made up of an underlying increase in demand of 12.2% and a demographic growth increase of 0.9%. The population growth is the same for 2016/17 however the increase in demand growth is unsustainable. For 2016/17 this higher rate of referrals has been modelled however only IHAM non-demographic growth has been included at 0.8% plus demographic change of 0.9% The overall impact of these modelled changes are an estimated 84 more two week wait referrals (+1.7%) for 2016/17.



EM17 Cancer 62 day treatments following an urgent GP referral

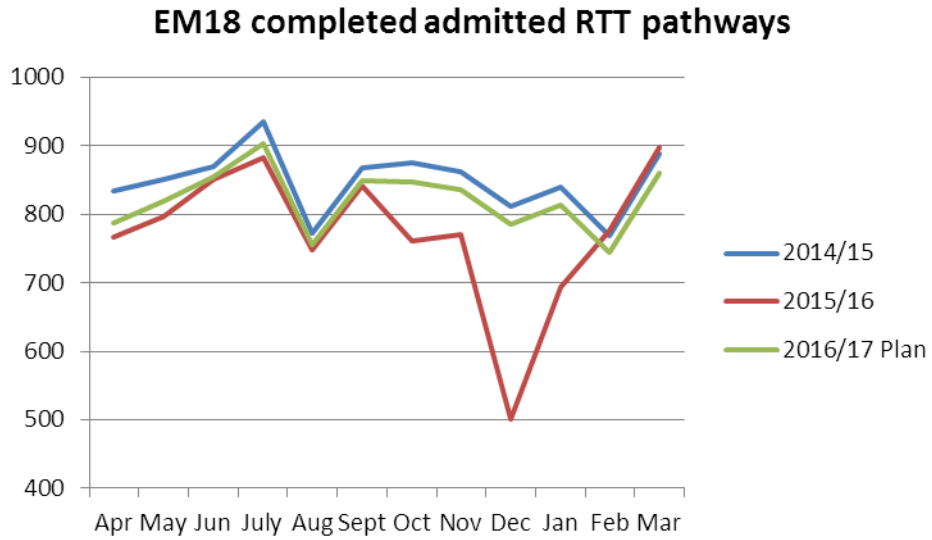
NHS Halton CCG witnessed an decrease of -0.3% (1 Num) in the number of patients treated for cancer following GP referral between 2014/15 and 2015/16 this decrease was made up of an underlying decrease in demand of -1.2% and a demographic growth increase of 0.9%. The population growth is the same for 2016/17, the level of non-demographic growth has been taken from the IHAM modelling tool of 0.8%The overall impact of demand and demographics means a small increase in the number of patients treated (+5 to 303) between 2015/16 and 2016/17



EM18 – number of completed admitted RTT pathways

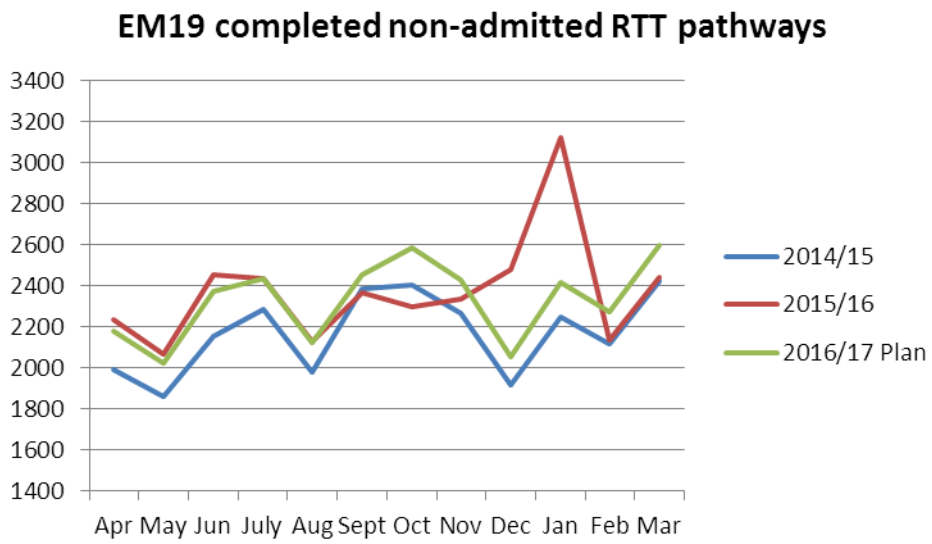
NHS Halton CCG witnessed a reduction of -8.8% (-891 Num) in the total number of completed RTT pathways between 2014/15 and 2015/16. A complex picture emerged in 2015/16, a reduction was seen during the first part of the year but December and January showed unrealistically low numbers. Following discussion with NHS

Warrington CCG it is believed this may be related to the introduction of the new Lorenzo patient administration system at Warrington hospital, whilst the number of completed admitted pathways showed a dramatic reduction the number of non-admitted pathways showed a dramatic increase. For the 2016/17 planning round NHS Halton CCG has attempted to make allowance for this "Lorenzo effect" by adding in additional activity (+4.4%) to bring 2016/17 more into line with 2014/15. In addition non-demographic growth of +0.8% and a demographic increase of 0.9% have been added. The net effect of these changes are a +6.6% increase (+570) on the 2015/16 baseline.



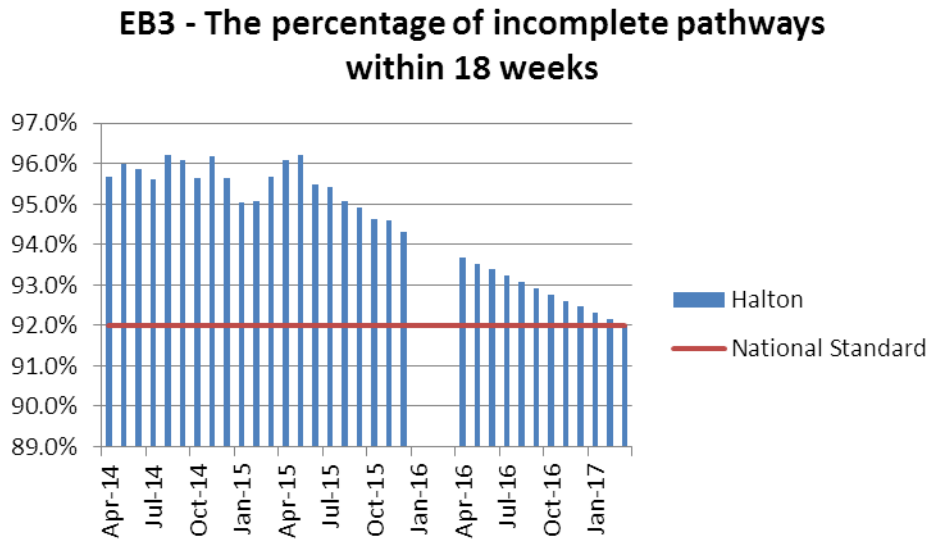
EM19 – number of completed non-admitted RTT pathways

NHS Halton CCG witnessed an increase of +9.5% (2476 num) in the total number of completed non-admitted RTT pathways between 2014/15 and 2015/16. Although an underlying increase has been witnessed the large proportion of this increase has been attributed to coding impacts of the new Lorenzo patient administration system at Warrington Hospital. NHS Halton CCG has attempted to make allowance for this by reducing the 2016/17 plan by 3.6%, however Halton has still included 0.8% non-demographic and 0.9% demographic growth. The net impact of these changes is a -1.9% reduction on the 2015/16 forecast out-turn.



EB3 – The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period.

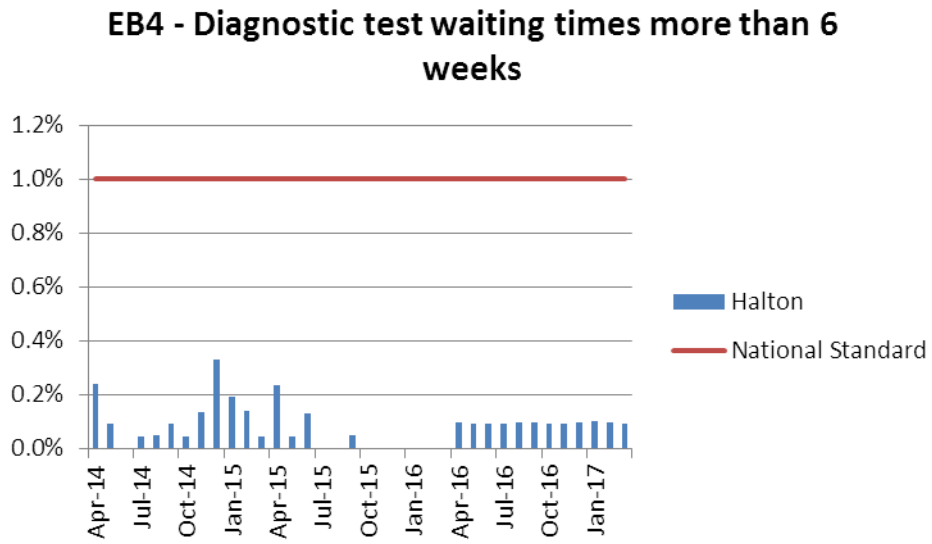
Until the beginning of 2015/16 performance against this standard was consistently between 95% and 96%, however following the removal of two other RTT standards performance against this standard has fallen month on month since May 2015. Given the pressures facing acute trusts and the current level of over performance for this standard it is likely that performance will fall further against this standard. Halton has planned for a deterioration in the measure during 2016/17 but still maintaining the national standard of 92%



EB4 – Diagnostic test waiting times more than 6 weeks

Halton has always performed exceptionally well with regard to diagnostic waiting times, just 10 Halton patients have waited more than 6 weeks for their diagnostic test between April and October 2015. The average monthly percentage of patients breaching this

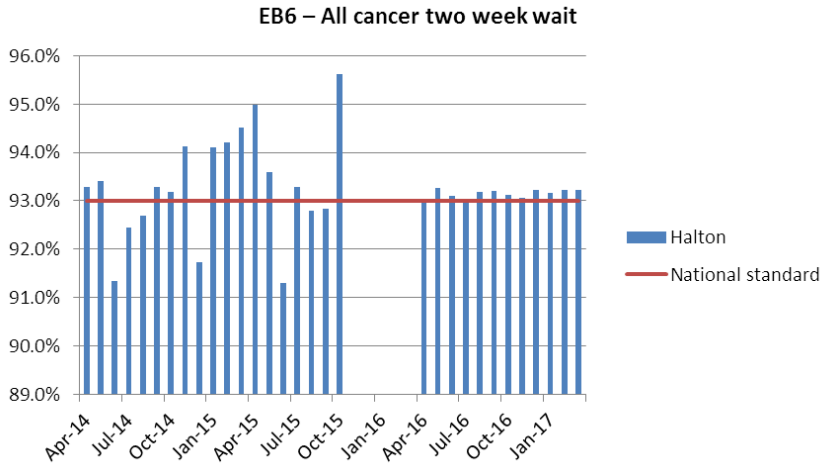
standard is just 0.1%, although the national standard is far greater at 1% Halton has planned for 16/17 performance to be in line with that witnessed in 2015/16 at just 0.1%



EB6 – All cancer two week wait

NHS Halton CCG has previously found this standard one of the more challenging ones to achieve due to large numbers of patients not attending their first appointment, however during 2015/16 the CCG has worked with GP's to encourage patients to attend their first consultant appointment including the use of leaflets handed to patients highlighting the importance of these appointments. As a result the CCG has witnessed an improvement in 2015/16 to an average of 93.5% against a national standard of 93%.

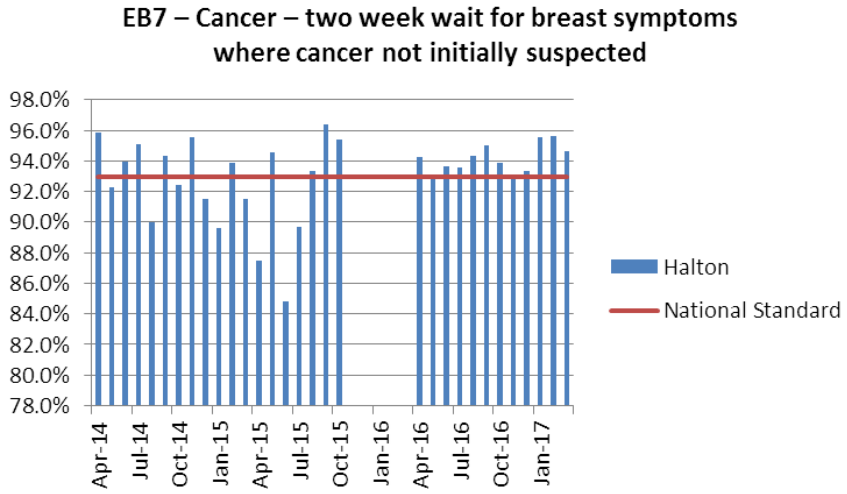
The CCG is planning to continue to meet the national standard for 2016/17.



EB7 – Cancer – two week wait for breast symptoms where cancer not initially suspected

Relatively small numbers being treated under this classification (approximately 50 per month) has led to a wide variation in month on month performance. Poor performance earlier in 2015/16 has meant a year to date monthly average of 91.7% against the national standard of 93%, improvements were seen in Q2 of 2015/16 with the last three months all exceeding the national standard.

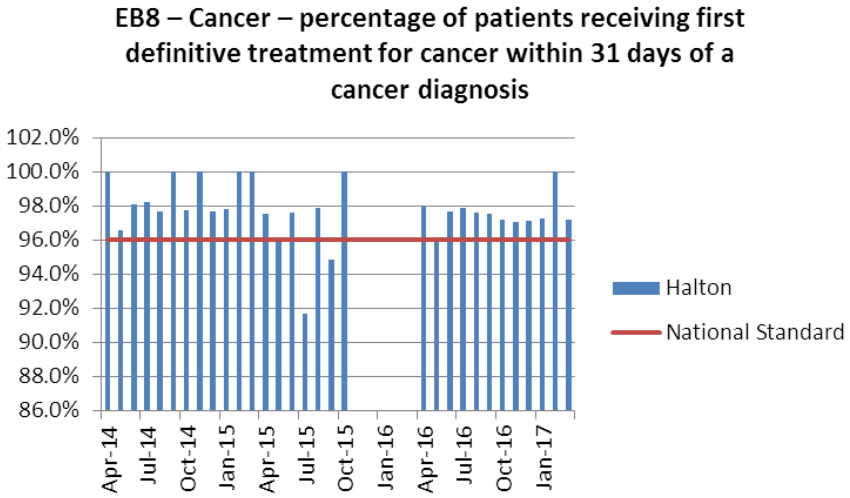
The CCG is planning on achieving the national standard for 2016/17



EB8 – Cancer – percentage of patients receiving first definitive treatment for cancer within 31 days of a cancer diagnosis

Halton performs well against the national standard of 96%. Due to small numbers (approximately 50 per month) there can be wide month-on-month variation, however, on average Halton exceeds the national standard with an average of 96.5% in 2015/16 year to date.

Halton plans to continue to exceed to the national standard during 2016/17



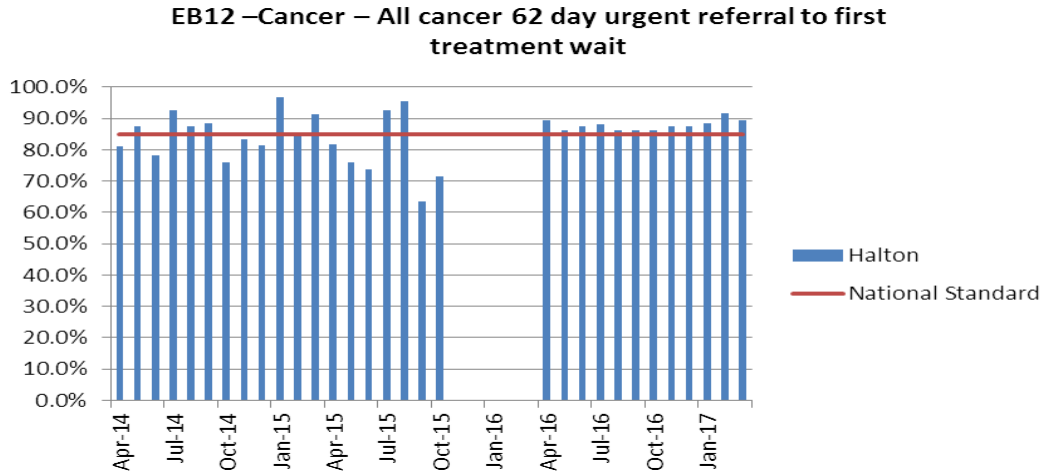
EB12 –Cancer – All cancer 62 day urgent referral to first treatment wait

Halton has historically found this standard challenging and the CCG is working closely with both St Helens & Knowsley Teaching Hospitals NHS Trust and Warrington & Halton Hospitals NHS Foundation Trust to identify the reasons behind individual patient breaches.

The trusts have identified where improvements can be made, particularly in relation to cancer tracking but also around individual cancer treatment pathways such as urology.

In addition Warrington Trust have introduced a local standard where all two week wait referrals are seen within a week, reducing waiting times further.

The CCG believes that by working closely with the acute trusts that performance can be improved and that the national standard of 85% can be achieved and maintained in 2016/17



REPORT TO: Health Policy & Performance Board

DATE: 21st June 2016

REPORTING OFFICER: Strategic Director, People & Economy

PORTFOLIO: Health & Wellbeing

SUBJECT: Windmill Hill - Contracting General Medical Services

WARD(S): Windmill Hill

1.0 **PURPOSE OF THE REPORT**

1.1 This reports sets out the background and options for commissioning a General Practice Service at Windmill Hill from April 2017.

2.0 **RECOMMENDATION: That the Board:**

i) Notes the update on the contracting of General Medical Services at Windmill Hill; and

ii) Provides comment on the proposed options.

3.0 **SUPPORTING INFORMATION**

3.1 Windmill Hill Medical Centre is located within the ward of Windmill Hill and has a branch surgery located in Widnes. It was originally two separate practices, one based in Windmill Hill and one in Widnes, both developed as part of the Equitable Access to Primary Medical Care (EAPMC) programme. In 2011/12, due to concerns about the financial viability of continuing to deliver the service at Widnes, it was agreed to reorganise the Widnes service as a branch of the Windmill Hill site. The current contract is held with Liverpool Community Health NHS Trust (LCH) and ends on 31 March 2017. Due to the organisational restructure that is currently being undertaken at LCH, there is no opportunity to extend the contract beyond 2017.

3.2 The practice currently has 2373 registered patients, 1958 from Runcorn and 415 from Widnes. Staffing includes:-

- 1.4 whole time equivalent (wte) salaried GP's;
- 0.4 wte practice nurse;
- 0.8 wte health care assistant;
- wte practice manager; and
- 3.1 wte administration staff.

3.3 The site at Windmill Hill is situated in a portacabin located on part of Windmill Hill

Primary School's playing fields. The planning permission for the site is due to expire in March 2017 and Halton Borough Council has been approached with regards to applying for a temporary extension. A permanent solution to the siting of a GP surgery is closely linked with the Windmill Hill Big Local. The Windmill Hill Community Hub Feasibility study, published in March 2016, recommended that '*The Big local should move forward on the basis of delivery of a combined health, wellbeing and community hub, incorporating a GP Surgery;*' and '*The Big Local should formally invite the Halton CCG to join the Big Local Partnership as a supporting partner with expertise of health*.'

3.4 The health of residents in Windmill Hill is a real concern, with both sexes having some of the lowest life expectancies in the Borough. Incidents of cancer, admission to hospital for alcohol related conditions and the percentage in need of care are again the worst in Halton. Windmill Hill also has more economically inactive residents than any ward in Halton and has the highest proportion of residents classed as long term sick and disabled.

3.5 A needs assessment and options paper was discussed by NHS Halton CCG's Primary Care Commissioning Committee (PCCC) in April 2016. The options considered were: commissioning as a branch surgery, procuring a new provider as a stand-along practice, full list dispersal and dispersal of Widnes patients.

Following discussion it was agreed that a delivery point for general medical services at the Windmill Hill site was still required and that two of the options should be explored further.

3.6 <u>Option One**:** Commission as a Branch Surgery</u>

The service is commissioned on a PMS contract and funded on a per capita basis. There would then be the option for local General Practice providers to be asked to express an interest in providing for the patient list as a branch practice (procurement advice would need to be sought in this respect).

Advantages

- Continued service provision at Windmill Hill site with local GP's.
- Allow certainty for patients.
- Greater chance of a sustainable service.
- Potential increase in service provision for patients.
- Development opportunity for local General Practice providers.
- Potential cost savings due to economies of scale.
- Opportunity to explore new model of care and access.
- Alignment with the NHS Halton General Practice Strategy

Disadvantages

- May need to offer opportunity wider than to local GP's.

3.7 <u>Option Two: List Dispersal of Widnes Patients (NB this could sit alongside Option one)</u>

The 415 Widnes patients are dispersed amongst neighbouring practices, of which

there are a number with open lists.

Advantages

- Patients will have a choice of provider.
- Patients will have a GP practice based in Widnes.
- Allow certainty for patients who re-register with their new GP.
- Quickest resolution for Widnes patients.
- Local General Practices will have the opportunity for growth.
- Potential costs savings on estates.
- Aligns with the NHS Halton CCG General Practice Strategy

Disadvantages

- Potential impact on all practices in Widnes, depending on where patients are resident.
- Void space in the Widnes UCC.

3.8 It should be noted that nationally there is a move away from single-handed practices on the grounds of sustainability, economies of scale and provision of quality services. Small practices have limited infrastructure to improve access and address variations in quality. They are vulnerable to marginal reductions in income and may have insufficient staff to respond to new clinical, administrative and regulatory demands. The financial viability of such a small practice might also have implications for any procurement and long-term sustainability if procured as a stand-alone practice.

3.9 Before a final decision is taken, the PCCC requested that an Equality Impact Assessment is undertaken and that a patient engagement exercise is also undertaken. Patient engagement commenced with a meeting with Windmill Hill's Patient Participation Group (PPG) on 10 May 2016. This was followed by a questionnaire which was developed in association with the PPG and circulated via the practice, local school and pharmacy, as well as being posted on both the CCG's and Liverpool Community Health's websites.

4.0 POLICY IMPLICATIONS

4.1 The commissioning of a quality, safe and effective general medical service at Windmill Hill is critical to ensuring the continued improvement in the health and wellbeing of residents.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 Commissioning as a branch surgery has the potential to realise cost savings on the delegated primary care budget which could be re-invested into General Practice.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**

The report will support the priority to improve the health and wellbeing of children and young people by focussing on the care provided by a Windmill Hill GP practice.

6.2 **Employment, Learning & Skills in Halton**
The report will help to support maintaining a healthy workforce by focussing on the care provided by a Windmill Hill GP practice.

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

6.4 **A Safer Halton**
None.

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

7.0 **RISK ANALYSIS**

7.1 The risks/opportunities associated with the proposed options were considered by the PCCC. The options selected for further analysis were the ones which the Committee felt offered optimum risk mitigation.

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**

9.1 None under the meaning of the Act.

REPORT TO: Health Policy & Performance Board

DATE: 21st June 2016

REPORTING OFFICER: Strategic Director, People & Economy

PORTFOLIO: Health & Wellbeing

SUBJECT: Alliance Local Delivery System (LDS)

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To provide the Board with some background to the development of the Alliance LDS and progress to date.

2.0 **RECOMMENDATION: That the Board:**

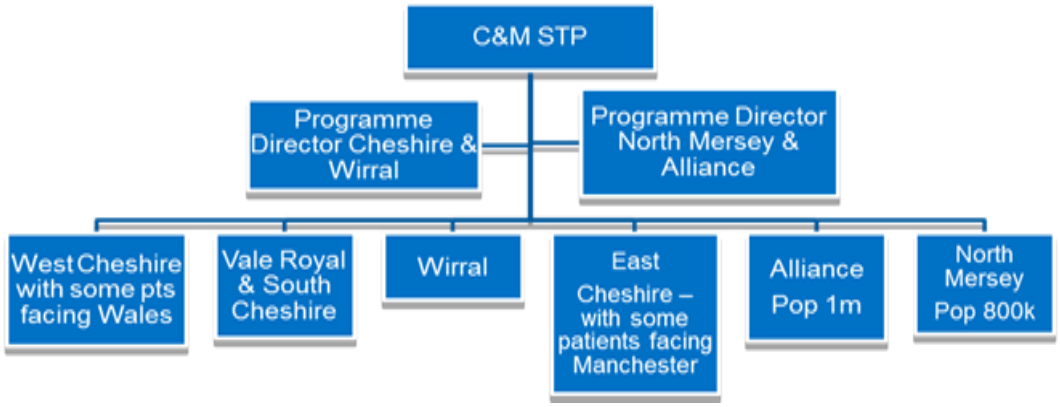
i) Note the contents of the report and update provided.

3.0 **SUPPORTING INFORMATION**

3.1 The NHS shared planning guidance 2016/17 – 2020/21 outlines a new approach to help ensure that health and care services are planned by place rather than around individual institutions. As in previous years, NHS organisations are required to produce individual operational plans for 2016/17. In addition, every health and care system is expected to work together to produce a multi-year Sustainability and Transformation Plan (STP), showing how local services will evolve and become sustainable over the next five years – ultimately delivering the Five Year Forward View vision.

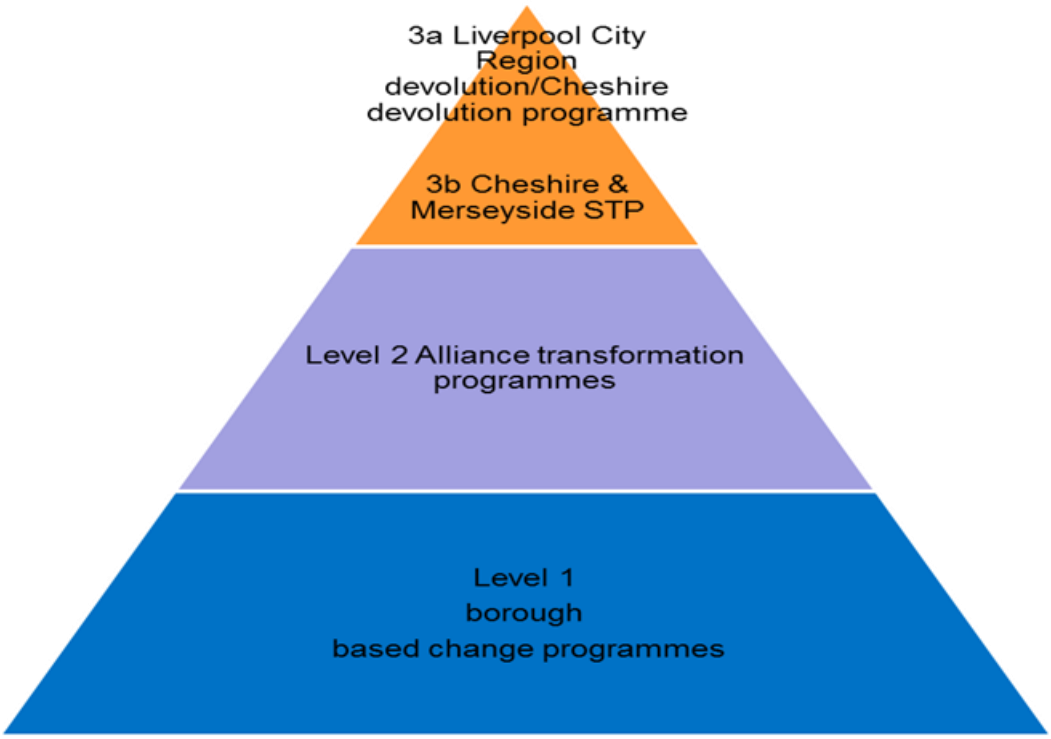
3.2 To do this, local health and care systems have come together in STP 'footprints'. The health and care organisations within these geographic footprints aim to work together to narrow the gaps in the quality of care, their population's health and wellbeing, and in NHS finances. Following initial guidance the Cheshire and Merseyside (C&M) STP was formed in January 2016 and it quickly established a working group with four lead Clinical Commissioning Group (CCG) Accountable Officers. The working group, liaising with NHS England, has now established clear governance arrangements; arrangements for which are constantly reviewed to ensure maximum transparency and lines of accountability.

3.3 The Governance structure is shown in the chart below:-



3.4 The C&M LDS accountable officers and chief executives met twice in March 2016 to agree a programme of work that would see the development of LDS' based on patient flow, agree key appointments and define the governance system.

3.5 The STP will be delivered through a series of different levels shown in the diagram below:



3.6 The 'Alliance' is one of the LDS' featuring in the Cheshire and Merseyside STP. The Alliance comprises of:

- **CCGs –** Halton, St Helens, Warrington, Knowlsey, Southport & Formby, West Lancashire;,
- **Acute Trusts** – St Helens & Knowsley Teaching Hospitals NHS Trust, Warrington and Halton Hospitals NHS Foundation Trust, Southport and Formby Hospital NHS Trust;
- **Community & Mental Health –** Bridgewater Community Healthcare NHS

Foundation Trust , 5 Boroughs Partnership NHS Foundation Trust

- **Local Authority –** Halton, St Helens, Warrington, Knowsley, Southport & Formby, West Lancashire (a proportion of Knowsley, Southport & Formby and West Lancashire face other LDS systems also).

3.7 A number of priorities in Level 2 of the STP have been identified.

The trusts have stated their wish to reconfigure clinical service lines into hot, warm and cold functions.

The priorities are:

1. Reconfiguration of individual secondary care service lines to achieve sustainability in terms of quality, workforce and finance.
2. Development of sustainable responsive out of hospital services: primary, community and social care.
3. Public health work to deliver greater wellbeing, with primary and secondary prevention of long term conditions.

4.0 POLICY IMPLICATIONS

4.1 None identified at this stage.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 The financial implications are not known at this time.

5.2 The Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 came into effect on 1 April 2013 revising existing legislation regarding health scrutiny.

In summary, the revised statutory framework authorises local authorities to:

- review and scrutinise any matter relating to the planning, provision and operation of the health service; and,
- consider consultations by a relevant NHS body or provider of NHS-funded services on any proposal for a substantial development or variation to the health service in the local authority's area.

5.3 As a result of this change Halton is signed up to the 'Protocol for establishment of Joint Health Scrutiny arrangements for Cheshire and Merseyside.

This protocol has been developed as a framework for the operation of joint health scrutiny arrangements across the local authorities of Cheshire and Merseyside. It allows for:

- scrutiny of substantial developments and variations of the health service; and,
- discretionary scrutiny of local health services.

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**

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

6.4 **A Safer Halton**

None

6.5 **Halton's Urban Renewal**

None

7.0 **RISK ANALYSIS**

7.1 As the priorities within Level 2 of the STP progress, appropriate engagement with all stakeholders will need to take place to ensure that the changes which occur result in the best outcomes for patients/service users.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None identified at this stage.

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

9.1 None under the meaning of the Act.

REPORT TO: Health Policy & Performance Board

DATE: 13 June 2016

REPORTING OFFICER: Strategic Director, People & Economy

PORTFOLIO: Health & Wellbeing

SUBJECT: Performance Management Reports, Quarter 4 2015-16

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 This Report introduces, through the submission of a structured thematic performance report, the progress of key performance indicators, milestones and targets relating to Health in Quarter 4 of 2015-16. This includes a description of factors which are affecting the service.

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

i) Receive the Quarter 4 Priority Based report

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

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

3.0 **SUPPORTING INFORMATION**

3.1 The Policy and Performance Board has a key role in monitoring and scrutinising the performance of the Council in delivering outcomes against its key health priorities. Therefore, in line with the Council's performance framework, the Board has been provided with a thematic report which identifies the key issues in performance arising in Quarter 4, 2015-16.

4.0 **POLICY IMPLICATIONS**

4.1 There are no policy implications associated with this report.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 There are no other implications associated with this report.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

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

6.2 Employment, Learning & Skills in Halton

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

6.3 A Healthy Halton

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

6.4 A Safer Halton

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

6.5 Halton's Urban Renewal

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

7.0 RISK ANALYSIS

7.1 Not applicable.

8.0 EQUALITY AND DIVERSITY ISSUES

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

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

None under the meaning of the Act.

Health Policy & Performance Board Priority Based Report

Reporting Period: Quarter 4: 1st January to 31st March 2016

1.0 Introduction

This report provides an overview of issues and progress against key service area objectives and milestones and performance targets, during the fourth quarter of 2015/16 for service areas within the remit of the Health Policy and Performance Board. These areas include:

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

2.0 Key Developments

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

PREVENTION & ASSESSMENT

Oak Meadow
Oak Meadow Community Support Centre received an unannounced visit from CQC on 29th December and a second announced visit on 5th January 2016. It has received an overall rating of good across all areas – safe, effective, caring, responsive and well led. Comments from people included 'I could have sat here and felt sorry for myself but they have given me hope for my future'. Work is ongoing to ensure that the service maintains standards and further improves on them.

Transforming Domiciliary Care
Work is under way to develop and redesign domiciliary care in the borough. The current workstreams include looking at an outcome based model of care, understanding the local market, identifying infrastructure requirements and co-production of the overall project. The first phase is to complete a needs assessment and then submit a funding application to an appropriate body by July 2016.

"Making a Difference" a strategy
The "Making a Difference" a strategy for transforming care management in Halton that is aimed at staff and partner agencies, continues to be developed. The overall purpose has been to provide a shared vision of the future of care management services and provide us with a plan to shape our future, over the next five years. This Care Management strategy has stemmed from the growing need to identify a future vision of assessment and care management services that are fit for purpose to meet the many challenges at national and local level whilst maintaining high quality, effective and safe practice. A key strand has been the successful development of, a "Progression Routes Policy and Procedure." It demonstrates Halton is committed to developing the careers of Social Workers through vocational and academic routes. Adopting a stepped advancement pathway that allows for the successful recruitment, retention and succession planning of social work staff within the Borough. This created a new role of Advanced Social Worker, which will

support practice and supervision, as required within the Professional Capability framework. We are currently, recruiting to two new posts.

Another important area to highlight is a regular "Social Work Matters Forum" where the Principal Social Worker meets with social workers to ensure the professionalism and voice of social work is supported within the integrated working environment. Social Workers are meeting in "Action Learning Sets" to enable opportunity for reflective learning, research, and support evidence based practice The forum will receive a visit from the chief social worker Lyn Romeo in July. Lyn Romeo issued her Annual Report in March this year which references the good practice being undertaken in Adult social work in Halton.

"Making it Real" in Personalisation

In Care Management Services as part of 'Personalisation' we will running a follow up event in June to evaluate the work that has been done with the 'Making it real' agenda regarding us marking our progress in Halton towards personalised, community based support. We will be co-producing a workshop with people using services that will help check our progress and completion of work.

Making Safeguarding Personal

The Local Government Association and ADASS (Directors of Adult Social Services) published an evaluation of Making Safeguarding Personal (MSP). This is the approach embedded within the Care Act and has moved safeguarding investigations from a process driven approach to one which focusses on outcomes for the person involved. The new IT system went live in July 2015 and the report on outcomes has been presented the Safeguarding Adult Board.

COMMISSIONING & COMPLEX CARE SERVICES

Mental Health Services

Review of the 5Boroughs Acute Care Pathway and Later Life and Memory Service: following the recent review of the above services, a number of multiagency work streams have been set up to take forward the review recommendations. The Council and CCG are fully involved in these developments, which are overseen locally by the Halton Mental Health Delivery Group.

CQC inspection of 5BoroughsPartnership NHS Trust: this detailed inspection took place across the whole footprint of the 5Boroughs in summer 2015. The final report has now been submitted to the 5Boroughs; mental health services were rated as good throughout; two other areas – forensic inpatient services and end of life care services – required improvement and are the subject of an internal action plan.

Other developments in the Commissioning and Complex Care Department:

Halton and St Helens Emergency Duty Team (EDT): following approaches from two local authorities to join the existing partnership to deliver the EDT across Halton and St Helens, and an understanding that the current requirements for the service have changed substantially since it was first set up in 2007, a review of the service delivery has been undertaken. This has concluded that it is not currently feasible to extend the service to include more partners, not least because of the complexity of incorporating additional IT systems. Internal work is now taking place to consider whether, in the medium term, the current model of service delivery should change.

PUBLIC HEALTH

Prevention and Early Detection of Cancer
In terms of cancer Halton is currently working across wider Merseyside authorities alongside PHE on a Bowel Cancer Screening Campaign to encourage individuals to 'Use your Kit'. Halton Health Improvement Health Trainers are now ringing patients who have not completed their bowel screening test and talking them through the procedure and this has resulted in an improved uptake.

The cancer breast screening unit is temporarily located within the grounds of Halton Select Stadium, for the remainder of the current screening round (until May 2016). If this venue proves successful it is hope that this will become a permanent location for future screening rounds, and provide an opportunity to improve the uptake and engage women attending in other health promoting activities.

Improved Child Development
Public Health and the CCG have recruited a paediatrician, who will start working in April 2016 in the community. The aims of the pilot are to increase access to paediatric expertise within the community for families and, importantly, for health professionals.

COMMUNITY & ENVIRONMENT

Frank Myler Pavilion Activity Programme
There are now 16 community activity classes available each week. The Multi-Use Games Area (MUGA) has been well used during the winter months for football and rugby teams regularly hiring the area for training sessions. Health Checks and Fresh Start have commenced during February, along with Falls Prevention classes now running twice a week. Halton Multi-Sports club has been delivered for 12 weeks through Children in Need funding, and will continue during term time as an after school offer for 8-13 year olds. New sessions include mamafit, Tai-Chi, and boxercise.

Community Alcohol Partnerships
A new initiative aimed at tackling underage drinking and related anti-social behaviour is being introduced in Halton. The Community Alcohol Partnership (CAP) is a partnership between alcohol retailers local authorities, the police, schools, alcohol services and communities, and is based upon the realities of how young people obtain alcohol.
The CAP is an opportunity to focus on the issues around alcohol and young people and work with the local residents and businesses to reduce alcohol consumption and anti-social behaviour. Consideration is also being given to addressing the use of legal highs in the CAP, in particular the use of nitrous oxide canisters and the impact that has on young people, local residents and the local environment.
CAPs are developed with and within individual communities. Each partnership is tailored to suit local needs and activity is designed to meet local objectives around three main themes; enforcement, education and public perception.
Evidence shows that whilst some young people buy alcohol themselves from shops, pubs and bars, more obtain it from parents and other adults. Therefore CAP recognises that retailers are part of the solution rather than part of the problem and traditional enforcement activity cannot, by itself, be the answer.
CAP focuses on promoting positive change through education and work on public perception, developing unique local partnerships that bring together everyone with an interest in challenging underage drinking in a co-ordinated effort to tackle the issues collectively in a particular locality.

The CAP initiative will initially be introduced as a pilot within an area identified as experiencing problems of under aged drinking and associated anti-social behaviour which could be rolled out across the rest of the Borough depending upon the outcomes.

3.0 Emerging Issues

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

PREVENTION & ASSESSMENT

Expansion of Care Home Support Team

The Care Home Support Team has been operating in Halton since July 2013.
The Team currently consists of 2 full time equivalent nurses employed by Bridgewater Community Healthcare NHS Foundation Trust.
It is evident that the work that the Team has undertaken with the Care Homes within Halton has generated positive outcomes for Service Users, but there are issues associated with capacity to be able to continue to support and work with the Care Homes to develop further etc. As such discussions are ongoing with Bridgewater to explore the feasibility of expanding the Team.

Care at Home Service

In response to the current strategic challenges within the domiciliary care market an 'in house' care service is being developed to undertake a pilot locally to meet the needs of people with complex health conditions. The intention is to provide some additional capacity within the sector for a three month period to allow some proposals for change to strengthen and develop the local care market to be considered and progressed.

Community Multi-Disciplinary Team (MDT)

There is ongoing development of a Community Multi-Disciplinary Team (MDT) approach in Halton. This is being introduced to help the management of people with Complex Needs and intends to Improve the health and well-being of people with complex needs, building on the current Social Care In Practice Model. We are working with GP's and CCG colleagues to look at integrate approaches, including assessment, IT, team working.

COMMISSIONING & COMPLEX CARE

Social Work for Better Mental Health: this is a national programme from the Department of Health designed to clarify the roles and functions of social work in mental health services across the country. Halton, along with Sefton Borough Council, is an early implementer site for this work. This follows the publication of national guidance in relation to this issue in 2014.
Two meetings have taken place, facilitated by the authors of the national guidance, and two more are planned. The facilitators will then produce a report with recommendations for the future, and this will then be incorporated into the partnership between the Borough Council and the 5BoroughsPartnership to deliver social work services within the Trust.

Direct Payments in Mental Health: following an internal review of the low uptake of direct payments within Halton's mental health services, the Halton Disability Partnership has been commissioned to work directly with people who use mental health services, to offer

them practical support and encourage them to take up this form of help. It is expected that this will lead to an increase in the take-up of direct payments.

PUBLIC HEALTH

Breach of cancer treatment referral timescales
62 day breaches for referral to a cancer treatment are now being reported through the Halton System Resilience Group which includes the CCG and adult social care. The 62 day referral is currently below target and it is unlikely that Halton will achieve the 85% target set.Breeches are now being reported through the Halton System Resilience Group which includes the CCG and adult social care. These will continue to be investigated to understand the root causes.

4.0 Risk Control Measures

Risk control forms an integral part of the Council's Business Planning and performance monitoring arrangements. As such Directorate Risk Registers were updated in tandem with the development of the suite of 2015-16 Directorate Business Plans.

Progress concerning the implementation of all Directorate high-risk mitigation measures was reported in Quarter 2 and Risk Registers are currently being reviewed for 2015/16 in tandem with the development of next year's Directorate Business Plans.

5.0 Progress against high priority equality actions

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

6.0 Performance Overview

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

"Rate per population" vs "Percentage" to express data
Four BCF KPIs are expressed as rates per population. "Rates per population" and "percentages" are both used to compare data but each expresses the same amount in a different way. A common guide used is that if a percent is less than 0.1 then a rate (e.g. per 100,000) is used. For example, permanent admissions to residential care expressed as a rate (50 admissions per or for every 100,000 people) makes more sense when comparing performance with other authorities rather than as a percentage (0.05%) which is quite a small number and could be somewhat confusing. More examples below:

Location	Rate per 100,000 population	Percent
Region A	338.0	0.34%
Region B	170.5	0.17%
Region C	225.6	0.23%

SALT

SALT (Short and Long Term Support) was introduced as a return for the year end 2014/15, which replaced Referrals, Assessments and Packages of Care return and Adult Social Care Combined Activity Return. SALT differs from its predecessors in that it attempts to track in a more meaningful way a client/carer's journey through social services from referral to service provision by identifying significant events (for example planned/unplanned hospital episodes, change of residence or safeguarding concern) and key outcomes of users (e.g. long term support, long term support ended/temporarily suspended). Several ASCOF measures are drawn from the SALT return and these provide performance information on the critical issues of:

- Self-directed support and direct payments
- Learning disability (LD) service users in paid employment and living in their own home or with their family
- Permanent Admissions to Residential / Nursing Care

Data for Self-directed Support and LD users in paid employment and settled accommodation is drawn from long term support services only, a significant difference from how these measures were generated previously. For statutory reporting purposes, the following service types are now categorised as short term support – Adaptations and Equipment including Telecare. As such these users have been excluded from these measures.

Given that SALT is only in its second year, the data needs to be looked at with some consideration for data quality issues due to differences in interpretation and how data capture systems have been configured. There will also be some discrepancies with comparability across previous years because base data used for ASCOF measures has changed – number of service users receiving self-directed support in 2013/14 included service types which are considered short term support in 2014/15 onwards, thus decreasing the potential number of clients receiving self-directed support.

Preliminary regional benchmarking has highlighted variances which point to interpretation issues and lack of clarity in Health and Social Care Information Centre guidance documents. These issues are due to be discussed in more detail within the North West performance leads group.

Figures for permanent admissions to residential / nursing care are different from those reported in Better Care Fund and to AQuA_ADASS benchmarking due to the fact that SALT tables report the intention to place client into care (outcome of an assessment/review) rather than actual placements made.

Reports will continue to be monitored for accuracy following year end returns.

Prevention and Assessment Services

Key Objectives / milestones

Ref	Milestones	Q4 Progress
PA 1	Monitor the effectiveness of the Better Care Fund pooled budget ensuring that budget comes out on target (**AOF 21, 25) March 2016.**	✓
PA 1	Implement the Care Act **(AOF 2,4,10, 21) March 2016.**	✓

Supporting Commentary

PA 1 Monitor effectiveness of Better Care Fund pooled budget:
The pooled budget is on target for a small underspend at year end.

PA 1 Implement the Care Act:
All key stages of the first phase of the implementation of the Care Act have been completed. Additional training in relation to the Care Act and the law has been identified and procured and will be delivered in May 2016.

Key Performance Indicators

Ref	Measure	14/15 Actual	15/16 Target	Q4 Actual	Q4 Progress	Direction of travel
PA 1	Numbers of people receiving Intermediate Care per 1,000 population (65+)	80	77	(Q4= 406; 1622) cumulative	✓	↑
PA 2	Percentage of VAA Assessments completed within 28 days	86.8%	85%	**85%** (estimated, further data quality work ongoing to confirm this)	✓	⇔
PA 6a	Percentage of items of equipment and adaptations delivered within 7 working days	95.5%	97%	**99%**	✓	↑
PA 6b	Percentage of items of equipment and adaptations delivered within 5 working days – new indicator	89.5%	95%	**92.10%**	✗	↑

Ref	Measure	14/15 Actual	15/16 Target	Q4 Actual	Q4 Progress	Direction of travel
PA 11	Permanent Admissions to residential and nursing care homes per 100,000 population,65+ (ASCOF 2A2) *Better Care Fund performance metric*	600.8	635.1	**541.7**	✓	↓
PA 12	Delayed transfers of care (delayed days) from hospital per 100,000 population *Better Care Fund performance metric*	tbc	2831	247 v target 236 (to January 2016)	✓	N/A
PA 14	Total non-elective admissions in to hospital (general & acute), all age, per 100,000 population *Better Care Fund performance metric*	tbc	12771.8 Admissions: 16,141 Pop: 126,380	15231 V plan 16668 (Feb 16)	✗	N/A
PA 15	Hospital re-admissions (within 28 days) where original admission was due to a fall (aged 65+) (directly standardised rate per 100,000 population aged 65+) *Better Care Fund performance metric*	823.89	884.2	**685.1**	✓	↑
PA 16	Proportion of Older People (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (ASCOF 2B1) *Better Care Fund performance metric*	65.6	70%	**Annual collection**	N/A	N/A
PA 20	Do care and support services help to have a better quality of life? (ASC survey Q 2b) *Better Care Fund performance metric*	93.3%	91%	**Annual collection**	N/A	N/A

Supporting Commentary

PA 1 Numbers of people receiving Intermediate Care per 1,000 population (65+):
The Q4 figure is provisional. There have been amendments to previous quarter figures which have meant an increase in some referral figures. Up to date figures for IC referrals for each quarter during 2015/16 are as follows: Q1 = 401, Q2 = 401, Q3 = 414.

PA 2 Percentage of VAA Assessments completed within 28 days:
This target has been achieved, albeit the figure is slightly lower than 2014/15; this is due to data loading issues; this will be addressed by a more detailed analysis of the completed safeguarding investigations for 2015/16, with a view to providing mandatory training for operational staff and support surgeries undertaken by the performance and carefirst teams to reduce the risk of these issues reoccurring in the future.

PA 6a Percentage of items of equipment and adaptations delivered within 7 working days:
This indicator has achieved in excess of its target figure; performance has improved compared to last year's figure. We are still missing information from Housing Maintenance Solutions, which was a new contract during the year.

PA 6b Percentage of items of equipment and adaptations delivered within 5 working days:
Although the quarter 4 figure is slightly below target it has increased compared to last year's figure; this is a stretched target and we need to bear in mind that these figures do not include Q4 figures from HMS.

PA 11 Permanent Admissions to residential and nursing care homes per 100,000 population, aged65+:
We have come in below target for 2015/16, which is what we should be aiming for when looking at permanent admissions to care, 110 clients aged 65 plus have been placed in permanent residential or nursing care for the 2015/16 period.

PA 12 Delayed transfers of care (delayed days) from hospital per 100,000 population:
Although performance in Q4 (January data only) is above target, the figure for the year to date is expected to be on target due to lower performance earlier in the year. The current forecast is for a rate of 233 per 100,000 per month against a target of 236 per 100,000 per month. annual figure of 2796 vs. annual target of 2831.

PA 14 Total non-elective admissions in to hospital (general & acute), all age, per 100,000 population:
Value reported here is total number, not rate per 100,000. The CCG has reported significantly under plan and is also forecast to be 2.5% lower than 2014/15 This is due to the impact of the NEL reduction schemes in place during 2015/16 including the Urgent Care Centres and £5 per head primary case schemes. This reduction bucks the trend both regionally and nationally for increases in non-elective admissions.

PA 15 Hospital re-admissions (within 28 days) where original admission was due to a fall, aged 65+:
Please note that the data included is for quarter 2 as the quarter 3 and quarter 4 information has not been completed due to some issues with data collection.

PA 16 Proportion of Older People (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services:
No data available, annual collection only.

PA 20 Do care and support services help to have a better quality of life?:
No data available, annual collection only.

Commissioning and Complex Care Services

Key Objectives / milestones

Ref	Milestones	Q4 Progress
CCC 1	Continue to monitor effectiveness of changes arising from review of services and support to children and adults with Autistic Spectrum Disorder. **Mar 2016.** (AOF 4)	✓
CCC 1	Continue to implement the Local Dementia Strategy, to ensure effective services are in place. **Mar 2016.** (AOF 4)	✓
CCC 1	Continue to work with the 5Boroughs NHS Foundation Trust proposals to redesign pathways for people with Acute Mental Health problems and services for older people with Mental Health problems. **Mar 2016.** (AOF 4)	✓
CCC 1	The Homelessness strategy be kept under annual review to determine if any changes or updates are required. **Mar 2016.** (AOF 4, AOF 18)	?

Supporting Commentary

CCC1 - Services / Support to children and adults with Autism:
The current autism strategy is presently being reviewed to identify gaps in services. The redesign of transition between children and adult services (due to be completed in June 2016) will further enhance support to children and young people with a diagnosis of autism.

CCC 1 Dementia Strategy:
The procurement process for the Dementia Community Pathway redesign is underway, with the provider interviews scheduled for April 2016, with the contract due to commence 1st May 2016. In the intervening period a waiver has been accepted by Procurement for a period of 1 month (31st March – 30th April 2016) to extend the existing provider contract until the new contract commences.
The Admiral Nurse service is now operational and actively promoting the service to engage with partners and generate referrals
The Dementia Action Alliance continues to engage with partners and public to promote local dementia related activity and seek insight from people living with dementia and their carers. The event held during the quarter attracted over 60 people, professionals and carers to educate around food, nutrition and supportive meal times for people living with dementia.

CCC 1 Mental Health:
The review of the Acute Care Pathway and the Later Life and Memory Service was completed and published at the end of 2015, with a number of recommendations for change, designed to

improve service delivery. Working groups have now been set up, both internally within Halton and more widely across the 5Boroughs, and the council is fully involved in each of these. The outcomes of these groups is monitored by the Halton Mental Health Delivery Group.

CCC 1 Homelessness Strategy:
Due to a new system being installed, this has led to some complications with generating reports. Unfortunately, the issue is being addressed by the consultant and as soon as the matter is resolved, I will complete and return the Q4 template.

Key Performance Indicators

Ref	Measure	14/15 Actual	15/16 Target	Q4 Actual	Q4 Progress	Direction of travel
CCC 3	Adults with mental health problems helped to live at home per 1,000 population	2.64	3.0	**2.37**	✗	↓
CCC 4	The proportion of households who were accepted as statutorily homeless, who were accepted by the same LA within the last 2 years (Previously CCC 6).	0	1.2	**0**	✓	↔
CCC 5	Number of households living in Temporary Accommodation (Previously NI 156, CCC 7).	19	11	**10**	✓	↓

Supporting Commentary

CCC 3 Adults with mental health problems helped to live at home per 1,000 population:
Following service redesign within the 5Boroughs and the increasing development of shared care within primary care services, the numbers of people dealt with by the Trust has reduced. This has also meant that the numbers of people seen by social work staff have also reduced. The work of delivering the recommendations into the review of the Acute Care Pathway will consider this and make recommendations for future service delivery.

CCC 4 The proportion of households who were accepted as statutorily homeless, who were accepted by the same LA within the last 2 years:
The Authority places strong emphasis upon homelessness prevention and achieving sustainable outcomes for clients.

The Authority will continue to strive to sustain a zero tolerance towards repeat homelessness within the district and facilitate reconnection with neighbouring authorities.

CCC 5 Number of households living in Temporary Accommodation:
The Housing Solutions Team has taken a proactive approach to preventing homelessness. There are established prevention measures in place and the Housing Solutions team fully utilise and continue to promote all service options available to clients.

The changes in the TA process and amended accommodation provider contracts, including the mainstay assessment process, has had a positive impact upon the level of placements.

The emphasis is focused on early intervention and empowerment to promote independent living.
The improved service process has developed stronger partnership working and contributed towards an effective move on process for clients.

Public Health

Key Objectives / milestones

Ref	Milestones	Q4 Progress
PH 01	Work with PHE to ensure targets for HPV vaccination are maintained in light of national immunisation Schedule Changes and Service reorganisations. **March 2016**	✓
PH 01	Working with partners to identify opportunities to increase uptake across the Cancer Screening Programmes by 10%. **March 2016**	✓
PH 01	Ensure Referral to treatment targets are achieved and minimise all avoidable breaches. **March 2016**	✗
PH 02	Facilitate the *Early Life Stages* development which focusses on a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, and health, well-being and parenting advice for ages 2½ years and 5 years. **March 2016**	✓
PH 02	Fully establish the Family Nurse Partnership programme **March 2016**	✓
PH 02	Facilitate the Halton Breastfeeding programme so that all mothers have access to breastfeeding-friendly premises and breastfeeding support from midwives and care support workers. Achieve UNICEF baby friendly stage 3 award **March 2016**	✓
PH 03	Development of new triage service between Rapid Access Rehabilitation Team and Falls Specialist Service. **March 2016**	✓
PH 03	New Voluntary sector pathway developed to support low-level intervention within falls in the borough. **March 2016**	✓
PH 04	Implement the Halton alcohol strategy action plan working with a range of partners in order to minimise the harm from alcohol and	✓

	deliver on three interlinked outcomes: reducing alcohol-related health harms; reducing alcohol-related crime, antisocial behaviour and domestic abuse and establishing a diverse, vibrant and safe night-time economy. **March 2016**	
PH 04	Deliver a local education campaign to increase the awareness of the harm of drinking alcohol when pregnant or trying to conceive. **March 2016**	✓
PH 04	Hold a community conversation around alcohol – using an Inquiry approach based on the citizen's jury model of community engagement and ensure recommendations for action are acted upon by all local partners. **March 2016**	✓
PH 05	Successfully implement a new tier 2 Children and Young Peoples Emotional Health and Wellbeing Service. **March 2016**	✓
PH 05	Monitor and review the Mental Health Action plan under new Mental Health Governance structures. **March 2016**	✓
PH 05	Implementation of the Suicide Action Plan. **March 2016**	✓

Supporting Commentary

PH 01 HPV vaccinations:
Initial preliminary results show that first dose HPV vaccination are above 90% target for year, and dose 2 is already almost at target despite not being formerly reported until 2017. We will continue to engage with current school nurse providers to support high level delivery.

PH 01 Cancer Screening Programmes:
Halton is currently working across wider Merseyside authorities alongside PHE on a Bowel Cancer Screening Campaign to encourage individuals to 'Use your Kit'. The campaign features TV, Radio as well as visible promotional materials on Street signs, bus shelters, buses, taxis etc. The evaluation is ongoing and previous evaluation of the marketing campaign has proven effective elsewhere. There is also a Direct Mail campaign being launched which will aim to encourage those who have previously not responded following initial invite to participate in Bowel Screening

Breast screening uptake at 71.4% is above the national target of 70%. There are still wide practice variation within uptake across the Borough. The service is offered from a mobile screening unit. Until recently the unit was located at the Highfield Hospital site, but due to essential demolition work, was forced to move location at short notice. Following negotiations, the unit is temporarily located within the grounds of Halton Select Stadium for the remainder of the current screening round (until May 2016). If this venue proves successful it is hope that this will become a permanent location for future screening rounds, and provide opportujity to improve uptake and engage women attending in other health promoting activities.

The Health and Wellbeing Service work has focused over the this Quarter on two particular interventions. The first one has been a large study to investigate the impact on telephone calls to non-responders in three GP practices (Appleton Village, Grove House, Oaks Place). 163 non-responders have been telephoned from GP practice by Health Improvement Health Trainers, with 32 people then going on to complete the FOBt kit requested. This has resulted in a substantial screening increase of 9.7%, taking two of the practices above both the regional and England average for the time period.
The other work has invoved West Bank surgery and breast screening, with contracting people

who had missed their appointment and re-engaging with them to book another screening appointment.

PH 01 Referral to treatment:
62 day breaches for referral to a cancer treatment are now being reported through the Halton System Resilience Group which includes the CCG and adult social care. Individual breaches by hospitals continue to be investigated and analysed so that the root causes for the delays can be assessed and mitigated. 62 day referral is currently below target and it is unlikely that Halton will achieve the 85% target (January 2016 data 79%). Public Health and CCG are currently working with Trusts to improve reporting and system wide assurance. A new Health and Wellbeing Cancer Action plan is being developed to address system wide issues which should help develop a system approach to reducing breaches.

PH 02 Early Life Stages:
The Health Visiting Service is delivering the additional components of the national Healthy Child Programme, including assessing the mothers emotional health at 6-8 weeks and completing and integrated developmental check at 2-21/2 , sharing the results with the early years setting to inform their assessment of the child, and services will collaboratively put in place a support package as required.

The BabyClear smoking cessation programme is underway to ensure women receive regular smoking cessation support throughout their pregnancy and all womens smoking during pregnancy is regularly monitored.

Public Health and the CCG have recruited a paediatrician, who will start working in April in the community. The aims of the pilot are to increase access to paediatric expertise within the community for families and importantly for health professionals. This will build knowledge and expertise, which has been shown elsewhere to improve patient care, and reduce attendance by families at A&E. A paediatrician has been recruited to the programme.

The CCG has invested in perinatal mental health, including training of health visitors and community staff to support mothers to bond with their baby and support mothers and fathers experiencing perinatal mental illness. Work to improve the perinatal pathway is also underway.

The report into child development in Halton has been completed and the final report is awaited.

Parent Craft
The development of a 4 week parent craft programme, which is to be piloted in May 2016. This programme will be delivered in partnership between HIT, Midwifery, Health Visiting, Family Nurse Partnership and Children's Centres.

Parent Workshops
Those schools with high levels of reception and overweight children, as identified through the NCMP data, have been offered a parent workshop which covers key issues such as portion sizes, rewarding with food, label reading etc. To date, up to 15 schools have accepted this offer.

Baby Clinics
The Infant Feeding Team has started to support the Health Visiting Team at the baby clinics, providing families with information regarding the introduction of solid foods at 6 months.

PH 02 Family Nurse Partnership programme:
Halton's Family Nurse Partnership programme is fully operational and 71 families are currently on the programme, each family is on the programme for early in pregnancy until the child's 2nd birthday. This programme supports young teenage parents to improve outcomes for the family and their children.
An event to mark 12 months of the programme running took place in January and was

successful and well attended. Cllr Philbin and the FNP board attended and met parents and their children that are on the programme.

PH 02 Breastfeeding programme:
Bridgewater Community Health Trust, Halton and St Helens division achieved Stage 3 UNICEF baby friendly inspection (BFI) status in July 2015. Achieving stage 3, the final BFI stage shows that the services are fully able to support women to breastfeed through their policies, training and staff knowledge. Breastfeeding support continues to be available across the borough in community and health settings. The infant feeding coordinator and children's centres are working towards achieving BFI in the children's centres.

Baby Welcome Award Data Jan – March 2016
50 settings have had their Baby Welcome award renewed during this period

National Breastfeeding Celebration Week in June 2016
Work towards the National Breastfeeding Celebration Week has begun. This year the focus will be on the parents, particularly Baby Friendly Premises.

Antenatal Clinics
The infant feeding team have started to support the midwifery team at the antenatal clinics, offering support for families who are considering breastfeeding.

Healthitude Programme
A Breastfeeding Awareness session has been introduced as part of the Healthitude programme. This session will be delivered in secondary schools (year 9), female only pupils initially, with the aim of raising the awareness of breastfeeding amongst young people and promoting positive attitudes towards breastfeeding.

PH 03 New triage service - Rapid Access Rehabilitation Team and Falls Specialist Service:
The triage service has been fully implemented and is showing considerable positive outcomes for individuals. A baseline review of this will be completed in October 2016.

PH 03 Voluntary sector pathway to support low-level intervention within falls:
Pathway is in place and is working well, there have been an increase in the number of referrals between organisations that has reduced waiting times for people accessing low-level services.

PH 04 Alcohol Strategy Action Plan:
Good progress continues to be made towards implementing the Halton alcohol strategy action plan. Key activity includes:

- Reviewing alcohol communications in line with the new Chief Medical Officer (CMO) guidelines.
- Delivery of alcohol education within local school settings (Healthitude, R U Different, Amy Winehouse Foundation, Cheshire Police, Alcohol education Trust, wellbeing web magazine).
- Reviewing and updating the early identification and brief advice (alcohol IBA) training and resources across the lifecourse stages (pregnancy, children and young people, working age adults, older people).
- Working closely with colleagues from licensing, the community safety team, trading standards and Cheshire Police to ensure that the local licensing policy supports the alcohol harm reduction agenda, promoting more responsible approaches to the sale of alcohol e.g. theough the development of a "Caring Landlords Declaration"
- Working to influence government policy and initiatives around alcohol e.g. 50p minimum unit price for alcohol, restrictions of all alcohol marketing, public health as a fifth licensing objective.

PH 04 Education campaign around alcohol:
The 'please stop drinking mummy' campaign ran from February to July 2015, and is still ongoing through social media and websites. The campaign has been well received with good traffic to sites, and positive feedback from midwives that it has helped them to discuss drinking habits with pregnant women.

Continued to roll out the FASD (Foetal Alcohol Syndrome) campaign across the borough.
Health Improvement planning to deliver making every contact count by delivering training to Family Nurse Partnerships and Breast Feeding Cooordinators to signpost and deliver advice on alcohol and Tobacco

PH 04 Community conversation around alcohol:
The Inquiry group have developed recommendations for local action related to: alcohol education in schools and educating parents, alcohol licensing and promoting responsible retailing, alcohol advertising and education around alcohol especially awareness of alcohol units and recommended safe drinking levels. These were shared with local stakeholders at a well-attended launch event held in June. Local stakeholders will now support the group going forward in making these recommendations a reality. Members of the Inquiry group attended the local alcohol stratgey group to ensure their recommendations are taken forward locally.

PH 05 Children and Young People Health and Wellbeing Service:
Five Boroughs NHS trust have been jointly commissioned by the CCG and Public Health to deliver the tier 2 children and young people's mental health service. This service has now been in place since July 2015 and as well as providing the targeted mental health service, work will include mental health and wellbeing training for staff working with children and young people, such as schools, school based face-to-face work and an online counselling service.

A training programme for teachers from 10 of Halton's schools has taken place to support them in early identification and intervention to support children's emotional health. Funding has also been made available from the CCG for training health visitors and children's workforce in emtional health.

PH 05 Mental Health Action plan:
The action plan and activity reports from sub groups are reviewed at the Mental Health Oversight Board.
A refresh of the mental Hleath action plans, and suggested high level indicators is due to begin shortly to reflect additional strategic direction guided by the 5 year foreward view for mental health.

PH 05 Suicide Action Plan:
Good progress is being made towards implementing the Suicide strategy action plan. This work is being overseen by the Halton suicide prevention partnership.
Key developments include:

- Working towards Halton being a suicide safer community
- Developing a local multi-agency suicide awareness campaign plan
- Developing a local training plan to deliver suicide awareness training for community members, local community groups and key professionals who interact with known groups at high risk of suicide

Halton being part of a pilot programme across Cheshire and Merseyside to provide a support service for individuals bereaved by suicide. The service became operational on the 1st April 2015 and is called Amparo. Amparo provides support to anyone who has been affected by suicide within Halton.

Key Performance Indicators

Ref	Measure	14/15 Actual	15/16 Target	Q4	Current Progress	Direction of travel
PH LI 01	Mortality from all cancers at ages under 75 Directly Standardised Rate, per 100,000 population *Published data based on calendar year, please note year for targets.*	179.8 *(2014)*	185.6 *(2015)*	169.2 *(2015)*	✓	↑
PH LI 02	A good level of child development	46% *(2013/14)*	56.7%	54.7% (2014/15)	N / A	↑
PH LI 03	Falls and injuries in the over 65s. Directly Standardised Rate, per 100,000 population (PHOF definition).	3237.6 *(2014/15)*	3263.9	2904.1 (Oct 14 – Sep 15)	✓	↑
PH LI 04	Alcohol related admission episodes - narrow definition Directly Standardised Rate, per 100,000 population	767.2 (2014/15)	808.4	753.2 (Q2 15/16)	✓	↑
PH LI 05	Under 18 alcohol-specific admissions Crude Rate, per 100,000 population	51.0 (12/13 to 14/15)	55.0	Annual data only	?	N / A
PH LI 06	Self-reported wellbeing: % of people with a low happiness score	12.1% *(2013/14)*	11.1%	11.8% (2014/15)	?	↑

Supporting Commentary

PH LI 01 Mortality from all cancers at ages under 75:
The Data methodology for this indicator has changed from previous years making comparison with previous year's data difficult. Despite some annual fluctuations data does show an overall continual improvement with decrease in premature death from cancer over recent years.

PH LI 02 Child development:
There has been an improvement in the number of children reaching a good level of development, but this remains low.

PH LI 03 Falls and injuries in the over 65s:
No update from previous quarter available

PH LI 04 Alcohol related admissions:
No update from previous quarter available

PH LI 05 Under 18 alcohol-specific admissions:
Good progress is being made related to this indicator with the number of under 18 alcohol-specific admissions continuing to reduce and below the 2015/16 threshold (target).

PH LI 06 Self-reported wellbeing:
Recent data identifies that we have not achieved target for 2014/15 with a higher self-reported low happiness score, though this still shows improvement on previous year's scores.

APPENDIX 1 – Financial Statements

The Council's 2015/16 year-end accounts are currently being finalised. The year-end position for each Department will therefore be made available via the Intranet by 30th June 2016.

APPENDIX 2 – Explanation of Symbols

Symbols are used in the following manner:

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

Direction of Travel Indicator

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

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