Updated July 2014

Better Care Fund planning template – Part 1

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

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

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

1) PLAN DETAILS

a) Summary of Plan

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

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	NHS Halton CCG

By	Simon Banks
Position	Chief Officer
Date	<date>

<Insert extra rows for additional CCGs as required>

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

<Insert extra rows for additional Councils as required>

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

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

c) Related documentation

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

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

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

2) VISION FOR HEALTH AND CARE SERVICES

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

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

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

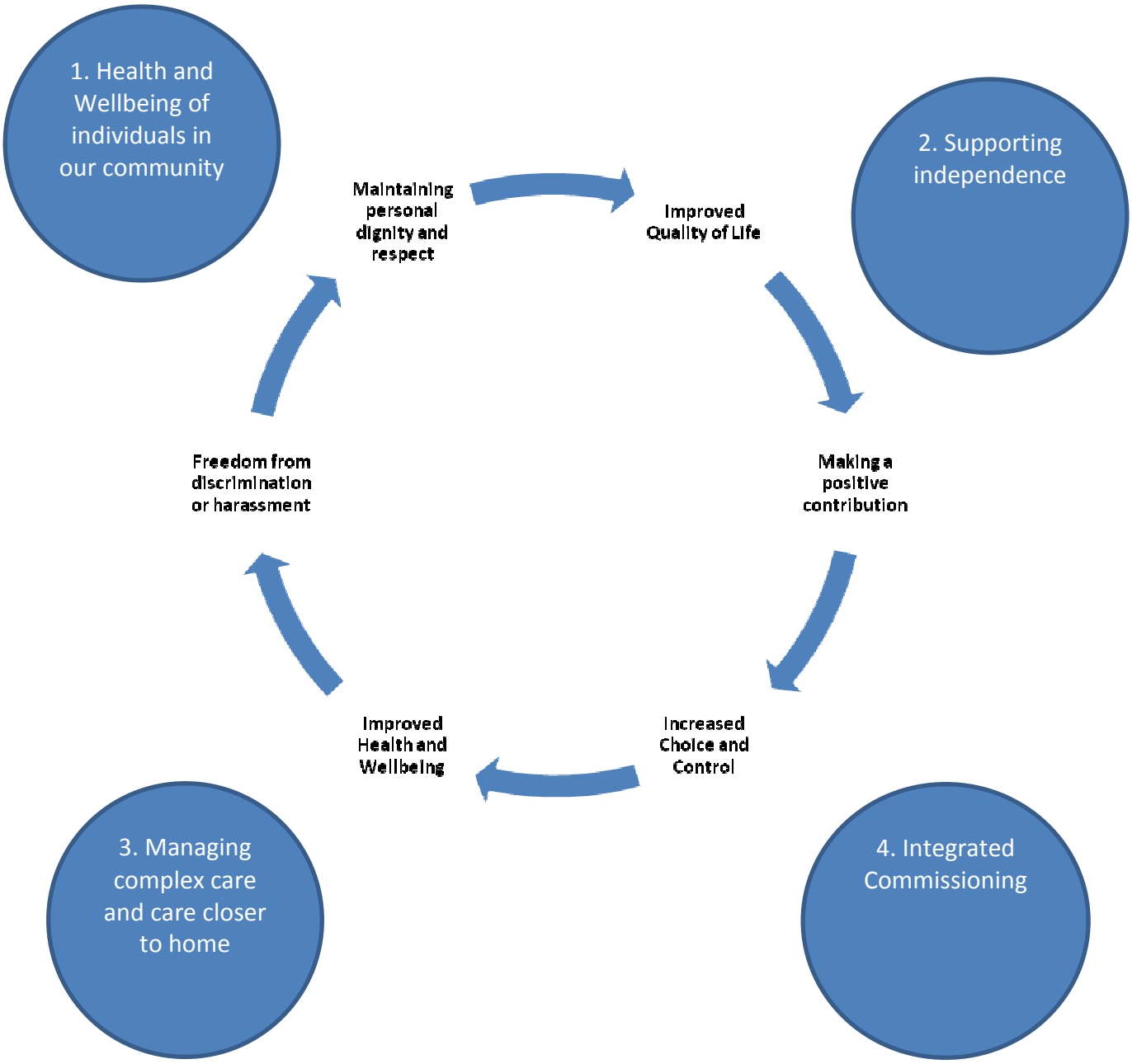
Parity of esteem is a way to embrace the physical and mental to ensure equity of provision for people with mental health problems. Currently people with Mental Health conditions die several years prematurely from people without these conditions. This is the result of a number of both physical and mental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

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

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

We will ensure that we:

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


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

Case Study

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

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

and I used to feel lonely

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

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

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

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

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

Supporting Performance Metrics

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3) CASE FOR CHANGE

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

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

The analysis provided by Capita includes:
"Working up analysis alongside local knowledge suggests that practices that have a focus on health and wellbeing and integrated care benefit from a reduced demand for acute services. Lower admission rates were highlighted for particular practices where there has been a recognised long term focus on health improvement and prevention."

One of the main conclusions from the Capita End-to End assessment highlighted the necessity to work towards greater integration.
"Modelled interventions are projected to keep pace with underlying growth over the next 3 years, after which this underlying demand is projected to overtake the reductions in activity that these initiatives are expected to make. This suggests that a more radical approach to meeting the challenge will be needed – current plans could be strengthened by exploring opportunities for more upstream intervention in health and wellbeing, shifting the emphasis from diversion to prevention of demand. In addition, the CCGs could explore more radical approaches to delivery of integrated, proactive care, involving redefining the role and shape of primary, community and social care for the longer term, with the current plans being used to generate headroom to put the necessary investment into non-acute services to enable long-term change."

NHS Halton CCG commissions acute services primarily from two providers, specific analysis has been undertaken on three patient groups identified as having the most to benefit from greater integrated care, this analysis concluded:
"Patients with dementia - Comparing lengths of stay for patients with a secondary diagnoses of dementia against patients with the same primary medical condition but no mental health co-morbidities shows a potential reduction of approximately 5,000 bed days (16 beds) at each of Warrington and Whiston.
Elderly patients (over 75's) - Modelling shows a potential reduction of up to 24,000 bed days (circa 73 beds) at both Warrington and Whiston hospitals. This is on the assumption that non-elective length of stays for elderly patients could be reduced to the same as younger patients with the same primary medical condition and similar levels of complication and co-morbidity.
Patients receiving end of life care - Comparing the length of stay of patients with and without palliative care for the same primary medical condition and similar complexity shows a potential shift of approximately 500 bed days (1.6 beds) at each of Warrington and Whiston.

All of the above are mutually exclusive, and in total represent potential reductions of around 20% in non-elective bed days for St Helens and Knowsley and Warrington and Halton Trusts.
The i5 report focussed on how schemes across the whole health economy in Halton (including both the CCG and the Local Authority) would impact on specific patient cohorts with specific conditions with regard

to hospital admissions and lengths of stay.

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

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

4) PLAN OF ACTION

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

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

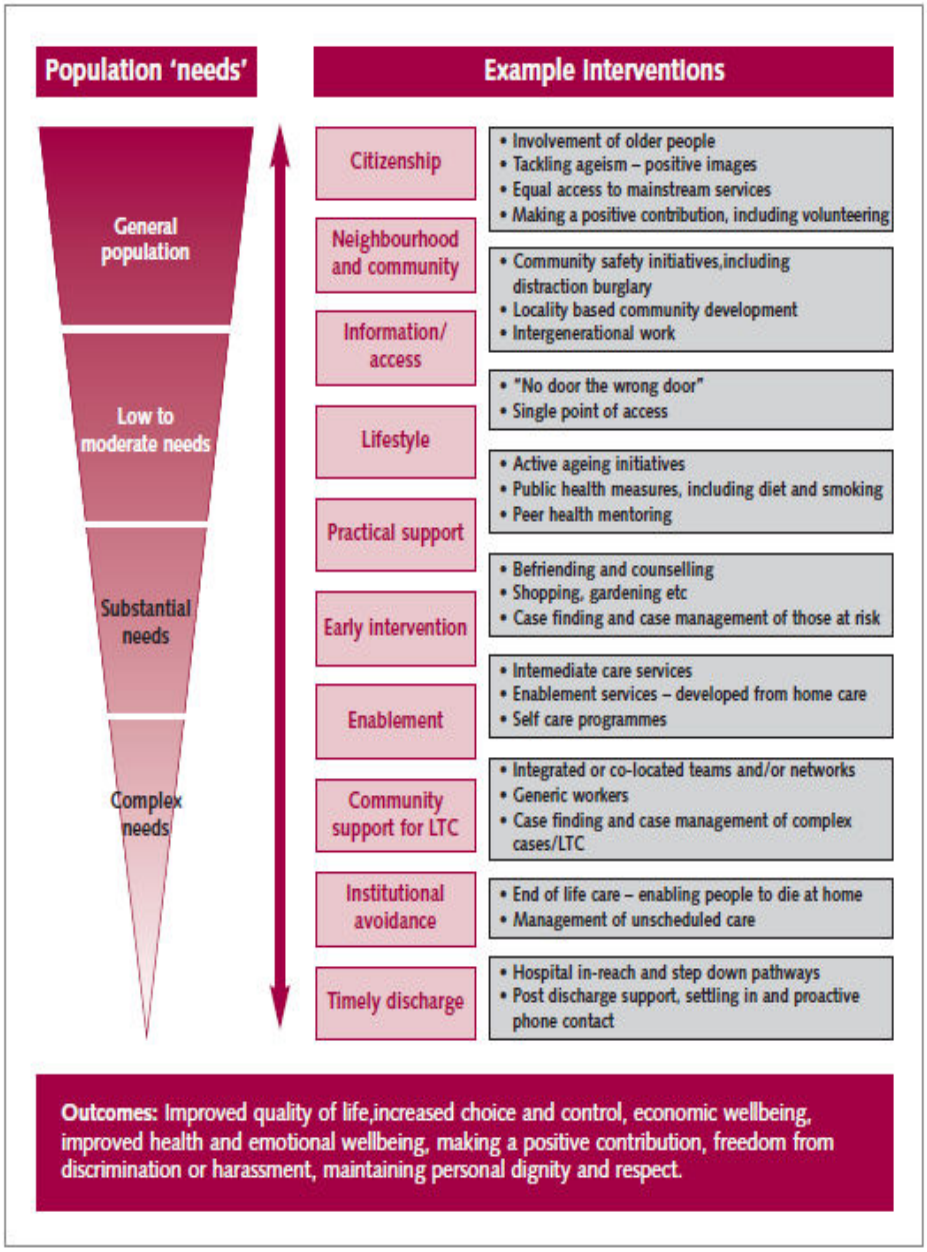
The Action Plan details both new and existing schemes within the BCF. It is useful to note that some of the schemes are also part-funded from other sources. The expenditure plan within Template 2 gives a breakdown of the finances for each scheme stating area of spend and commissioner. The following information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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

and send through monthly reports to them.

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

d) **List of planned BCF schemes**

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

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

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

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

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

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

5) RISKS AND CONTINGENCY

a) Risk log

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

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

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

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

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

b) Contingency plan and risk sharing

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

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

Risk Assessment & Mitigation

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

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

Controls to mitigate against these risks fall into three categories.

1) **Financial systems**

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

2) **Internal governance**

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

3) **Relationships and risk sharing**

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

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

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

6) ALIGNMENT

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

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

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

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

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

- Use of enabling technologies such as telecare and telehealth.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7) NATIONAL CONDITIONS

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

a) Protecting social care services

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

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

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

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

The BCF will help to protect these services by:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

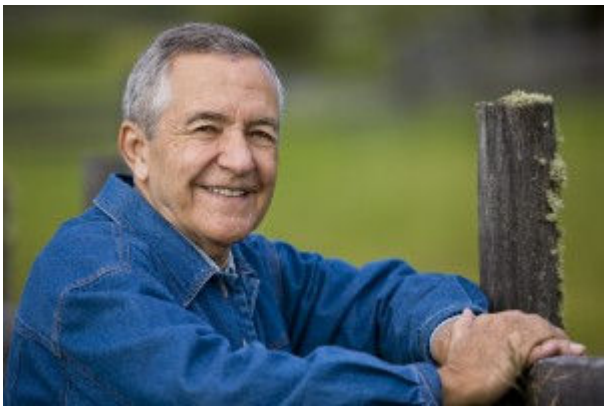
In providing carer specific support services, the Council and CCG have pooled their budgets and agreed that the Council will take the lead on commissioning carers services. The total budget available for commissioning carer specific support services is **£843,968** (Halton CCG; **£358,943** & Halton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

The pooled funding will be used in three ways:

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

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

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



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

suffered from depression

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

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

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

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

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

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

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

b) 7 day services to support discharge

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

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

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

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

c) Data sharing

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8) ENGAGEMENT

a) Patient, service user and public engagement

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

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

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

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

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

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

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

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

b) Service provider engagement

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

i) NHS Foundation Trusts and NHS Trusts

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

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

ii) primary care providers

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

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

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

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

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

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

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

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

c) Implications for acute providers

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

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

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

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

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

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

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

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

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

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