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	
By	Simon Banks
Position	Chief Officer
Date	17/09/14

Signed on behalf of the Council	
By	David Parr
Position	Chief Executive
Date	17/09/14

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Rob Polhill
Date	17/09/14

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.

Ref No	Page No	Document or information title	Synopsis and links
BCF 1	**4**	**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.
BCF 2	**8**	**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.
BCF 3	**4**	**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.
BCF 4	**33**	**CCG 5 year strategic plan**	Detailed plans by the CCG delivery of services and associated performance measures and efficiency targets.
BCF 5	**33**	**CCG 2 year operational plan**	Detailed plans by the CCG delivery of services and associated performance measures and efficiency targets.

BCF 6	**6**	**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.
BCF 7	**11**	**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.
BCF 8	**22**	**Complex Care Business Plan**	
BCF 9	**8**	**Joint Prevention and Early Intervention Strategy**	Strategy developed to establish a clear framework and rationale to support an increased shift to improving preventive and early intervention services in the borough.
BCF 10	**9**	**Telecare Strategy**	Two years into its five-year plan, Halton's Telecare strategy has been an undoubted success. Feedback from individual users' annual reviews (or those of their carers) has been very positive. The service has been able to expand to its present (2012) level of 250 individuals, with funding already in place (£170,000 per annum), for a further expansion and consolidation to 350 over the next two years (a total of £340,000 to cover staff and equipment). Data shows significant reductions in admissions to: hospital, long-term care and in re-admissions to hospital. There has also been an overall improvement in crisis intervention and an increase in the number of people supported at home.
BCF 11	**34**	**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.

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

Halton is a small Borough with high levels of deprivation and poor health indicators. We have known that in order to effect the change and improvements, each organisation cannot work in isolation but have to form integrated relationships at both strategic and operational levels. Within 5 years Halton will be a fully integrated system both from an operational and commissioning perspective. Throughout this plan we aim to see a reduction in A&E attendances and non-elective admissions and will further develop our urgent care system to deliver proactive, high quality, person centred care enabling the acute sector to deliver acute care. Community resilience will continue to play an integral part in building mental resilience and demonstrating a major shift in wellbeing and mental wellness. Preventative responses will be at the core of all our strategies which will improve our population's mental and physical wellbeing.

Central to this approach is the existing commitment to strengthen joint working arrangements between Halton Borough Council (HBC) and NHS Halton CCG. The aim of these arrangements is to work collaboratively together to achieve and sustain good health and wellbeing for the people of Halton. By working together and embracing Halton's vibrant community spirit and strong local pride our aim is to provide a range of options to support people in their lives by jointly designing and delivering services around the needs of local people and communities rather than focusing on the boundaries of our individual organisations.

In order to deliver a truly integrated approach to the commissioning and provision of services, Halton already has much of the architecture in place. Halton began its journey of integration back in 2003 with a pooled budget for intermediate care and equipment services and specific grants allocations. Since the inception of NHS Halton CCG in 2013, an extended pooled budget has been in place with Halton Borough Council incorporating adult social care community care budget and continuing healthcare. Governance, monitoring and performance management systems are already in place for this £31 million. This pool forms the basis of our Better Care Fund which will increase to £41 million for 2015/16 with the Better Care financial allocation. Attached at ***Annex 6*** is our Section 75 Joint Working Agreement which details the governance and financial arrangements and the desired outcomes.

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.

This vision is strategically underpinned by the Joint Health and Wellbeing Strategy (2012 – 2015) **Ref BCF 3**. The strategy sets the framework for the commissioning of health and wellbeing services in Halton with a particular emphasis on prevention and early intervention. This has been identified as an area of strategic focus for the BCF. The JSNA **(Ref BCF 1)** has been critical in the development of the JHWS, promoting a life-course approach to improving the general population's health and wellbeing. Priority areas in the Strategy and taken from the JSNA are:

- ***Prevention and early detection of cancer***
- ***Improved child development***
- ***Reduction in the number of falls in adults***
- ***Reduction in the harm from alcohol***
- ***Prevention and early detection of mental health conditions***

The Marmot report ***Fair Society Healthy Lives*** brought forward the best available global evidence on health inequalities. This report demonstrated that health is socially derived, from the conditions of which we are born, live, work and age. Taking this evidence Halton is making a concerted effort to work collaboratively to develop social responses to the health challenges we face as a borough. 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.

Underneath these priorities there are identified key areas of focus, including emergency admissions, dementia and frail older people. Use has also been made of the Atlas of Ambition and Commissioning for Value Tools to assist in setting common goals.

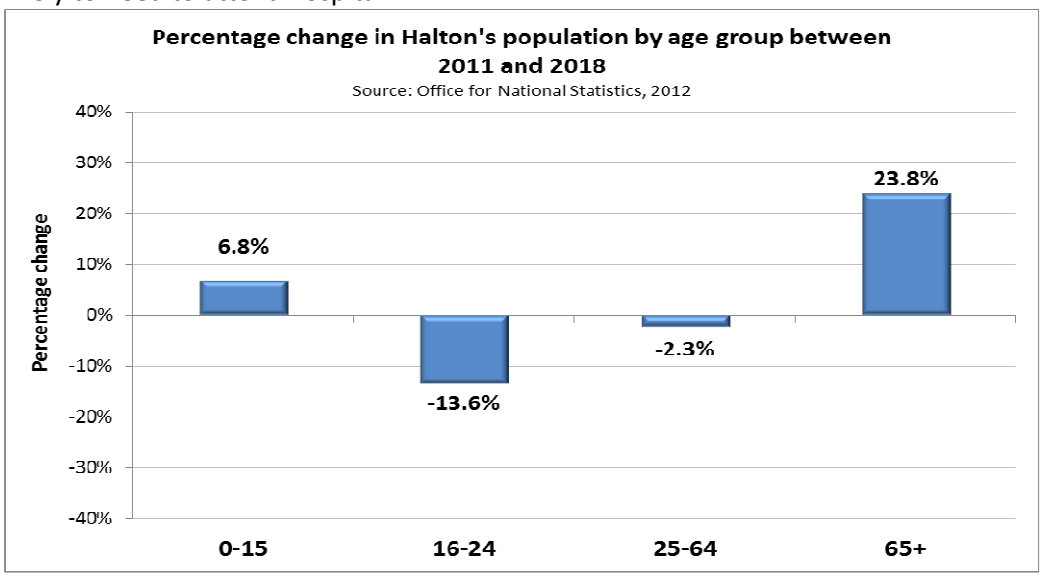
Understanding Current Need

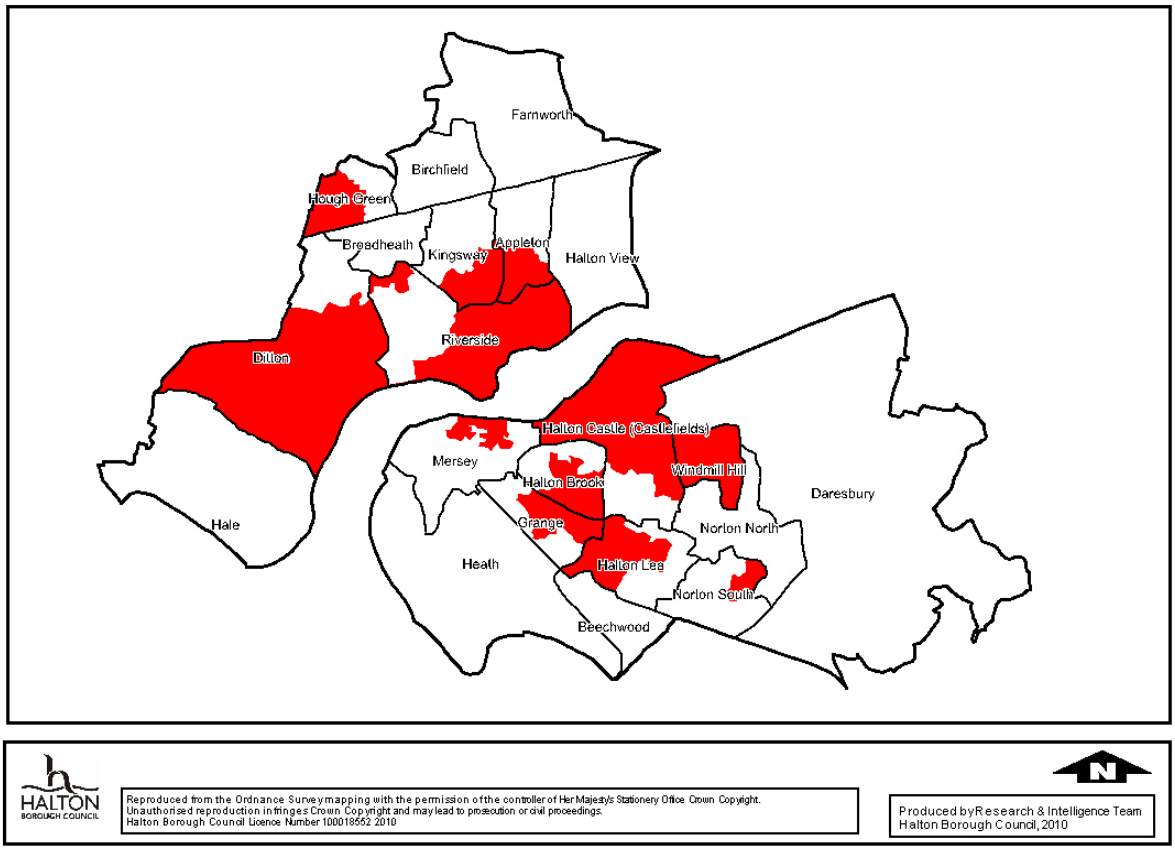
Our population of approximately 125,000 is centred on two towns with strong, supportive and active local communities. We have 17 GP practices with NHS Halton Clinical Commissioning Group (HCCG) co-

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 active third, faith and voluntary sectors. Whilst we have high levels of deprivation and challenging health outcomes we are seeing improvements in a number of key areas.

The above vision and ambition for transformation has been informed by our understanding the needs of individuals living within the Borough of Halton and by considering the key issues influencing the health and wellbeing of our residents. Halton Borough Council and NHS Halton Clinical Commissioning Group commissioned work from both i5 and Capita, to provide a detailed analysis of where opportunities existed for the Health economy in Halton to change and provide services which would deliver better outcomes and better value for money, and ensure that acute services are only used by people in acute need. The analysis highlighted that both A&E attendances and hospital admissions for certain conditions were the significant areas where opportunities for change existed.

Linking to that analysis work, the graph below shows how the population of Halton will change over the next 5 years. The Office for National Statistics predicts that there will be an increase of 23.8% in the population in those aged 65+. It is likely therefore, that there will be more demand on unplanned hospital and community care over the next 5 years as the evidence shows that older people are more likely to need to attend hospital.





Locally we developed an Urgent Care Strategy **(Ref BCF 6)** in 2012. This identified a number of key objectives for the Borough. As part of this work we gathered evidence from our residents and acute hospitals that indicated that 23% of the A&E attendances did not warrant acute care. In 2014/15 we are developing Urgent Care Centres in Widnes and Runcorn to provide real alternatives to A&E. Utilising GP and consultant oversight these will offer a central location for 7 day access to speedy diagnostics and the management of minor illness, minor injury and a range of ambulatory care conditions within the borough. Furthermore, these Centres will form a key resource for the delivery of 7 day access to primary medical care.

Another factor in looking at current need is deprivation. Halton is ranked 27th most deprived (out of 326 local authorities) nationally for overall Index of Multiple Deprivation (IMD) 2010. The regional position shows Halton as 9th most deprived out of 39 North West local authorities. The map below demonstrates the top 10% most deprived Lower Super Output Areas (LSOAs) nationally, that fall within Halton, equating to 21 areas (out of 79 in total). 26% of Halton's population live in areas that fall in the top 10% most deprived nationally.

Removing the boundaries between acute and community health services and aligning clinical pathways for ambulatory care conditions and specific chronic conditions will enable a seamless approach to patient care. The developing Primary Care Strategy and the redesign of community health and social care provision will enable multi-professional teams to be wrapped around cohorts of GP surgeries. This is supported by the use of Risk Stratification and clinical knowledge to identify people with complex care needs and those who frequently use services. This will support a targeted approach to delivering pro-active care.

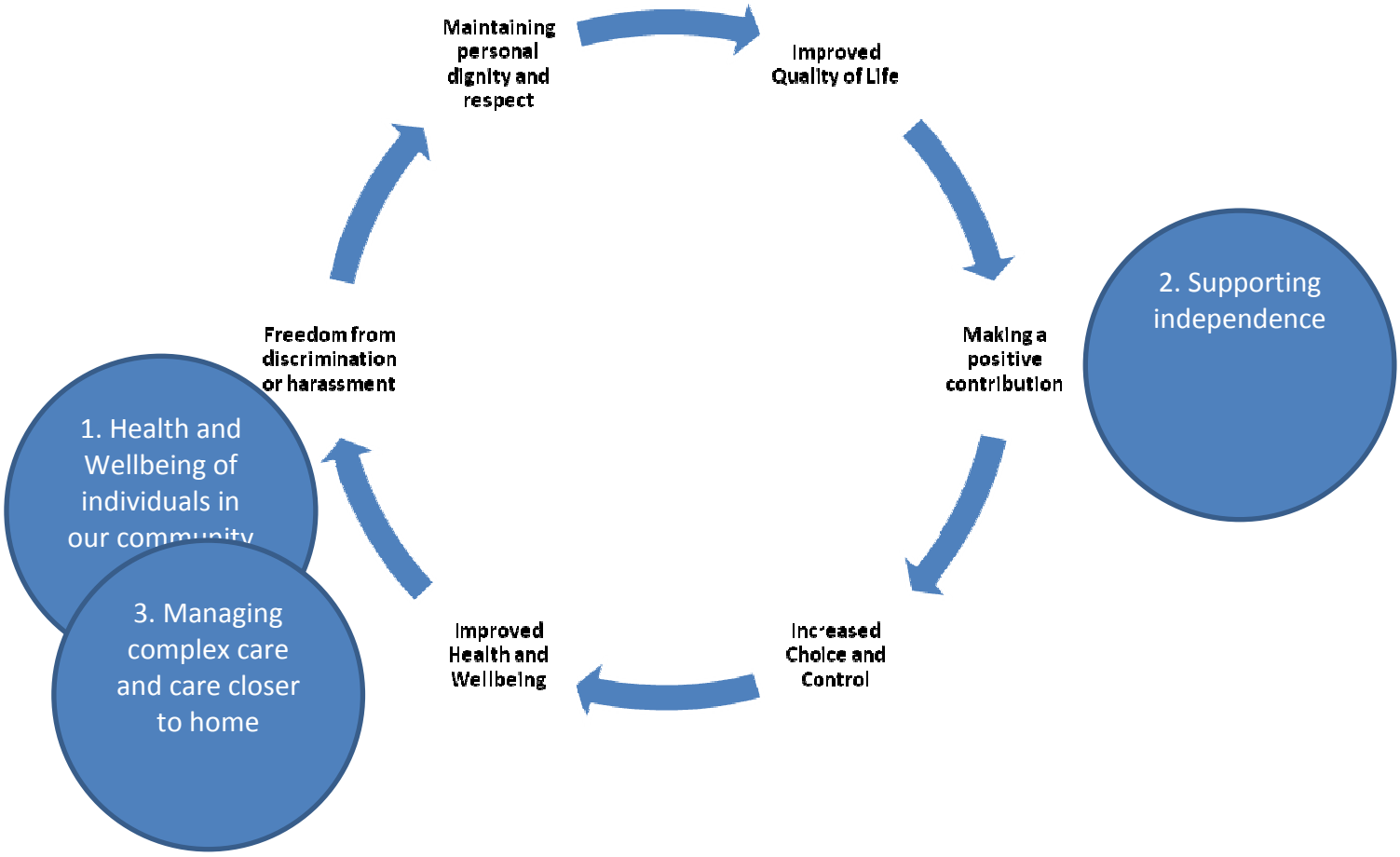
Local people will be at the centre of the assessment for and creation of the care and support they need. This will be achieved through the continued development of the health and social care market to deliver personalisation and innovative approaches to support self-care described in the Transformation

Programme below.

Transformation Programme

In delivering our strategic approach we have identified three core objectives for our transformational plan:

1. **Health and Wellbeing of individuals in our community**
2. **Supporting independence**
3. **Managing Complex Care and Care Closer to Home**



1. **Health and Wellbeing of individuals in our community**

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 (Ref BCF 2)*** 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.

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.

HBC and NHS Halton have developed a Joint Prevention and Early Intervention Strategy **(Ref BCF 9)** to establish a clear framework and rationale to support an increased shift to improving preventive and early intervention services in the borough. The document is a local response to the National picture and is informed by a number of National documents 'Making a strategic shift to prevention and early intervention – a guide' Department of Health (2008), 'Our health, our care, our say' (2006), 'Putting People First' (2007), 'Transforming Social Care (2008) and 'High quality care for all' ('the Darzi report', 2008). **(Scheme 15)**

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.

A central objective of this approach is the development of an integrated wellness service following a review of current wellbeing services. A wellness service could be described as a service (or system of services) that specifically aim to promote and improve health and wellbeing, in its widest, most holistic definition, rather than diagnosis and treat illnesses or their direct cause. The service would include healthy lifestyles interventions and/or psychosocial interventions for an individual, for families or groups. The approach will involve a combination of services and interventions such as smoking cessation, weight management, physical activity, alcohol brief interventions, social prescribing/referral, debt advice, welfare benefits, housing, legal advice, and psychological wellbeing interventions. The Better Care Fund will support this approach. **(Scheme 17)**

Work is ongoing with general practitioners to support their role in tackling health inequalities within the Borough through the Prevention and Early Intervention Strategy.

2. Supporting independence

HBC and NHS HCCG already have pooled budget arrangements in place to support people at home or within the community with various services to prevent more intensive intervention and to improve health gains. These intermediate care services focus on promoting recovery from illness, preventing unnecessary hospital admissions or premature admissions to residential care, supporting timely discharge from hospital and maximising opportunities for independent living. The Better Care Fund will continue to support these services and provide additional capacity.

Diversity of organisations and service delivery will reflect the complexity and diversity of needs within our community. Integration will be around pathways of support, care and treatment utilising case management approaches as needed to support individuals, families and communities to take control of their health and well-being. Where it is appropriate then organisational integration will be encouraged to improve such pathways. This will result in appropriate admissions to the acute sector.

Technology will be central to supporting people to improve and maintain their health and well-being, offering a range of platforms and sophistication dependent on intensity of need and desired outcomes. Consultation, assessment and intervention work by a range of health, social care and community practitioners will be focused around General Practice and associated neighbourhoods providing quick access to multi-disciplinary and multi-agency teams as determined by presentation and need. These will support into other community settings such as schools, community centres and housing schemes. This means more people can live independently and there will be fewer people admitted to care and residential homes. Where hospital care is unavoidable people will be able to transfer home without delay.

The Better Care Fund will support the development of, and contribute towards additional capacity to the following existing and new schemes:

i) Further development of the Integration of services and working together at all levels, such as the Multi-Disciplinary Team, Integrated Care in GP Practices. Timely return to the Borough from acute and specialist services will be enabled through network approaches to case management. Proactive case finding, long term condition management, monitoring systems and a range of alternatives for urgent care needs will be in place. This will support the transformation of the acute hospital sector and associated demand management issues **(Scheme 9).**

ii) Further develop our approach to Telecare and Telehealth interventions to support people to live as independently as possible within the community. Services will be tailored to individual needs and encourage a whole system/whole person approach to care, building on the Telecare Strategy **(Ref BCF 10) (Scheme 3).**

iii) Further development of an integrated approach to dementia care. This will allow a shift from traditional pathways and services that are rooted in an acute or clinical setting, to delivering a complete service from diagnosis in primary care to community and social care, voluntary sector and low-level health interventions **(Scheme 6).**

iv) Progress the whole system Model of Care for Adults with Learning Disabilities. The Model is focused on a stepped care approach, from mainstream health and community services to more intensive specialist support. The most effective intervention is offered with the aim of supporting the person in their own home and not being overly restrictive or intrusive **(Schemes 11 and 12).**

v) Develop our approach to Mental Health within primary care, enhancing the Council's Mental Health Outreach team by working directly with GP surgeries to identify people who may benefit from this service and therefore prevent relapse, a further priority will be extending the range of day services and work-related opportunities **(Scheme 10).**

vi) Progress the redesign of primary care. This will strengthen the GPs role at the heart of out of hospital care and supporting people to stay healthy by identifying people at risk of hospital admission including the introduction of a named accountable clinician. Support GP practices and other providers where appropriate to deliver services over and above their core contractual responsibilities (Local Commissioning Schemes – previously known as Enhanced Services). Develop a strategy for sustainable general practice services in Halton **(Schemes 1, 3 and 9).**

3. Managing complex care and Care Closer to Home

The multiple pathways and processes associated with the provision of services to Adults with complex needs are often duplicated and fragmented across Health and Social Care organisational boundaries; this presents challenges in achieving a whole system co-ordinated approach to the assessment and provision of services. The development of new pathways in addition to a pooled budget arrangement for all community care, including Intermediate Care, equipment and Mental Health Services enables Practitioners to work more effectively across those organisational boundaries, utilising the flexibility within the pooled budget to commission holistic services and to improve health gains. This will result in reduced need for emergency bed days and a reduction in lengths of stay in hospital where admission is unavoidable. Acute and specialist services will only be utilised by those with acute and specialist needs. Timely return to the Borough from acute and specialist services will be enabled through network approaches to case management and discharge between the acute areas and community services – a combination of push and pull through the acute/specialist systems. Proactive case finding, long term condition management, monitoring systems and a range of alternatives for urgent care needs will be in place. This will support the transformation of the acute hospital sector and associated demand management issues.

The Better Care Fund will be used to support this approach with the following new and existing schemes:

i) Support the development of 2 Urgent Care Centres providing new and expanded diagnostic services, medical and nursing capacity for the management of ambulatory and sub-acute conditions and minor illness and injury **(Scheme 1)**

ii) Expand existing Intermediate Care bed and community capacity to increase number of frail older people who can receive treatment, care and support as an alternative to hospital care **(Scheme 2)**

iii) Continue to develop the reconfiguration of both Adult Social Care and Community nursing teams, including aligning the teams around local GP communities to strengthen the capacity of the teams, and provide for greater opportunities to work more closely to deliver integrated care and better outcomes and health gains for people in the community. This reconfiguration will use Risk Stratification and pro-active care model to support people with complex needs and those who use services frequently **(Scheme 9).**

iv) Strengthen and expand the provision for those at risk of falls and injury in line with our Falls Prevention Strategy **(Ref BCF 7). (Scheme 5)**

v) Develop the Integrated care home support team to improve the range of healthcare interventions and services that currently are not easily accessible to people who live in residential and nursing homes. This will result in the improved health and well-being of residents of care homes **(Scheme 13).**

vi) Continue with the improvements in the Integrated Hospital Discharge Teams who provide assessment and care management to inpatients in two local hospitals and which reduces lengths of hospital stay. Proactive discharge planning takes place irrespective of whether the primary need could be described as a health or social care need **(Scheme 7).**

vii) Expand the capacity of an existing end of life care and support service to enable more people to feel confident in choosing to die at home **(Scheme 8)**

viii) Further develop the Integrated Safeguarding Unit to improve the delivery of a flexible and responsive multi-agency service, with a focus on the more complex cases within institutional settings and link this to the Quality Assurance Team covering all independent sectors providers of community health and social care services. This will ensure a renewed focus on the quality, effectiveness, efficiency and safety of this provision **(Scheme 13).**

ix) Expand the Mental Health Outreach Team in delivering focused interventions to people who may be at risk of being referred to secondary services. One social worker is already targeted at this group of people and the plan is to concentrate more resource in this area. This will enhance community based provision whilst supporting secondary care to focus on core service delivery **(Scheme 10).**

x) We have been working in conjunction with the 5boroughs NHS Foundation Trust to redesign

pathways around acute services, which have now been in place for one year. The emphasis is on preventing admissions wherever possible and adopting a recovery model to support those with more serious mental health problems. The Council's Mental Health social workers are co-located with colleagues from the 5boroughs NHS Foundation Trust and there is a multi-agency Mental Health Strategic Commissioning Board (NHS HCCG, HBC, 5boroughs and others) which oversees strategic developments. Current pressures include those upon acute beds in line with the national position, and continuing pressure upon the community care budget. We therefore intend to connect this work with the re-design of mental health primary care **(Schemes 6 and 10).**

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

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."

Performance Measures

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. We have 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"***.

Permanent Admissions to Residential and Nursing Care	Baseline 13/14	Planned 14/15	Planned 15/16
Numerator Population Figure	125 19,605	134 21,048	138 21,730

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. Therefore, by "maintaining" our rate of admissions, this is a "cost avoidance".

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 13/14	Planned 14/15	Planned 15/16
Numerator	2293	2293	2235

Our plan for 2014/15 is a 0% change and then a 2.5% reduction from 2015/16.

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.

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?

Over the next five years our focus will be on delivering changes to the way in which our local population have access to and experience health and social care services. We will expect and articulate through a variety of levers (contractual, performance, financial) the requirement for all health and social care providers to deliver integrated personalised pathways of care that cross organisational and professional boundaries.

Work is advanced on the development of our Urgent Care Centres where we have brought together two acute hospitals, community health provider, acute mental health provider, primary care and the GP out of hours provider to deliver these services collectively. We have also been working with two acute hospitals to support the development of clinically effective, safe and efficient provision of acute stroke care. These centres will deliver ambulatory care pathways, sub-acute trauma and medical services, minor illness and injury through this Urgent Care network approach linking medical, nursing, radiology, pathology, paramedic, social, intermediate and mental health care.

Key to delivering this future model is the development of the interoperability of IT systems to ensure seamless care across pathways where multiple organisations contribute to their delivery. **Scheme 14** will support this challenging agenda.

The Better Care Fund will contribute to delivering these new patterns and configurations of services by investing in areas where transitions and hand-offs between organisations and professional boundaries have a detrimental effect on health outcomes.

The precise pattern and configuration of services is difficult to predict. It is clear that there will be a continuing need for the existing expertise provided by acute and community services and this will increasingly be focussed on delivering treatment, care and support in and close to people's homes.

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 suggested:

"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.

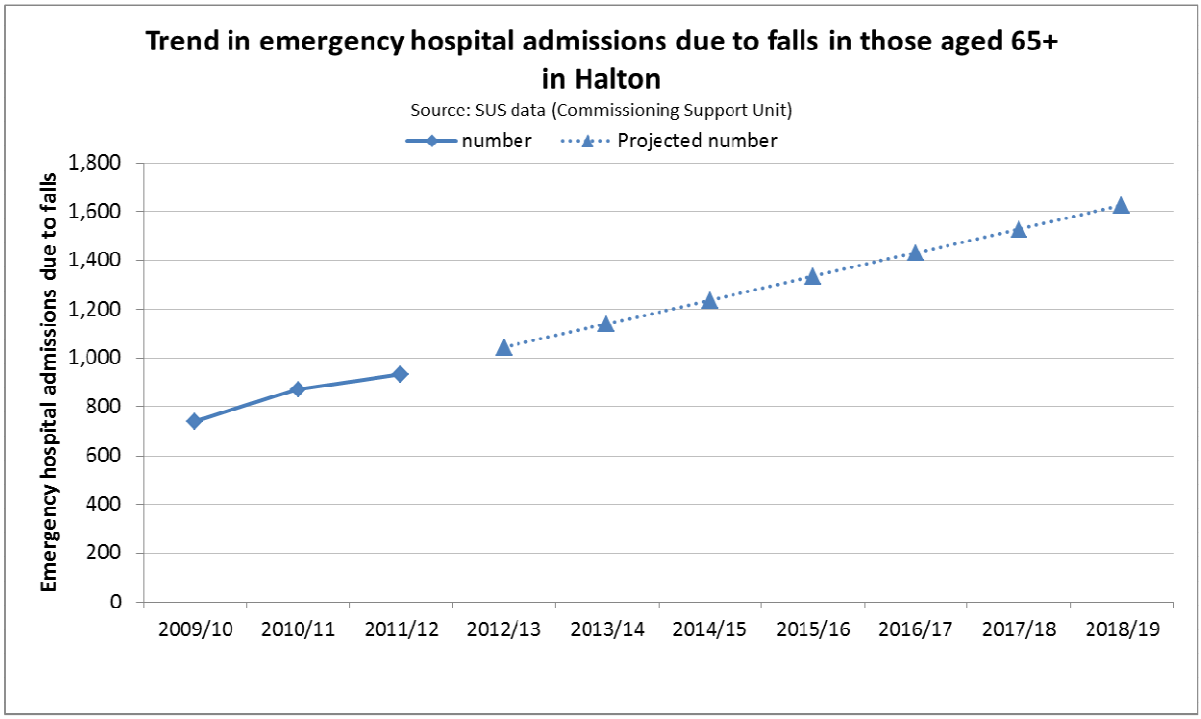
The i5 report focussed on how schemes across the whole health economy in Halton (including both the CCG and the Local Authority) would impact on specific patient cohorts with specific conditions with regard to hospital admissions and lengths of stay.

Overall both the i5 and Capita assessments give assurance that the Halton Health Economy's plans (2 and 5 year and draft BCF) were focussed in the right areas (deflect form acute care, focus on 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. This is reflected in how a large proportion of the BCF is focused on these areas.

The key statistics below identify some of the priority areas for the locality and again are reflected some of the core areas of the BCF

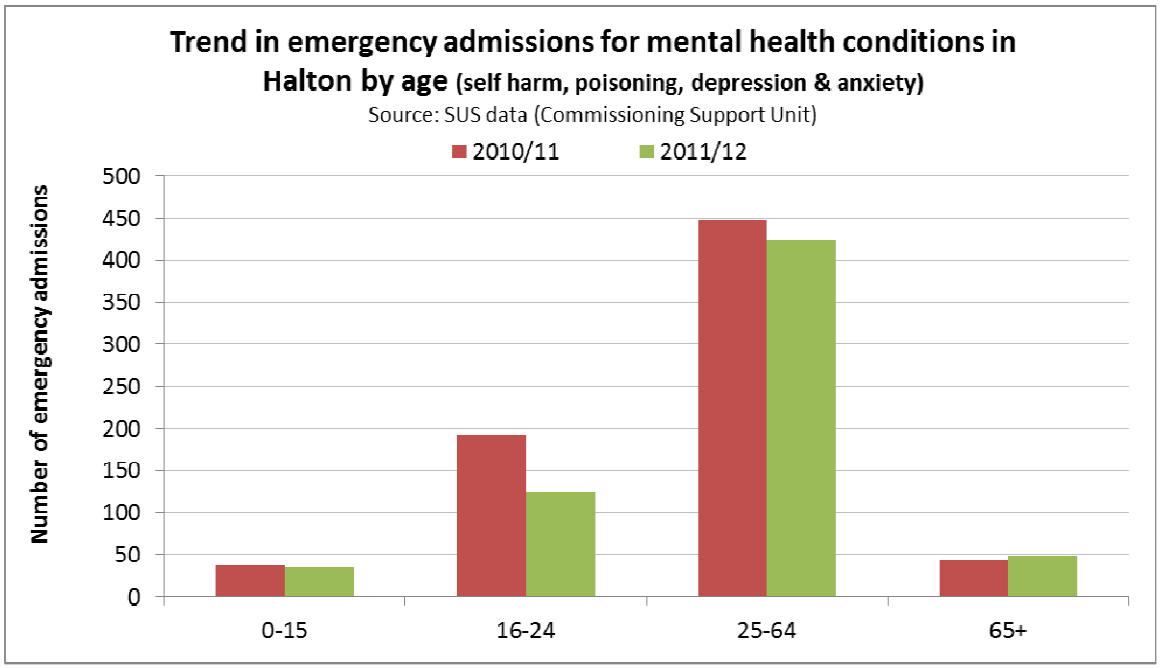
Falls and injuries

The chart below shows the trend in falls over the last 3 years, by age: emergency admissions for falls in those aged 65+ has increased each year, whereas the numbers for all other age bands have remained static or seen a slight decrease.

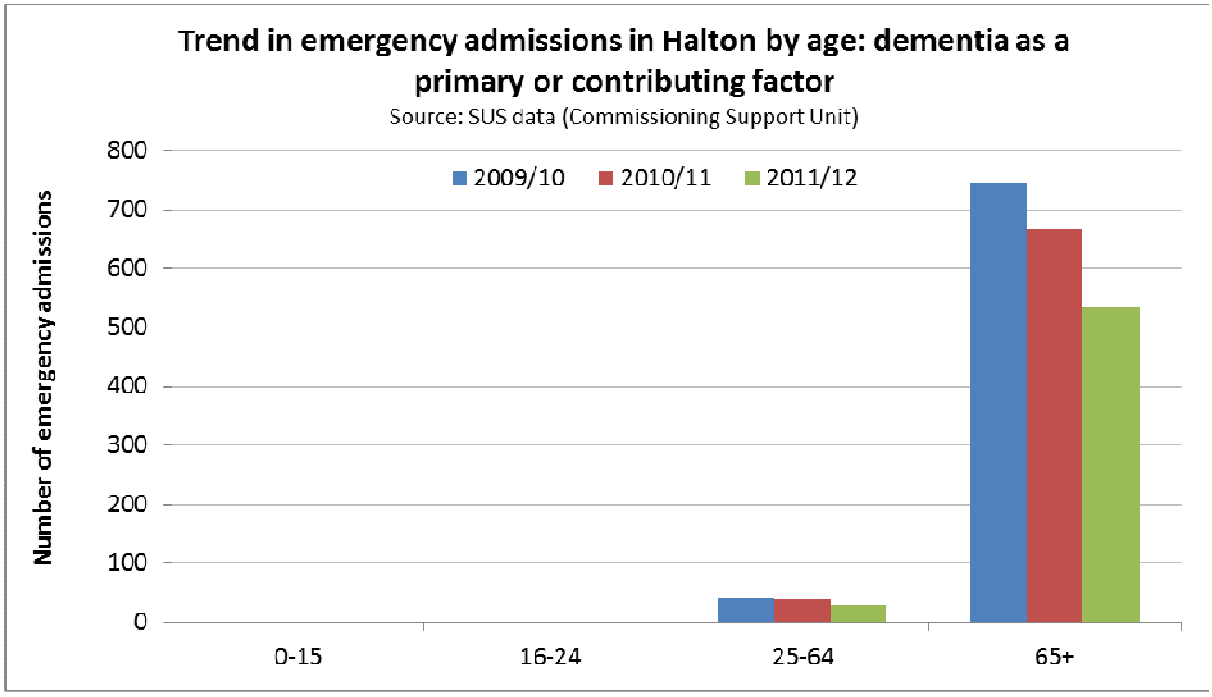


Mental Health

The number of emergency hospital admissions from mental health conditions have not seen much change over the last 2 years. The chart below shows that the majority are seen in those aged 25-64.



Emergency admissions for dementia and self-harm have decreased (where these are the primary reason for admission or a contributing factor).

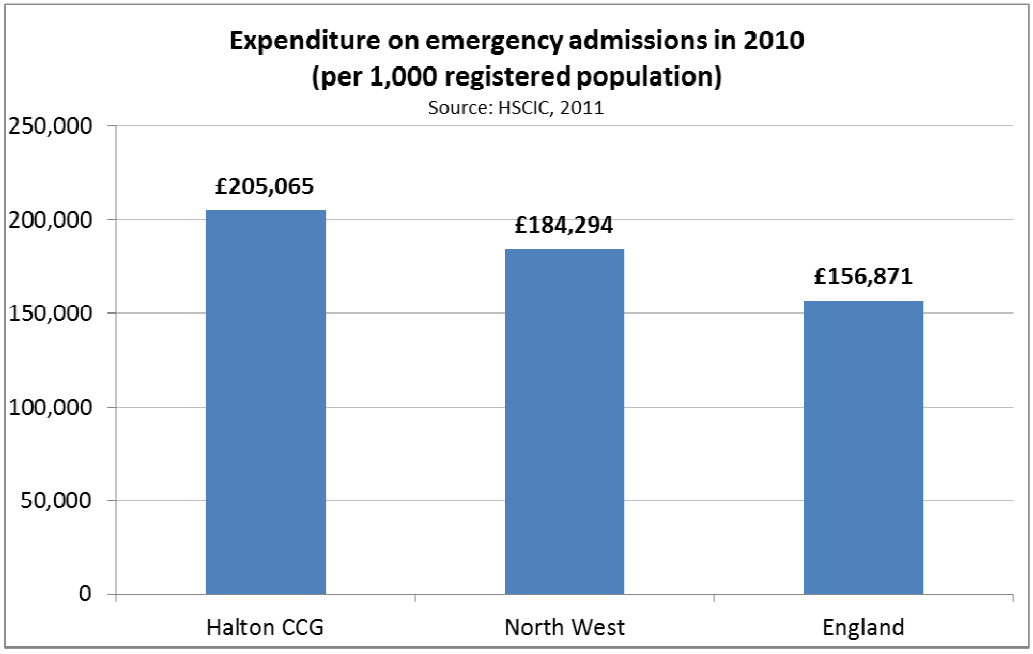


Dementia prevalence in those aged 65+: projection
Source: POPPI, 2012

	2012	2014	2016	2018
Population in Halton aged 65+ predicted to have dementia	1,229	1,256	1,314	1,421
Percentage change 2012-2018: 16%				

Cost

The latest comparable cost data available is for 2010. The chart below shows that Halton CCG spend more on emergency admissions than the North West and England averages, per 1,000 registered population.



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 below and details the overarching actions and key milestones associated with the delivery of our Better Care Fund plan. Within our plan of action and the schemes listed below, 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.

ACTION	MILESTONES	PROGRESS	RESPONSIBLE BOARD
Evidence Review	October 2013 – commence National and local evidence review	Complete	Better Care ECB
Consultation	October 2013 – Halton People's Health Forum (HPHF) January 2014 – HPHF January 2014 – HWBB consultation event January 2014 – NHS Halton CCG Governing Body February 2014 – Urgent Care Working Group Executive Board – March 2014 August 2014 – Service Resilience Group	Complete Complete Complete Complete Complete Complete Complete	Better Care Board for all
Engagement Plan with Acute providers	January 2015 – Develop engagement plan with acute providers		Service Resilience Group
Programme Development	February 2014 – commence programme development	Complete	Better Care ECB
Governance Arrangements	April 2014 review terms of reference May 2014 BCB sign off ToR	Complete Complete	Better Care ECB Better Care Board
Approval by Health and Wellbeing Board	August 2014	Complete	Better Care Board
Programme Implementation (New Schemes)	April 2015	See Working document (Annex 3) for detail	Better Care ECB
Performance Monitoring	November 2014 – finalise dashboard December 2014 – Ongoing monthly reports January 2015 – Ongoing bi-	Complete	Better Care ECB Better Care ECB Better Care Board

	monthly reports		
Programme Review	October 2015 – complete review November 2015 – report to ECB January 2016 – report to BCB		Better Care ECB Better Care Board

We also have a Working Document **(*Annex 3*)** that details both new and existing schemes within the BCF. This Working Document is used by the Better Care ECB to monitor progress with each scheme within the BCF. It is useful to note that some of the schemes are also 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 summary that describes the benefits that each scheme contributes towards. Schemes 1 – 9 are linked directly to the performance and finance associated with the 4 key metrics. Schemes 10 – 17 contribute to these but are not included in the Benefits section to avoid issues of double counting and over emphasis of performance.

Scheme Name and Number	**Benefits Summary**				
Project Description	Reduction in Non-Elective Admissions	Maintaining long-term care	Reduction in delayed transfers of care	Increased effectiveness of Reablement	Falls Prevention
1 – Urgent Care	✓				
2 – Intermediate Care	✓	✓	✓		
3 - Telecare	✓	✓			
4 - Carers	✓		✓		
5 - Falls	✓	✓			✓
6 – Dementia		✓	✓		
7 – Early Supported Discharge		✓	✓		
8 – Care at End of Life		✓	✓		
9 – Integrated Social Care and Health				✓	

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.

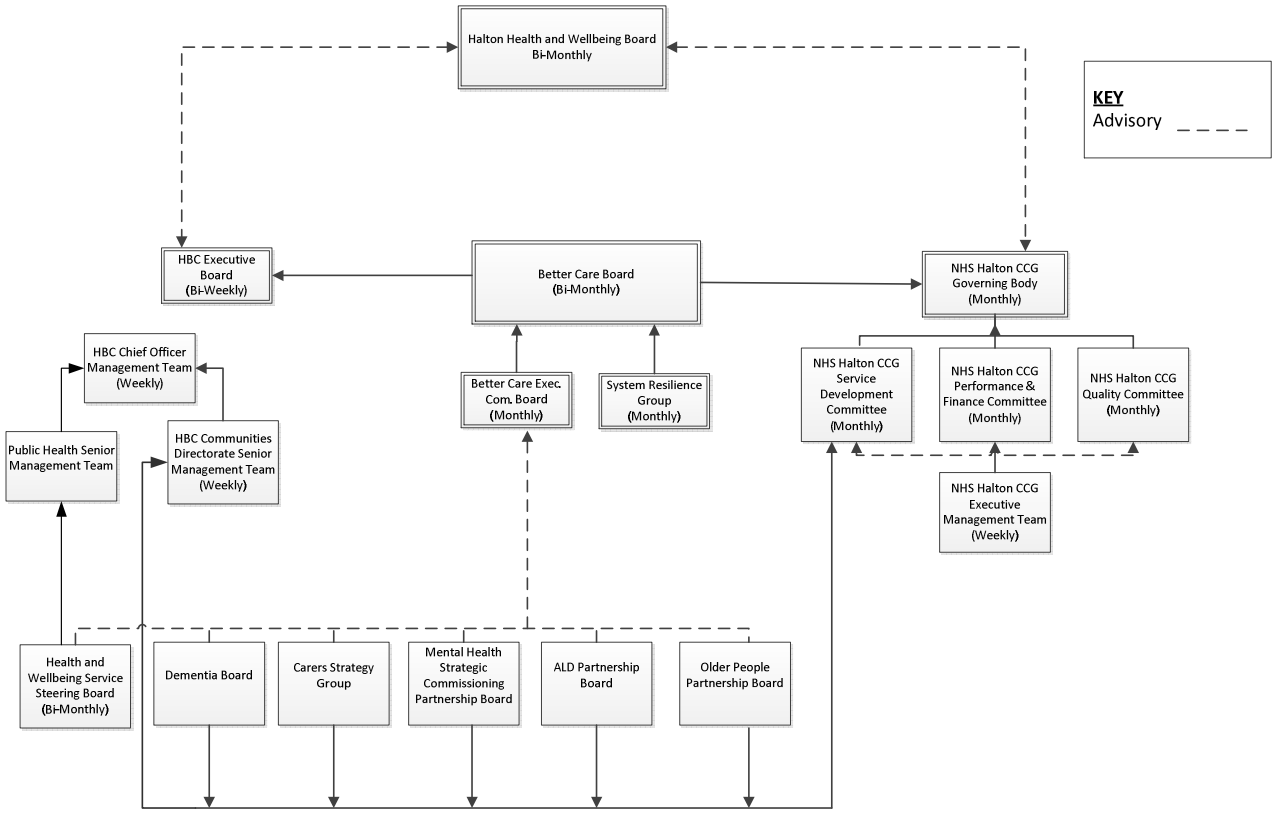
The diagram below shows the current governance structure outlining the key strategic partnership board/groups within Halton.

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.

Integrated Commissioning and Delivery Governance Structure



Governance Principles, as set out in the Section 75 current Joint Working Agreement (Annex 6) are:

i) Each Party will retain statutory responsibility for their respective functions carried out under the Pooled Fund arrangements and the activity of their employees in undertaking clinical and/or social care duties;

ii) The Parties have established a Complex Care Board (renamed Better Care Board) for the purpose of discharging their duties in relation to the commissioning and provision of Complex Care. The legitimacy of the Complex Care Board to undertake this role is derived from the Board's membership of Executive Members from the Parties (or their appointed deputies). The Board is not an autonomous body and does not therefore have legal status.

iii) Governance arrangements exist within the Parties to address the issues of clinical governance, public accountability and probity as well as satisfy HBC and NHS Halton CCG Standing Orders and Standing Financial Instructions. The Complex Care Board will discharge these duties on behalf of the Parties and report to the Executive Boards of the respective Parties.

iv) The Parties have established the Executive Commissioning Board (ECB) (renamed as the Better Care ECB) as the joint committee within the meaning of Regulation 10 (2) of the Regulations. The ECB will report to the Better Care Board.

v) Decisions of the ECB and/or the Pool Manager which are beyond their respective delegated authority limits or are inconsistent with the terms of this agreement would require the approval and ratification of the governing bodies of the Parties organisations.

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

The Better Care Executive Commissioning Board is responsible for the programme management, monitoring and evaluation of all the schemes and areas of work associated with the Better Care Fund (see also Action Plan Section 4). This is achieved through monthly performance and progress reports, consideration of new areas of work for development and financial monitoring of the pooled fund. The Better Care ECB reports to the Better Care Board which, in turn, reports directly into the Health and Wellbeing Board. This ensures that the integrated system is appropriately managed and that the resources available to both Health and Social Care, including the Better Care Fund, are effectively used in the delivery of personalised, responsive and holistic care linked to the key strategic objectives. Detailed terms of Reference for the Better Care ECB can be found at ***Annex 4*** and detailed terms of reference for the Better Care Board can be found at ***Annex 5***.

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 Working Document at ***Annex 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	**Urgent Care Centres –** During 2014/15 the existing walk-in-centre and minor injuries units will be developed into Urgent Care Centres with a Clinical Assessment Unit and assessment bed capacity. These will form part of a wider approach to the development of ambulatory care pathways dovetailing with the work in secondary and primary care. Coupled with this is the on-going development of 7 day working across community and social care.
2	**Intermediate Care –** The service builds a multi-disciplinary team around the individual based on their needs and key areas of work to be undertaken. Personalised treatment, rehabilitation and care plans are agreed with the person and their significant other. Where long-term services are required following this period of care these are arranged by the Multi-disciplinary team.
3	**Telecare –** The existing community alarm and telecare service will be expanded to deliver a larger number of specialist sensors in people's own homes.
4	**Carers –** The strategic objective of this scheme is to Improve the quality of life for carers' in Halton, and prevent or delay the need for care and support.
5	**Falls Prevention -** 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.
6	**Dementia -** 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.
7	**Early Supported Discharge –** Continue a range of integrated services designed to increase the effectiveness of the pathways through acute care using proactive approaches to case identification and improving access to services 7 days a week. Our local population utilise 2 acute hospitals and there are arrangements with acute providers, neighbouring boroughs and community health care provider to ensure seamless pathways irrespective of place of residence. Early supported discharge for stroke services have also developed across the 2 acute providers.
8	**Care At the End of Life –** Halton Borough Council Reablement service has been block contracted by CCG to provide 280 hours care per week. The aim of the service is to provide quality, flexible domically care to a person in their end stage of life in their own home.
9	**Integrated Social Care and Health –** The strategic aim is to deliver high quality, effective and efficient assessment, care and support planning for people with a wide range of health and social care needs.
10	**Integrated Mental Health Services –** This scheme aims to shift the focus of intervention of social care assessment and support services to a much earlier stage in the journey of a person with mental health needs, working directly with primary care services, the private and voluntary sectors and other key statutory partners to divert people from secondary mental health services, reduce the use of local acute hospital services, and support people currently in secondary mental health care to be discharged more quickly into the care of their local community services.
11	**Positive Behaviour Support Service (PBSS) –** The service takes a peripatetic lifespan approach working with individuals with Learning Disabilities and/or Autism that challenge services. All interventions are person centred taking account both the natural informal support and paid support. The service works across Halton and with individuals in out of borough placements. The aim of the service is to improve an individual's life opportunities and enable them to remain living within their own community and accessing local services.
12	**LD Nurses and Therapy Services –** Progress the whole system Model of Care for Adults with Learning Disabilities. The Model is focused on a stepped care approach, from mainstream health and community services to more intensive specialist support. The most effective intervention is offered with the aim of supporting the person in their own home and not being overly restrictive or intrusive, therefore ensuring people can live longer in their own home, reducing the need for long-term care and reducing the amount of non-elective admissions to hospital.
13	**Integrated Services and Quality Assurance -** To deliver a consistent, proactive, outcome focused approach to safeguarding adults with an increased emphasis on prevention and quality assurance. Building on the pilot work in 2013/14, develop and commission a model of support into care homes to improve access to treatment, care and support for all residents. Establishment of a Joint Quality Assurance Unit and aligning performance systems across health and social care.
14	**Information Technology Strategy –** This integrated strategy spans health and social care within Halton and will ensure that innovative technology is being utilised to improve communication, efficiency and data co-ordination across services.
15	**Prevention –** This scheme includes the: Delivery of the loneliness strategy; the development of an overarching advocacy hub that will act as a triage to all local advocacy services; the development of information and advice network that will help people access

	the relevant information that they need to maintain their own independence; and prevention services within the voluntary sector include home environment services.
16	**DFG and Equipment / Adaptations–** providing equipment and adaptations to enable people to remain independent.
17	**Integrated Wellness Service -** This proposal aims to further develop the joint delivery role into a single streamlined service called a wellbeing hub which will bring together the various strands of wellbeing and lifestyle services across Halton, recognise the current strengths of individually commissioned services and broaden the involvement and scope of the services though greater input from the third sector agencies also working on similar agendas through Halton.

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 highlights a number of high level risks that we have identified as being the most significant to the BCF and to integration as a whole based upon the schemes that form part of the BCF Plan an in relation to wider strategic and organisational challenges. In addition to this, the Section 75 Working Agreement at Appendix 6 includes the sharing of risks. The Working Document at Appendix 3 breaks down each scheme with details of responsible officer and Board, along with timescales.

There is a risk that:	**Associated schemes**	**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**	**Responsible Officer**	**Time-scales**
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 because emergency admissions continue to rise due to Halton's demography, impacting the overall funding available to support core services and future schemes.	2, 3, 5, 8, 10, 13, 14, 15, 18	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.	Chair of Better Care ECB – Operational Director for Prevention and Assessment, HBC	On a quarterly basis
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.	ALL	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	Operational Director for Prevention and Assessment, HBC	On a monthly basis

					temporary Principal Policy Officer has been recruited to lead on this. Regular reports to both the NHS Halton CCG and HBC on progress.		
Financial fragility because of the ongoing efficiencies across both HBC and the NHS Halton CCG could results in schemes not being implemented.	ALL	2	5	10	Work on-going to forecast financial situation and continue to identify efficiencies across both organisations. BCF Action Plan monitored regularly through the BC ECB and reported directly to the HWBB.	Chair of Better Care Board – Portfolio Holder for Health and Wellbeing, HBC	Monthly and quarterly basis
The required cultural change in the workforce across HBC and NHS Halton CCG does not take place due to unwillingness or inability to work across organisations could result in staff feeling isolated; anxious and worried; and a reduction in job performance.	ALL	2	3	6	Building trust through effective communication, shared values, equal opportunities and effective leadership is crucial to the successful development of integrated teams.	Chair of Better Care Board – Portfolio holder for Health and Wellbeing, HBC	Quarterly basis
Shifting of resources to fund new joint interventions and schemes will destabilise current service providers, particularly in the acute sector.	ALL	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. Providers are on Boards and contribute to decision-making.	Operational Director for Transformation, HBC and NHS HCCG	March 2015

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.	ALL	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.	Chair of Better Care ECB - Operational Director for Prevention and Assessment, HBC	On a quarterly basis
If we do not manage Communication carefully there is a risk that staff, public and stakeholders do not know what is happening, why and when. Relationships may suffer and have a negative effect on the implementation of the BCF.	ALL	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. • Engagement plan set to include all relevant providers and acute trusts • 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.	Operational Directors for Transformation and Prevention and Assessment, HBC and NHS HCCG	Bi-monthly basis March 2015 March 2015
Failure with Information Governance, including informed consent to share	18	2	3	6	• Regularly monitor this project to ensure it is on	Divisional Manager for	March 2015

information across HBC and the NHS Halton CCB would undermine potential IT solutions					track and report progress to the BC ECB.	Service Improvement, HBC	

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

HBC and the NHS Halton CCG have in place a Section 75 Joint Working Agreement **(Annex 6)** and as part of that undertake to share the risks jointly in Complex Care. One of the main roles of the Better Care Board is to ensure that any on-going risks associated with the process which might impact on the success of the agreement are identified and appropriate risk control measures established to mitigate against them.

The Better Care Board Performance Framework **(Annex 7)** incorporates a number of measures which help provide assurances to the Better Care Board that necessary outcomes are being met. 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.

The framework is divided into three areas, as follows :-

- Section 1 links directly to relevant indicators contained in the National Outcome Frameworks both Adult Social Care and Health
- Section 2 contains a number of local Performance measures; and
- Section 3 outlines a number of local indicators which are intended to provide assurances to the Board in respect of both the quality and safety of care.

Although performance is closely monitored on a monthly basis by appropriate officers, the information is reported through to the Better Care Board formally on a quarterly basis and a key issues report from the NHS Halton CCG Governing Body to the Better Care Board on a regular basis.

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) Commissioner and Acute Provider Risk Sharing

NHS Halton CCG is an associate commissioner to the NHS contracts held with the NHS Trusts which provide services to the Halton registered population. All providers have a Contract Review process in place which review and assess the risk of contract over performance. Halton CCG engages in this process and works with the relevant coordinating commissioner to mitigate the financial risks associated with contract variation and the overall financial viability of the Trusts.

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.

Some of the above will be delivered through the following initiatives:

Redesign of health and social care teams - Halton has been developing an integrated model for community health and social care over the past 12 months involving adult social care, community nursing, community therapy, health and wellbeing services and general practice. The emerging model has a focus on case identification, early intervention, management of people with complex needs and/or frequent use of services. Initial assessment leads to focussed intervention work by an appropriate multi-disciplinary team with regular case review. Where appropriate, short term care and support is used to prevent deterioration and improve health, social and psychological functioning. Where long term needs are identified then the integration of the continuing healthcare assessment nursing team into social care enables a focus on robust personalised support planning across health and social care needs and the joint commissioning of services.

Redesign of Mental Health pathway for adults and older people - This scheme aims to shift the focus of intervention of social care assessment and support services to a much earlier stage in the journey of a person with mental health needs, working directly with primary care services, the private and voluntary sectors and other key statutory partners to divert people from secondary mental health services, reduce the use of local acute hospital services, and support people currently in secondary mental health care to be discharged more quickly into the care of their local community services.

GP Redesign - In response to NHS England's 'A Call to Action' and to inform the challenges facing general practice and provide a sustainable future for membership practices, NHS Halton CCG has begun working with its member practices and key stakeholders to undertake a review of its services and their sustainability. To meet the increasing challenges faced, there is a need to reshape the range of services offered within general practice, thereby enhancing the sustainability of practices whilst preserving the local roots of general practice that are valued highly by patients. The strategy describes how Halton CCG is working with its partners and the public to develop and commission standardised high quality General Practice that balance the benefits of organisational scale with preservation of the local nature of general practice. The following ten principles are emerging and considered fundamental to the future design, configuration, commissioning and delivery of local General Practice:

- Commissioning and delivering consistent high quality care for every local resident;

- Care continuity for patients with Long Term Conditions;

- Reducing unwarranted variation;

- Strong local clinical leadership;

- Embracing the opportunity to offer services at scale, delivered locally to individual people;

- High levels of population and patient engagement;
- Commissioning and contracting for outcomes, not inputs or processes;
- Services working in greater collaboration in the community as multi-disciplinary teams of care professionals working together;
- Improving access to all services and better coordination of care pathways;
- Focus on prevention.

To achieve this, it is proposed that a new model is established with community services centred around people, ensuring everyone's needs are met through an integrated health and social care delivery model. This will see GP practices working together, in a much more integrated way with Community, Mental Health and Wellbeing, Social Care, Urgent Care, Voluntary Sector and Pharmacy services all wrapped around local delivery points. It is proposed that the model will see services and teams aligned to community 'hubs'. Each 'hub' will determine how to best configure itself to meet the needs of its local population. This includes service delivery, governance, population engagement, performance management and strategic planning. It is recognised that in certain circumstances, it will be advantageous to continue to commission and deliver services across the whole borough of Halton, however, this will be for each 'hub' to determine and influence.

Links to Housing

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.

Personal Budgets

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 **(Ref BCF 4)** 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 **(Ref BCF 5).** 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 NHS Halton CCG Plan on a Page below is taken from its five year integrated plan and building upon its two year operating plan summaries how the BCF is already an integral part of our vision.

Local Government Planning documents

Local Government Planning documents that the BCF plan aligns with are:

- Joint Health and Wellbeing Strategy **(Ref BCF 3)**
- Halton's Corporate Plan
- Communities Directorate Business Plan
- Market Position Statement **(Ref BCF 11)**
- Commissioning Strategies covering all areas, such as, Mental Health, Carers, etc.

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

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

Outcome Ambition 1 - Securing additional years of life for the people of Halton with treatable mental and physical

Outcome Ambition 2 - Improving the quality of life for people with long term conditions by 8%

Outcome Ambition 3 - To reduce the number of avoidable emergency admissions to hospital by 15%

Outcome Ambition 4 - To Increase the proportion of people living

Outcome Ambition 5 - To Increase the number of people having a positive experience of hospital

Outcome Ambition 6 - To increase the number of people having a positive experience of care

Outcome Ambition 7 - To reduce hospital avoidable

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

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

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

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

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

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

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

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

Governance

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

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

Sustainability

NHS Halton CCG faces a 'do nothing' 5 year finance gap of £46m. For the health economy to be sustainable the goals are:

-All organisations within the health economy are financially viable in 2018/19
-System objectives are achieved
-Long term reduction seen in A&E activity
-Long term reduction seen in inappropriate non-elective admissions into secondary care

System Values and Principles

- Partnership
- Openness
- Caring
- Honesty
-Leadership
- Quality
-Transformation

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.

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.

The BCF has an allocation of £1,756,000 for protecting eligibility criteria in social care. Additional funds of £1,167,000 are identified in the Integrating Social Care and Health scheme 9 to provide additional resilience across the system.

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 long term social care provision
- Developing integrated 7 day services
- Allowing additional capacity to develop services and improve efficiency

Investment in the following areas will support a reduction in the need for long term social care provision and improve the effectiveness and efficiency of existing services.

Integrated H&SC teams - Halton has been developing an integrated model for community health and social care over the past 12 months involving adult social care, community nursing, community therapy, health and wellbeing services and general practice. The emerging model has a focus on case identification, early intervention, management of people with complex needs and/or frequent use of services. Initial assessment leads to focussed intervention work by an appropriate multi-disciplinary team

with regular case review. Where long term needs are identified then the integration of the continuing healthcare assessment nursing team into social care enables a focus on robust personalised support planning across health and social care needs and the joint commissioning of services.

Intermediate Care – Investment here will enable increased capacity to deliver timely short-term health and social care interventions to prevent further deterioration and improvement in self-care and independence.

Preventative Services – The service areas will support delaying the need for high cost complex care interventions.

Joint Quality Assurance - The team will proactively monitor the contracts funded through social care, continuing care and funded nursing care budgets drawing in clinical expertise as required. The team will support providers to develop systems that monitor the quality and safety of the care delivered. The team will utilise a range of tools including site visits and service user feedback to ensure high quality safe care is delivered providing assurance to the local authority, CCG and the CQC.

Integrated Adults Safeguarding Unit – The unit was established in 2011 to deliver a consistent, proactive, outcome focused approach to safeguarding adults with an increased emphasis on prevention and quality assurance. The model also serves to support all partner organisations and care management teams within the Local Authority involved in safeguarding adults by reducing the impact on these services, enabling them to prioritise other work streams.

Care Homes Teams - Building on the pilot work in 2013/14, the care homes team project aims to develop and commission a model of support into care homes to improve access to treatment, care and support for all residents. This will incorporate 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.

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**. £1.7M is for protecting ***Eligibility Criteria*** and the remaining funds are used to maintain current social care services. 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 in the BCF for commissioning carer specific support services is **£495,000**, although there is further funding for carers which sits outside of the BCF.

The pooled funding will be used in three ways:

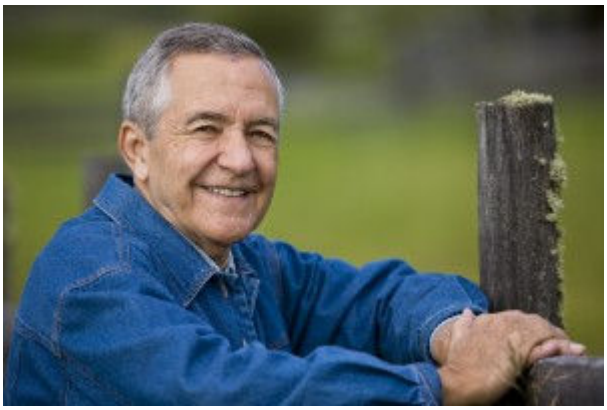
- To provide a budget for carers direct payments following assessment
- To re-design support services at Halton Carers Centre
- To widen the scope and availability of activities and peer support for carers in the Borough

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

Acute trusts are commissioned by neighbouring CCGs. Work is ongoing with both these CCGs, LAs, and the acute trusts on delivering a full package of health and social care services to support daily senior review and services for discharge. Intermediate care services already operate 7 days a week for both admission avoidance and hospital discharge. The CCG are developing their primary care strategy, a strand of which will address the need for primary care services 7 days a week. This ties in with the provision of medical services through the urgent care centres 7 days a week from 08:00 to 22:00. It is not clear at this point what the full impact of providing a similar level of service across 7 days a week will be. Initial work at St Helens and Knowsley Trust has demonstrated improvements in inpatient care and outcomes linked to daily senior review. Data from this trust also suggests that the weekly total of discharges remains static, but is more evenly spread across 7 days. Further evaluation is required as will continue to implement 7 day services. Data sharing - social care is the only outstanding partner who do not routinely use NHS number. Work is underway to modify the Carefirst 6 system to require an NHS number as a unique identifier. This will improve the available information across partners for the management of people with complex care needs utilising the multi-agency proactive care model in primary care.

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.

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 uses the COIN network system and NHS.UK and is 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 is 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.

ii) 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.

Information Governance leads from all partner agencies are located within the respective IT departments. These are the same people that are developing the information sharing approaches across the different IT networks.

Caldicott 2 has recently been released and the Local Authority is working through the document to ensure compliance across all appropriate areas of Council. Full compliance with Caldicott 2 and the associated

Information Governance and Data Protection Act controls will be achieved by **1st April 2015**.

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.

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 carer's 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. The lead professional will co-ordinate the treatment, care and support with the patient and organise regular reviews.

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

2% of each practice population has a care plan as per NHS recommendations. 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.

Making It Real

Making It Real is a crucial concept in ensuring patients and service users have their say, which Halton has taken on board. On Wednesday 4th June 2014, HBC held a 'Making it Real: Live' event at the Select Security Stadium, Widnes in order to check on the progress in working towards personalisation within Halton, linking in to many of our schemes. Attendees included people who access adult social care services, carers, council staff, user-led organisations and the health and voluntary sectors, including Healthwatch, Halton Speak Out, Halton Disability Partnership, European Lifestyles, Halton Carers Centre, 5 boroughs partnership, residential and nursing home providers and Age UK. Making it Real is built around 'I' statements, which express what people who actually use adult social care services want to see and experience. Our ambition is to support people towards these statements:

1. ***Information and advice: having the information I need, when I need it***

    a. "I have the information and support I need in order to remain as independent as possible."
    b. "I have access to easy-to-understand information about care and support which is consistent, accurate, accessible and up to date."
    c. "I can speak to people who know something about care and support and can make things happen."
    d. "I have help to make informed choices if I need and want it."
    e. "I know where to get information about what is going on in my community."

2. ***Active and supportive communities: keeping friends, family and place***

    a. "I have access to a range of support that helps me to live the life I want and remain a contributing member of my community."
    b. "I have a network of people who support me – carers, family, friends, community and if needed paid support staff."
    c. "I have opportunities to train, study, work or engage in activities that match my interests, skills, abilities."
    d. "I feel welcomed and included in my local community."
    e. "I feel valued for the contribution that I can make to my community."

3. ***Flexible integrated care and support: my support, my own way***

    a. "I am in control of planning my care and support."
    b. "I have care and support that is directed by me and responsive to my needs."
    c. "My support is coordinated, co-operative and works well together and
    d. I know who to contact to get things changed."
    e. "I have a clear line of communication, action and follow up."

4. ***Workforce: my support staff***

    a. "I have good information and advice on the range of options for choosing my support staff."
    b. "I have considerate support delivered by competent people."
    c. "I have access to a pool of people, advice on how to employ them and the opportunity to get advice from my peers."
    d. "I am supported by people who help me to make links in my local community."

5. ***Risk enablement: feeling in control and safe***

    a. "I can plan ahead and keep control in a crisis."
    b. "I feel safe, I can live the life I want and I am supported to manage any risks."
    c. "I feel that my community is a safe place to live and local people look out for me and each other."
    d. "I have systems in place so that I can get help at an early stage to avoid a crisis."

6. ***Personal budgets and self-funding: my money***

    a. "I can decide the kind of support I need and when, where and how to receive it".
    b. "I know the amount of money available to me for care and support needs, and I can determine how this is used (whether it's my own money, direct payment, or a council managed personal budget)."
    c. "I can get access to the money quickly without having to go through over-complicated procedures."
    d. "I am able to get skilled advice to plan my care and support, and also be given help to understand costs and make best use of the money involved where I want and need this."

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 Strategic 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. Terms of reference for the group can be found at **Annex 8**.

The ***Service Development Committee*** consists of CCG Commissioning Managers and all GPs within the area and 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.

Our BCF Plan is aligned to neighbouring local provider plans for 2015/16. Local acute providers are fully committed members of Halton's System Resilience Group (described above in 8 b) ii)) and during August 2014 all provider plans were shared and discussed to ensure they are consistent with the BCF plan.

An extract from the minutes of that meeting on 19th August states *"It was agreed for future planning as a whole there needs to be a proper understanding of the demographic footprint. Key to this is the Urgent Care Centre development and the impact this will have. The reduction in short term admissions and the shift away from primary care services into secondary care services in the community will also have to be factored in to future plans. There will be substantial financial implications to be considered. They will need to ensure that projects being commissioned will deliver and sustain the population base over the next 3 to 4 years and consider what will be the longer term implications if substantial resource is invested now to certain arears what will be the impact of this down the line say in ten or twenty years' time. It will require working at a high level to get it right. Any plans will have to link to public health data to obtain a clear understanding of the needs of the population and what it requires to deliver. An understanding of the greatest cause of loss of life for example there is a high number of people dying with respiratory related illness in Halton. The rapid rise in population in the Borough will be a major factor."*

Based on the above implications for the Acute Sector, the main metrics the BCF is focussed on is around the non-elective admissions. There are also other contributing factors towards this metric that do not form part of the BCF. 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)	4,200	4,034	3,951	3,981

The figures above equate to a 3.5% 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 £883,570 which links in with the HWB Benefits Plan on Tab 4 of Template 2 for 2015/16.

In terms of the benefits, owing to the fact that the majority of schemes will only become fully funded and operational in 2015/16 the majority of the benefit will also be seen in this financial year, a small amount of benefit is expected to be seen in Q4 2014/15 and so falls within the 2015 calendar year so is included in these calculations, conversely a larger amount of benefit is expected in the final quarter of 2015/16 which falls outside of the 2015 calendar year calculation for the BCF. The overall impact of this is that the full benefit of the schemes detailed for 2015/16 will not be reflected in the benefits calculated for the calendar year 2015.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
1
Scheme name
Urgent Care Centres
What is the strategic objective of this scheme?
Attendance at A&E and non-elective admissions rose from 2009/10 to 2013/14 though the rate of increase has been declining. Utilisation of primary care is high. The options for the local population to access Urgent Care are limited in the borough with an existing nurse led minor injuries unit in one town and a nurse led minor illness / walk in centre in the other. The Halton Urgent Care Strategy places the development of effective and efficient services within the borough to meet the local populations urgent care needs at the centre of its intention. Additional resources from the Better Care Fund will support the development of an existing project that will convert a Walk in Centre and a Minor Injuries Unit into 2 Urgent Care Centres. These centres will deflect A&E attendances and non-elective admissions from 2 acute hospitals
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
During 2014/15 the existing walk-in-centre and minor injuries units are being developed into Urgent Care Centres with a Clinical Assessment Unit and assessment bed capacity. These will form part of a wider approach to the development of ambulatory care pathways dovetailing with the work in secondary and primary care. Both Centres will have x-ray, ultra-sound and access to urgent pathology from 08:00 – 22:00, 7 days a week. A dedicated medical team will work in both centres. Additional nursing staff are being recruited to strengthen existing numbers and skill mix. Both centres will be kite-marked with North West Ambulance Service enabling conveyance by paramedic staff rather than to A&E. Pathways are being developed to establish rapid intervention from a range of health and social care community services to assist flow through the centres

The patient cohort will be older people, adults and children with minor injuries, minor illnesses, sub-acute trauma and a range of ambulatory care conditions. The centres will mange people who walk in and those referred by health care professionals

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

This scheme is the responsibility of the System Resilience Group and the Operational Directors for Transformation and Prevention and Assessment.

The Urgent Care Centres are being developed via a partnership/collaborative approach. Warrington and Halton Hospitals NHS Foundation Trust are leading on the implementation of the Urgent Care Centres through a project board. The Trust has brought together all key partner organisations to achieve this shared vision for urgent care provision in Halton. The key stakeholders are: St Helens and Knowsley Teaching Hospitals NHS Trust, Bridgewater Community Healthcare NHS Trust, North West Ambulance Service, Urgent Care 24(Out of hours GP provider), 5 Boroughs Partnership Foundation Trust, Adult and Children social care. Robust management and governance arrangements are in development between the respective partners

Ambulatory care pathways have been developed covering 13 adult and 5 children conditions. More will be developed as the centres become operational.

The management of minor illnesses, minor ailments and sub-acute trauma have been strengthened with training and development from both acute hospitals clinical teams.

The centres will manage patients that walk in as well as those conveyed by paramedic ambulance and those referred in by other health professionals.

The SRG have developed a Performance Dashboard which provides details of all the elective and non-elective Key Performance Indicators (KPIs). This Dashboard contains indicators which will allow Halton to assess the impact that the Urgent Care Centres are having on the health economy once fully operational.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

<u>Design of the Scheme</u>

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.

A number of options were considered for the delivery of an urgent care model within Halton. The model chosen, following extensive consultation with both professionals/clinicians and members of the public, was to create an Urgent Care Centre

on the site of the current Minor Injuries Unit in Runcorn and enhance the services currently provided at the Walk in Centre at Widnes, in effect providing a parity of services across both Runcorn and Widnes.

Corby CCG have developed a very similar model to NHS Halton CCG's model of Urgent Care, a published article[1] of the scheme demonstrates that such a scheme reduces both A&E attendances and Non-Elective admissions, A&E attendances have almost halved and there has been a 27% reduction in adult 24-hour admissions.

The centres have also been designed with reference to developing national guidance on the commissioning of Urgent Care Centres as part of the national review of urgent care.

Assumptions on Impact and Outcomes

Local work undertaken reviewed those people who attended A&E with a low HRG and were subsequently admitted for zero or one day. This equated to 1836 over 12 months for people who attended between 08:00 and 22:00 seven days per week. This work identified key ambulatory pathways and correlated with the analysis from i5 and Capita.

Given the new development of the centres we confidently project that the UCC's will deflect:

30 non-elective admissions in 2014/15 – low number due to phased implementation

401 non-elective admissions in 2015/16

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

2014/15	**2015/16**
£50,000	**£640,000**

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The key additional benefits to redesigning urgent care services in Halton include the:-

- Provision of a service that meets with patient needs, either through immediate treatment or by arranging future appointments with an appropriate service;
- Provision of an urgent care service that is accessible for the local population;
- Provision of a service that caters for both minor injury and illness;
- Improvement of performance by streaming patients into the appropriate service (i.e. reduction in A&E attendances and NEI admissions);
- Provision of a service that is safe and of high quality;
- Provision of access for harder to reach groups of people (e.g.: working men aged 18 -49)
- Additional medical capacity outside of an acute hospital 7 days per week

[1] http://www.pulsetoday.co.uk/how-we-reduced-emergency-admissions-through-an-urgent-care-centre/20004077.article

Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
During the first 12 – 18 months of operation, a full evaluation of the effectiveness of the Centres will be conducted to inform the configuration of services from the Urgent Care Centres in the future. This will include analysis of usage and outcomes, impact on primary and secondary care. This will be reported through the System Resillence Group to the Better Care Board
What are the key success factors for implementation of this scheme?
Key factors include: • Partnership/collaborative working arrangements in place; • Appropriate funding in place; • Appropriate infrastructure in place, e.g. buildings, workforce, IT, etc.; • Effective communication and marketing strategy in place to ensure people in Halton use the services available.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
2
Scheme name:
Intermediate Care
What is the strategic objective of this scheme?
Halton has an ageing population with the proportions of older and the very old populations projected to increase above the national rate and that of the North West. Non-elective admissions and length of stay within acute care for older people are higher due to comorbidity. Older people can often need longer to recover from illness and injury and require varying levels of support to maintain and improve function and self-care ability. Intermediate Care services within the borough are designed to: 1) Reduce reliance on and use of, secondary care for frail older people through admission avoidance and early supported discharge 2) Provide comprehensive assessment to manage current and future risks such as falls
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The service is able to meet the needs of people with complex, chronic conditions, sub-acute, rehabilitation and reablement needs; this includes people with physical, mental and learning impairment. The service is provided in a range of settings including dedicated sub-acute (22 beds) and residential (19 beds) establishments as well as in people's own homes. The service builds a multi-disciplinary team around the individual based on their needs and key areas of work to be undertaken. Personalised treatment, rehabilitation and care plans are agreed with the person and their significant other. Where long-term services are required following this period of care these are arranged by the multi-disciplinary team. The access criteria includes the following elements: the service user must be registered either with a Halton GP or be a Resident in the Borough of Halton; the service is available to patient's aged 18+ according to assessed need; the setting where the service is provided may vary according to age and presenting circumstances; the person must agree to referral. The Better Care Fund will enable additional bed based capacity (equating to 120 placements per annum) and community services capacity (equating to 150 people per annum)

Whilst the service is open to adults aged 18+ ongoing analysis of the caseload indicates that the main patient cohort to be those aged 75+.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Intermediate Care services are jointly commissioned between NHS Halton CCG and Halton Borough Council and have been funded through a pooled budget for 8 years

Halton Borough Council are the lead provider with Warrington & Halton Hospitals NHS Foundation Trust; Bridgewater Community Healthcare NHS Trust and local GP's providing clinical services.

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Evidence for Scheme Design

The National Service Framework for Older People - Intermediate Care (2001); Community Care Delayed Discharge Act (2003); Halfway Home (2009), Health and Social Care Act (2012); The Care Act (2014) are directives which have shaped implementation and development of services over a number of years.

The current service operates a single point of referral and assessment. There is an even split between referrals from the community and for people in acute hospital settings, with over 1200 referrals a year. 92% of referrals are assessed within 24 hours

25% of people who require a bed based service come from their own homes. The average length of stay in a bed is circa 26 days. 80% of people are discharged from a bed based service to their own home with or without support; 15% require an acute admission for further treatment. 3% are admitted to a long-term residential or nursing home placement and 2% die (palliative care)

40% of people who require a service in their own home are discharge from an acute hospital. 90% of people are still in their own home at discharge from the service, 8% require an acute hospital admission for treatment and 2% are admitted into long term residential or nursing home care.

The services are linking into the development of discharge to assess and frailty pathways in the 2 acute trusts

Assumptions for Impact and Outcome

Additional resources from the Better Care Fund will increase the capacity of the bed based service by 120 placements per annum and community services by 150 placements per annum.

Based on the admission pathways and discharge outcomes of the existing schemes

we project this additional capacity will support: Reduced Non-Elective Admissions by 148 in 2015/16 – 100 from bed based services and 48 from community services Reduce Delayed Transfer of Care Bed Days by a minimum of 26 days Maintain the levels of long term care admissions by managing increased population demand
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
2014/15 **2015/16** **£0** **£795,000.00**
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Outcomes as per Part 2, Tab 4
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Performance form's part of the developed dashboard for the Better Care Fund and includes process, outcome, user satisfaction and experience; safety domains. This is reported through the Better Care Executive Commissioning Board.
What are the key success factors for implementation of this scheme?
Management of flows into, through and out of bed and community based services Recruiting additional staff Procurement of additional bed based capacity

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
3
Scheme name
Telecare and Telehealth
What is the strategic objective of this 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. This has the potential to reduce costs in acute and residential care. This are key local outcomes articulated in our Health and Wellbeing Strategy. Telecare and telehealth services in Halton provide vulnerable people, their families and carers with technological and human responses in crisis situations and assist the ongoing monitoring of risks and long term conditions to support treatment and care management. This ultimately supports people to maintain their existing housing option, promote independence and tailor services to meet demand
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The existing community alarm and telecare service will be expanded to deliver a larger number of specialist sensors in people's own homes. The service operates 24/7 with contact centre and mobile warden response. The patient cohort is adults and older people.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The scheme is commissioned by the Better Care Executive Commissioning Board (ECB). Inputs, outputs and outcomes are already monitored by the Better Care Executive Commissioning Board. The service is provided by Halton Borough Council and links with community health and social care providers
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
<u>Design of Scheme</u> The existing provision supports circa 1900 people in the borough, is accredited with the

Telecare Services Association and is expanding to include the management of Telehealth provision in the borough.

Assumptions for Impact and Outcomes

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.

The government has made a firm commitment to Telecare (and Telehealth) as a means of helping people live independently while monitoring their health remotely. The NHS operating framework published in the BNJ (2011, 343: d7712, doi:10.1136/bmj.d7712) says:

> "PCTs working with local authorities and emerging clinical commissioning groups should spread the benefits of innovations such as Telehealth and Telecare as part of their ongoing transformation of NHS services. They should also take full consideration of the use of Telehealth and Telecare as part of any local configuration plans…use of both these technologies in a transformed service can lead to significant reductions in hospital admissions and better outcomes for patients."

A clear message emerges from local consultations and from the Department of Health Whole System Demonstrator (WSD) research programme (2008-2011). People, especially individuals with long-term conditions, don't want to spend time in hospital unnecessarily. Instead, they prefer to have more control over decisions made about their care and they want to live a normal life in their own home where possible. The use of assistive technology such as Telecare and Telehealth, can facilitate this kind of control, allowing people to live independently and be responsible for their own health and care.

> "It has changed my life by enabling me to stay independent and I can get on with my daily activities."

Initial findings from WSD show that Telehealth and Telecare can substantially reduce mortality, the need for admissions to hospital, lower the number of bed days spent in hospital and reduce the overall time spent in A&E.

The telecare service response callout list for the last quarter of 2011 shows that 237 falls and 37 medical issues were attended none of which led to additional services (hospitalisation) being required. These figures, if multiplied up for a full year, imply that Telecare is potentially reducing the number of ambulance call-outs and hospital visits annually for frail older people, by over 1000. However it is clear that not all of this figure would convert to ambulance call out, A&E attendance and non-elective admissions

We project that the additional capacity will support:

Reduction in non-elective admissions by 112 in 2014/15

Maintain the levels of long term care admissions by managing increased population demand

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

2014/15	**2015/16**
£0	**£140,000**

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Anticipated outcomes are detailed in Part 2, Tab 4

Further anticipated outcomes are:

Reduction in ambulance call-outs

Reduction in A&E attendances

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

A full evaluation of the project will be undertaken annually. The Better Care ECB will monitor the project and ensure its delivery

What are the key success factors for implementation of this scheme?

- Identification and procurement of appropriate equipment
- Ensuring increased demand in alarm activations and the need for human response

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
4
Scheme name
Carers
What is the strategic objective of this scheme?
Halton has the second highest prevalence nationally of unpaid care provision of 50 or more hours per week (ONS data). Halton is tenth highest rank of 'unpaid care expectancy' (an estimate of the average lifespan spent occupying an unpaid carer role) for men at age 65 (ONS data) 24% of carers in Halton report a long standing illness (National Carers Survey)Only 6 % of carers surveyed had been offered a carers assessment (Survey of Carers in Households 2009-10). Our vision is to improve the quality of life for carers' in Halton by enabling carers to access support through advice, information, education, training and the provision of services. This will prevent or delay the need for care and support, reduce non-elective admissions to hospital, reduce length of stay and delayed transfers of care.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Carers will be able to access a range of information, advice and support from a number of existing gateways. The key elements in delivering support to carers in Halton are; 1. Providing financial resources for procuring services to meet need following a carer's assessment. 2. The identification of carers' at the earliest opportunity, specifically targeting groups considered to be 'seldom seen' or 'hidden'. 3. The provision of information, advice and guidance. 4. Providing short term, intensive support to those carers identified by adult social care and health care services where there is a significant risk of 'carer breakdown'. 5. Supporting carers' to take part in educational, training or work opportunities that they may feel excluded from because of their caring responsibilities. 6. Providing a range of learning and development opportunities for carers', front line staff and the community. 7. Through a variety of methodologies, gathering and reporting on carer experiences of using mainstream health and social care services; and supporting carers to participate in the planning, commissioning and quality assurance of health and social care services. Whilst the service is 'universal', there are a number of groups of carers that will be prioritised under these arrangements, including: older carers in poor health; male carers aged over 65; individuals providing over 50 hours of care per week; and where there is

significant risk of carer 'breakdown'.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

This scheme is the responsibility of the Care Act Group and the Carers Strategy Group with lead commissioning from Halton Borough Council

The service will be delivered across the borough through the existing partnership between Halton Carers Centre, Adult Social Care Management Teams, the Hospital Supported Discharge Teams and the primary care Multi-Disciplinary Teams.

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

<u>Design of the Scheme</u>

The additional resources will be used by existing access routes to information, advice and support for carers

The national strategy 'Recognised, Valued and Supported'. The priority areas identified for action were;

- Supporting those with caring responsibilities to identify themselves as carers at an early stage, recognising the value of their contribution and involving them from the outset both in designing local care provision and in planning individual care packages.
- Enabling those with caring responsibilities to fulfil their educational and employment potential.
- Personalised support both for carers and those they support, enabling them to have a family and community life.
- Supporting carers to remain mentally and physically well.

RCGP Commissioning for Carers 2013;

- The challenge facing the NHS is to become truly patient-centred, where patients participate in designing services and are able to exercise choice as customers, whilst seeking always to ensure that no community or part of a community gets left behind

The legal duties as a consequence of the Care Act to;

- Provide advice and information
- Promote well-being
- Prevent, reduce or delay needs
- Provide both assessment of need and services to meet this need

<u>Assumptions for Impact and Outcome</u>

Data from surveys analysed at a national and local level show;

- Halton has the second highest prevalence nationally of unpaid care provision of 50 or more hours per week (ONS data)

- Halton is tenth highest rank of 'unpaid care expectancy' (an estimate of the average lifespan spent occupying an unpaid carer role) for men at age 65 (ONS data)
- 24% of carers in Halton report a long standing illness (National Carers Survey)
- Only 6 % of carers surveyed had been offered a carers assessment (Survey of Carers in Households 2009-10)

In Halton there were a total of 3,505 non elective admissions during 2013/14 for people aged over 75, of these 803 admissions were for conditions that would not usually require admission. Using the "whole system approach" figure that 20% of these admissions were due to a carer breakdown this would equate to 160 admissions which could have been avoided if the carer breakdown did not occur.
During 2013/14 there were approximately 2000 delayed transfer of care days lost. Using the same 20% of admissions due to a carer breakdown and applying that to discharges would equate to approximately 400 delayed days.

We anticipate that the additional capacity will support:

Reduction in non-elective admissions by 112 in 2015/16

Reduce Delayed Transfers of Care by a minimum of 8 days in 2015/16

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

2014/15	**2015/16**
£0	**£809,000**

£359,000.00 will provide additional services through the carers centre

£350,000.00 will be held to meet the new duties under the Care Act

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The anticipated outcomes are listed in Part 2, Tab 4.

Further anticipated outcomes include:

- Carers are supported to continue caring;
- Carers are supported to maintain or improve their health and well-being;
- Carers are supported to maintain or improve their social contacts and personal relationships;
- Carers are enabled to participate in work, leisure activities or education; and
- Carers' are able to easily access advice and information that will assist them in making informed choices regarding their caring role.

As an example, during 2013/14 Halton assessed 1,128 carers and 85% of them went on to receive a service. This scheme will contribute to improving performance in this area.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand

what is and is not working in terms of integrated care in your area?
The Better Care Board will monitor the scheme through regular performance information relating to the Carers Centre contract.
What are the key success factors for implementation of this scheme?
• Identification and pooling of resources to support the delivery of the scheme • Willingness between health, social care and the Carers Centre to provide an integrated, person centred service for carers. • Strong track record of delivery in this area. • Use of data and research to inform strategic decision making

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
5
Scheme name
Falls Prevention
What is the strategic objective of this scheme?
In 2012 a review was undertaken to look at the falls service in Halton. This work was conducted by a multi-agency steering group and it became clear from very early on that services linked to falls were fragmented and there was no overarching vision. In addition to this overall performance was significantly worse than the national average, for example the hip fracture rate in people over 65 in Halton was 499 per 100,000, the National average was 452 per 100,000. It was agreed that a falls strategy was required and the strategy was developed and agreed to cover the period of time between 2013 and 2018. The strategy was important because for the first time it allowed agencies to focus on eight key deliverables (below) that could and should improve performance. Additional resources will be used to expand existing provision to further positively impact on reducing falls and their consequences.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Current provision includes: low level awareness, education and training for citizens and staff across health, housing and social care; exercise based approaches to prevent primary and secondary falls occurring; higher intensity medical, rehabilitation and social interventions for those at the highest risk of primary and secondary falls. In enhancing the provision of falls prevention services we will incorporate Home falls risk and postural stability assessment, in reach into sheltered and residential settings, closer links with the Ambulance and secondary care services, development of an E-learning package across health and social care community services. Patient cohort is those at risk of falls which is predominantly older people.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Halton Borough Council (HBC) and NHS Halton CCG are joint commissioners for this provision. The lead provider is Bridgewater Community NHS Trust working across HBC Helath

Improvement Team and the providers of residential. Nursing and Domiciliary care; housing providers.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

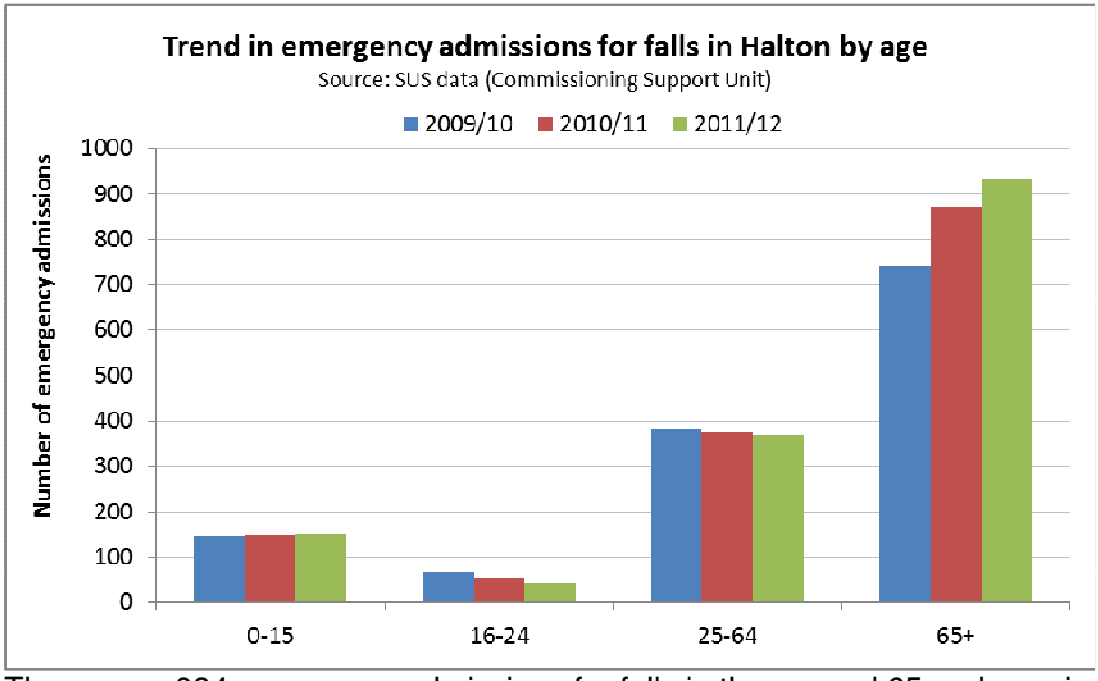
Scheme Design

The existing provision contains all the elements contained within NIHCE guidance. Evaluation of the existing provision demonstrated

- There is currently a ten week waiting time for physiotherapy within the higher intensity falls service and response times for initial falls assessment were 5 weeks
- APEX training is limited to just 2 courses per year so there is often a waiting list, sometimes for as long as 18 weeks
- There is no additional access to online falls training for the public and professionals that could supplement the existing falls training.
- Currently less than 15% of the services referrals come from hospital discharge.

Assumptions for Impact and Outcomes

Local evidence can be drawn from Halton's JSNA, the Health and Wellbeing Strategy, "The Future impact of demographic changes on unplanned hospital care in Halton" and the Falls Business Case, for example:



There were 934 emergency admissions for falls in those aged 65 and over in 2011/12. This represents a 26% increase since 2009/10 (7% in the last year from 2010/11 to 2011/12). This increase is likely to continue, as the number of falls in people aged 65+ is projected to rise by 17% between 2012-2018.

Additional investment so far has demonstrated improvements in two key areas:

- Admissions to hospital due to a fall have decreased from 944 in 2011/12 to 811 in 2013/14, this represents a 14% reduction
- Admissions to hospital due to an injury have decreased from 667 in 2011/12 to 646 in 2013/14, this represents a 3% reduction

We project that the increase in capacity across the components of the falls service will:

Reduce the number of non-elective admissions by 75 per annum

Maintain the levels of long term care admissions by managing increased population demand

Reduce the numbers of older people readmitted to hospital within 28 days (where the first admission was due to a fall) from 923.1 per 100,000 population in 2014/15 to 884.2

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

2014/15	**2015/16**
£0	**£130,000**

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The anticipated outcomes are listed in Part 2. Tab 4.

Additional anticipated outcomes include:

Increasing the numbers of people who access education and intervention work will support an increase in independence and quality of life for a substantial number of people.

Reduction in the number of falls will reduce the demand on crisis response and ambulance services.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Services are already integrated across the falls pathway.

We have developed a dashboard of key performance indicators to measure the impact of increasing the diversity and capacity of the existing falls provision within the borough. Key metrics monitored on a quarterly / annual basis are:

- Mortality due to falls (all ages)
- Mortality due to falls (65+)
- Hospital admissions due to falls (65+) annual figure
- Hospital admissions for injuries due to falls (65+) (quarterly)

- Hospital re-admissions, where original admission due to a fall (65+) (quarterly)
- Number of Fracture of Femur (quarterly)
- Top cause of hospital admission (quarterly)

Service inputs, outputs, capacity, demand and patient satisfaction are also monitored to understand performance

The Falls Strategy Board meets on a quarterly basis to oversee this area.

What are the key success factors for implementation of this scheme?

Uptake of training and information awareness.
Recruitment and training of staff to undertake APEX courses
Recruitment of additional staff into the Falls Service (nursing and physiotherapy)

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
6
Scheme name
DFG, HICES and Adaptations
What is the strategic objective of this scheme?
Timely access to equipment and adaptations to: 1. Prevent admissions to hospitals or care homes; prevent delayed transfers of care; prevent or delay deterioration in health. 2. Enable individuals to continue to carry out everyday tasks and maintain their independence in the community. 3. Enable care and nursing needs to be attended to safely in a community setting by either paid or family Carers.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The key components to providing equipment and adaptations to enable people to remain independent are: i. Assessment of individuals need for specialist equipment or adaptation by an 'Approved Prescriber'. NHS staff may also prescribe equipment that supports the treatment or, maintains health or end of life care. Multi-professional collaboration may occasionally be required, where there is more than one prescriber from a different service area involved in dealing with the disabled person ii. Selection and order of equipment or adaptation including specialist or bespoke by prescriber with regard to the level of disability iii. Procuring equipment as requested by Approved Prescribers to the standards and guidance as set out by the Medical and Healthcare Product Regulatory Agency (MHRA) and identified within the NHS Controls Assurance Standards; iv. Delivering appropriate items of equipment for daily living or nursing equipment to people's homes or community settings, within specified timescales v. Fitting, installing, adjusting and/or assembling equipment and demonstrating the safe use of.

vi. Servicing, maintenance and repair of all items of equipment supplied in accordance with the manufacturer's recommendations, including regular service of hoists and while the equipment is on issue to individuals.

vii. Collecting equipment from people's homes or community setting when no longer required within timescales as instructed by the service specification.

viii. Cleaning and refurbishment of returned equipment to recycle as quickly as reasonably practicable in accordance with national guidelines.

ix. Safe disposal of all equipment collected from or returned by individuals where the equipment is unsuitable for re-use and beyond economic repair.

x. Providing on-site technical advice, working with practitioners/clinicians, attending joint visits and advising clinicians on all aspects of minor adaptations and technicalities around equipment.

xi. Providing and maintaining the Equipment Catalogue.

xii. Providing and administrating the Disabled Facilities Grant to provided for works to adapt the homes of chronically sick or disabled persons to enable them to continue to live independently in their homes

These arrangements are available to children and adults of all ages where it appears that a person has a permanent and substantial disability :

- as defined by the Equality Act 2010
- A child in need as defined by The Children Act 1989
- Someone who is "ordinary resident" in the local authority area and meets the relevant criteria
- Registered with a Halton GP

In Halton, more than 1 in 5 people (21.4%) are living a greater proportion of their lives with an illness or health problem that limits their daily activities.

In November 2012, 7,780 (9.4%) working age adults were claiming Incapacity Benefit (now Employment Support Allowance). This is higher than the North West and England averages and most of these people have been receiving this benefit for more than three years.

ONS population projections for Halton 2014

Halton UA	0-15	25,700
Halton UA	16-64	80,000
Halton UA	65+	20,800
Halton UA	All ages	126,800

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Assessments are completed by nurses, therapists and rehabilitation officers working across health and social care.

Bridgewater Community NHS Trust are commissioned to deliver the integrated community equipment service through a partnership agreement and pooled budget arrangement between Halton CCG and Halton Borough Council.

The minor adaptations service is commissioned by Halton Borough Council and provided by Helena Partnerships Ltd

The Disabled Facilities Grant works are managed by Halton Borough Councils Home Improvement Agency

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

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.

Areas identified in this report with a potential for increased demand, due to population changes, are:

Emergency admissions for:

- falls in those aged 65 and over
- injuries to the body, particularly in those aged 65+
- dementia (aged 65+)
- respiratory conditions (infections and asthma aged 0-15; flu, pneumonia and chronic obstructive pulmonary disease in 65+)
- General symptoms and signs (aged 65+)
- digestive conditions (aged 65+)
- circulatory conditions (heart diseases and stroke aged 65+)
- emergency re-admissions within 28 days, for those aged 65+
- A&E attendances in those aged 65+

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The benefits align with reduction in long-term care, reduction in delayed transfers of care.

The desired outcomes are:

- Increase a disabled person's independence
- Maintain independence
- Assist recovery

- Support carers to provide safe care

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Monitoring of efficacy will be through monthly performance reports to the Better Care Board including:

- Total number of adaptations
- Number/% completed within target timescales
- Total number of equipment items delivered
- Number/% delivered within target timescales
- Total number of equipment items collected
- Value of items collected

Alongside these direct performance measures local metrics include data on numbers of people helped to live at home.

Providers also conduct their own customer satisfaction surveys which are reported to Commissioners.

Prescribers from across health and social care and operational managers meet regularly to ensure best practice is followed, the equipment catalogue remains current and to address any process issues.

What are the key success factors for implementation of this scheme?

Respond to demographic pressures and increased demand for support to live at home.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
7
Scheme name
Early Supported Discharge
What is the strategic objective of this scheme?
In Halton we are committed to ensuring our local population access the right services, at the right time and in the right place. Where acute care is required we expect that discharge planning is a fundamental part of that care to ensure people move through the acute services and into community based care in a timely manner. Additional resources will be used to expand a range of integrated services designed to increase the effectiveness of the pathways through acute care using proactive approaches to case identification and improving access to services 7 days a week. Our local population utilise 2 acute hospitals and there are arrangements with acute providers, neighbouring boroughs and community health care provider to ensure seamless pathways irrespective of place of residence. Early supported discharge for stroke services are also being developed across the 2 acute providers.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Halton discharge teams are based in two main hospitals Warrington and Whiston. **Halton Integrated Discharge Team (HIDT) at Warrington Hospital** The HIDT is a dedicated multi-disciplinary discharge team which incorporates assessment into A&E, ensuring a focus on the proactive identification of people likely to require supported discharge. The team delivers on all the discharge pathways out of Warrington and Halton Hospitals Foundation Trust (WHHFT) including Social Care, Continuing Health Care (CHC), Community Health Services and Intermediate Care. The team also manages discharges for Halton residents in out of area hospitals. The staff group consists of Nurses, Social Workers, Community care Workers, District Nurses and Community Psychiatric Nurse. The benefits of this approach to discharge include earlier engagement with patients and families to better manage need and expectations, therefore reducing delays in hospital beds and admissions to long term care. HIDT undertake a proactive approach to identifying Halton residents within Warrington

Hospital and do not necessarily wait for a formal referral.

On a daily basis a list of adults (50+) that have been admitted overnight is provided to the HIDT. Designated Care Managers then track and monitor the person's hospital journey during the duration of their stay.

Whiston Integrated Discharge Team (WIDT) at Whiston Hospital

In Whiston Hospital the Integrated Discharge Team ("IDT") is a single point of referral for all St Helens, Knowsley, and Halton resident patients identified by the ward staff as requiring support on discharge. The team comprises of discharge workers, social workers, band 6 and 7 nurses, a physiotherapist and support staff, working under a team manager and two assistant managers. This staff group was drawn from both health and social care to create a multi-disciplinary team.

Staff are allocated to specific wards to enable them to build relationships and become involved in decision making at the earliest opportunity. The workers will deal with all Halton, St Helens and Knowsley patients on their allocated wards, regardless of their employing organisation. The Intermediate Care (IC) assessors within the team will respond to referrals for those identified for IC, either via the ward direct or the ward allocated worker.

Early Supported Discharge for Stroke

There is a small multi-disciplinary team capacity operating an outreach model for ESD for Stroke from Warrington Hospital. The model is best on best practice but requires new capacity around speech and language therapy. Further resource is required to support people who attend Whiston hospital with a stroke to enable ESD.

All services positively impact on Delayed Transfers of Care and enable pathways into intermediate and transitional care.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The Halton components of the discharge teams are commissioned by Halton Borough Council and NHS Halton CCG with partners in St Helens

Halton Borough Council is the Lead Provider for the Warrington Hospital team

St Helens Borough Council is the Lead Provider for the Whiston Hospital Team

The acute Trusts will provide the ESD for stroke as out-reach models

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

<u>Scheme Design</u>

Existing provision will be expanded. Local evaluation has demonstrated reductions in

length of stay, lower than benchmarked admissions direct to long term care from acute hospitals. These services sit within a wider context of pathways redesign within the acute hospital sector and expansion of services across the 7 day period

Assumptions for Impact and Outcome

There are a number of pathways through which people requiring support for and on hospital discharge can be directed. Achieving timely discharge for people who need support is dependent on a number of related factors including:

- commencement of discharge planning on admission;
- the availability of information about the individuals self-care ability and health status prior to admission;
- frailty of the individual pre and post admission;
- the responsive of diagnostic departments and analysis of results;
- the trajectory of the presenting condition and response to treatment;
- recovery processes;
- involvement of the individuals significant others;
- knowledge of all staff in the relevant agencies of the type and availability of community services (health and social care);
- discharge process management;
- the complexity of different services and pathways criteria's and responsiveness

Both Trusts are developing case identification, discharge to assess and frailty pathways using evidenced based models. These have had positive results in other areas for the deflection of admissions and reduced length of stay.

Furthermore, both Trusts have phased approaches to delivering 7 day working across all specialities to enable daily senior review, improve the quality of care and increase discharges at the weekend

Additional resource from the Better Care Fund will enable 7 day working in both discharge teams and expand the existing ESD for stroke.

We project that the additional investment will:

Reduce Delayed Transfer of Care Bed Days by a minimum of 8 days in 2015/16

Maintain the levels of long term care admissions by managing increased population demand

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

2014/15	**2015/16**
£0	**£210,000**

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in

headline metrics below
The anticipated outcomes are listed in Part 2, Tab 4
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
All services teams are monitored in relation to length of stay and outcome on discharge. Operational reports monitor key time processes which affect length of stay. More widely this is linked into internal work within the acute trusts on reducing overall length of stay. Performance is monitored through the Better Care ECB.
What are the key success factors for implementation of this scheme?
Ongoing redesign of pathways through acute care and out of hospital care Recruitment of additional staff

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
8
Scheme name
Care at the End of Life
What is the strategic objective of this scheme?
National research demonstrates that whilst a high proportion of people express a wish to die in their own homes, this does not occur for the majority of people. The additional resources will enable the number of people who choose to die at home to do so through additional capacity in the provision of care and support available 24 hours a day, 7 days a week
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
People identified as nearing the end of their life are case managed by the District Nursing service. Where the person and the District Nurse identify the need for care and support then this is provided through an existing care provider. The service can be accessed 24 hours a day / 7 days a week. The service has been in operation for 5 years. Improvements in supporting people nearing the end of their lives to make choices about where they wish to die have resulted in increased demand on the care and support service. Additional resources will enable an expansion of this service to meet this demand The patient cohort is people deemed eligible via District Nurse Service. Patients may require discharge from an acute hospital, hospice, care home or reside in their own home.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
NHS Halton CCG commission the service District Nursing Service case manage the individual and undertake reviews of the care and support delivery.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
<u>Scheme Design, Impact and Outcomes</u> This is an existing scheme that has well established pathways into and through the

service. Local evaluation demonstrates over 95% of people who receive the service die at home. Capacity issues have delayed transfers from acute hospital and hospice care.

Nice guidance: "A pathways approach to commissioning high-quality integrated end of life care for adults"[2] has supported the further development of this servive

End of Life Case Study: North East Lincolnshire[3]

In 2012 North East Lincolnshire CCG, with key partners launched a new 24 hour end of life service for patients, families and carers. The evidence so far shows that significant improvements have been made in terms of people dying in their preferred place of care, and fewer people dying in hospital.

We project that this expansion will:

Reduce Delayed Transfers of Care by a minimum of 6 days in 2015/16

Maintain the levels of long term care admissions by managing increased population demand

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

2014/15	**2015/16**
£0	**£192,000**

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The anticipated outcomes are listed in Part 2, Tab 4.

Further anticipated benefits include:

An increase in the proportion of people of people who died in their preferred place of care

A reduction in the number of attendances to A&E and non-elective admissions

Ensure patients and carers experience a coherent and integrated system of End of Life care and support, matched to their personal circumstances

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand

[2] http://www.nice.org.uk/guidance/cmg42/chapter/2-a-pathways-approach-to-commissioning-high-quality-integrated-end-of-life-care-for-adults

[3] http://www.google.co.uk/url?url=http://www.icase.org.uk/dl/cv_content/135216&rct=j&frm=1&q=&esrc=s&sa=U&ei=hPphVODbN8PQ7Aao4YGYCw&ved=0CEEQFjAIOAo&usg=AFQjCNEx_byhTTtNSNVFbhoa0uRRblcMrw

what is and is not working in terms of integrated care in your area?
Monthly activity reports are produced and reported to the CCG. These reports detail the numbers of referrals, reasons for referrals and outcome for individuals. In addition quarterly meetings between the commissioners and providers take place. These are a forum for both parties to discuss any issues, challenges or proposals to work differently. Performance of the scheme will be monitored through the Better Care ECB
What are the key success factors for implementation of this scheme?
Increase in the number of PPC (Preferred place of care) forms completed, increase in the number of people dying in their PPC. Flexibility, provider able to meet the demand if that demand exceeds the contracted hours.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
9
Scheme name
Integrated Health and Social Care Teams
What is the strategic objective of this scheme?
A fundamental aspect of the delivery of health and social care within Haltos is to deliver services in and close to where people live. A prime focus is redesigning health and social care around primary care to deliver high quality, effective and efficient assessment, care and support planning for people with a wide range of health and social care needs. We will continue the development of pro-active case finding through case identification and risk stratification.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Halton has been developing an integrated model for community health and social care over the past 12 months involving adult social care, community nursing, community therapy, health and wellbeing services, general practice and the voluntary sector. Centred within General Practice, the emerging model has a focus on case identification, early intervention, management of people with complex needs and/or frequent users of services. Case managers / lead professionals will be agreed with the individual and the multi-disciplinary team. Initial assessment leads to focussed intervention work by an appropriate multi-disciplinary team with regular case review. Where appropriate, short term reablement / intermediate care and support are used to prevent deterioration and improve health, social and psychological functioning. Where long term needs are identified then the integration of the continuing healthcare assessment nursing team into social care enables a focus on robust personalised support planning across health and social care needs and the joint commissioning of services. These teams will play a central role in delivering the requirements of the Care Act from April 2015. Additional investment will be used to ensure sufficient workforce capacity to manage more people outside of the acute sector and prevent readmissions. The patient cohort is all adults and older people who present with needs and/or are identified through case finding methods. Adults and older people in permanent placements within the borough and out of area. Adults and older people in receipt of

care in the community.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

This development is jointly commissioned between Halton Borough Council and NHS Halton CCG.

The providers are Bridgewater Community NHS Trust, 5 Boroughs Partnerships Trust (Mental Health), Warrington and Halton Hospitals Foundation Trust, Halton Borough Council, General Practices and a range of independent and third sector health and wellbeing services. Structures are in place within General Practice for regular case finding and review meetings.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Scheme Design

The existing model will be expanded to increase the number of case managers and support the continued development of the model. Preliminary local evaluation is demonstrating positive impacts on preventing admissions and readmission for the cohort of people identified for this approach.

Halton's Joint Strategic Needs Assessment (JSNA) identified that in the growth in the population of older people with increasing complex health and social care needs will mean additional demands for both formal and informal support. Small decreases in the working age population mean there are fewer people to provide and pay for this additional support.

There is an increasing requirement for joint working between health and social care to be facilitated to ensure the population's health inequalities and needs are being addressed. Growing evidence supports the establishment of multi-professional health and social care teams to address the needs of high risk people within the community.

Assumptions for Impact and Outcomes

Proactive case management of people at high risk of hospital and long term care admission coupled with utilisation of a range of self-care, supported interventions and contingency planning are beginning to demonstrate positive outcomes on reducing the need for higher level health care and supporting people to remain in their own homes.

We are projecting that this scheme will impact on the proportion of older people still at home 91 days post discharge into Reablement / rehabilitation

4.6% increase in 2014/15

1.8% increase in 2015/16

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB

Expenditure Plan
2014/15 **£483,000.00 Preparation for Implementation of Care Act** **2015/16** **£463,000.00 Implementation of Care Act** **£383,000.00 Redesign and Increase Capacity Integrated Social Care and Health** **£500,000.00 Complex Care Provision** **£1,756,000.00 Protecting Eligibility Criteria Social Care**
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
The anticipated outcomes are listed in Part 2, Tab 4 Additional anticipated outcomes include: Reduce attendances to A&E and non-elective admissions Strengthen the capacity of the teams to deliver an increased workload due to the impact of personalisation; Respond to the financial constraints and changing demographics in the borough; Develop a relationship with and expertise of a local population and community; Greater opportunity to influence and enhance the current commissioning model; The potential for further efficiencies as the model develops; and Provide better outcomes for people's first contact with adult social care and health.
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
The existing model has a range of performance metrics, inputs, outputs and outcome measures that are monitored through the Better Care ECB.
What are the key success factors for implementation of this scheme?
Utilisation of systems to identify people at risk of hospital admission / readmission Recruitment of key staff Further engagement of existing staff in delivering the model of care

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
10
Scheme name
Integrated Health and Social Care Mental Health Services
What is the strategic objective of this scheme?
This scheme aims to shift the focus of intervention of social care assessment and support services to a much earlier stage in the journey of a person with mental health needs, working directly with primary care services, the private and voluntary sectors and other key statutory partners to divert people from secondary mental health services, reduce the use of local acute hospital services, and support people currently in secondary mental health care to be discharged more quickly into the care of their local community services.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Currently all the Council's social care resources for people with mental health needs are targeted at providing support to people with the most complex needs and highest levels of risk. Social workers are attached to and work alongside the local mental health NHS Provider – the 5BoroughsPartnership – and deliver an assessment and care management approach through the Care Programme Approach, as well as providing the AMHP function for assessments for admission to hospital under the 1983 Mental Health Act. If community support services are required, these are provided either by the Council's Mental Health Outreach Team (which is jointly funded by the local CCG) or by lower-level voluntary sector services provided by both specialist mental health and more generic organisations, such as MIND. This scheme will redesign some existing services to provide: • Social work intervention for people who are not known to secondary services, where this might reduce or prevent onward referral to secondary care or the acute services • Follow-up of people who have had an initial single contact with secondary care around the prevention of readmissions • Structured, focused and time-limited support from the Mental Health Outreach Team, offering individually tailored programmes of intervention designed to achieve specific outcomes • Clearly defined and effective pathways into lower level support services and a range of universal services

The target group for intervention includes:

- People with lower level mental health needs who have social care needs which, if met, could improve their mental health
- People without a clear diagnosis but whose presentation demands time and resource from primary care
- People with repeat presentations to Accident and Emergency Departments for physical health problems, but where these presentations are considered to be because of the person's social circumstances or lower-level mental health needs
- People who have made a suicide attempt who are not referred for specialist psychiatric follow-up
- Inpatients in acute hospitals with lower-level mental health needs which might delay their discharge form hospital
- People with drugs and alcohol issues and an associated mental health problem, where social care intervention could
- People who have been detained under the police powers of Section 136 Mental Health Act but not received follow-up from secondary services
- People who have been referred for secondary mental health support but who, on triage, have not been deemed to meet the criteria for those services
- Current inpatients who are at risk of losing contact with their own localities and communities
- Prisoners with identified mental health problems who may be moving back to the community

By providing social care staff who already work in a service which is very closely aligned to acute hospitals and secondary mental health services, this will also allow faster and more comprehensive assessments of people, and more effective engagement with people who are currently known and need to be discharged back into the care of their local communities.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

This scheme is the responsibility of the Mental Health Deliver Group and the Operational Directors for Complex Care and Transformation.

The local mental health service provided by secondary care is already jointly commissioned by Halton Borough Council and the Halton Clinical Commissioning Group, along with a range of lower level community support services.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

An initial project has already taken place within the Mental Health Outreach team which has shown very positive results. Four surgeries are actively engaged with the project and are making referrals; others are interested. In addition the 5Boroughs Partnership Assessment Team, which acts as the triage for secondary care, is also

making referrals, and there have been two referrals from the Recovery Team within the service. As a part of the extension of the service, referral pathways would be established from the Accident and Emergency Departments in Whiston and Warrington Hospitals and the inpatient wards in both hospitals.

This project is being closely evaluated. At the first point of contact, a star-based assessment is completed with the person, to establish the baselines in terms of their emotional state, their social functioning and any other issues that are important to them. This is then reviewed with the person on a regular basis to establish whether the interventions are effective. The information from each assessment is collated on a spreadsheet and forms part of a quarterly report. Additional information is kept about the range of move-on services to which a person is referred, to evidence the extent to which people are able to engage with local health services and with their communities.

In the nine months since the project began, 72 referrals have been made. 20 cases have been closed as completed (of whom 4 proved impossible to engage with, and one further person died). Of the remaining 15, all have shown improvements in their self assessed scores for mood and functioning. 21 other people are currently being worked with; of that group, 12 have been worked with for long enough to assess changes in their levels of functioning, and improvements have been shown in 11 (the only exception was a person who suffered a bereavement during the time period). There are 31 cases awaiting allocation.

Although outcomes can be expressed in terms of numbers, stories can tell more. In terms of individual personal outcomes, the following can be reported:

- one man was making suicide attempts or threats at least once a week, sometimes more; the threats involved the potential of jumping from a local bridge and the police had to apprehend him on a number of occasions. This behaviour has now completely stopped following intervention, and he been re-engaged with alcohol services, he was linked to a social group and he is planning to attend a part-time course at college in September 2014. Family relationships are reported to have improved
- a woman who had lost all her confidence after a road accident was supported to re-learn how to go out and use public transport. She then completed a six-week counselling course and is now working as a volunteer for a local mental health charity
- A woman who had not been out her home for over 12 months is now independently taking herself to yoga classes following intervention by the team; her home environment – which was previously very neglected – has improved substantially
- One woman was visiting her GP on a weekly basis – she now has not been to see the GP for over two months
- One man reports that he is reducing use of his antidepressants – with the support of his GP
- One man, who was self-employed, was getting depressed and anxious about his finances; he has now become employed by someone else so has maintained employment and his family life has improved
- A woman who was physically unwell and was nervous of medical and dental contact is starting to keep appointments with medical services, she has

managed her new diet effectively and she has developed confidence in shopping

- A woman who was depressed and has a lung condition has been supported to join a pulmonary exercise course through the Health Improvement Team, and she has been supported to apply for enhanced financial support and has achieved this, and she will be accessing social activities through the Wellbeing Enterprise Team
- Two other people are now seeking voluntary work or employment
- One man, who was isolated because of a lack of money and because of some debts, has been supported to improve his finances and he has now joined a local fishing group

Local evidence can be drawn from Halton's JSNA, the Health and Wellbeing Strategy, "The Future impact of demographic changes on unplanned hospital care in Halton", for example see chart below:

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

2014/15	**2015/16**
£0	**£496,000**

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

This scheme contributes to:

- Prevention of deterioration
- Improved patient/service user experience

Other outcomes include:

- a reduction in the numbers of people referred to secondary mental health services
- reductions in the numbers of repeat attendances at surgeries
- reductions in the use of anti-depressant medications
- reductions in suicide attempts
- reductions in repeat attendances at Accident and Emergency Departments
- reductions in use of inpatient services in acute hospitals for people with social needs or lower level mental health needs
- faster and more appropriate discharge of people from hospital settings

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The process for assessing the impact of interventions delivered by the Mental Health Outreach Team has been described in an earlier section; as the service extends to include wider social care services, then the monitoring and evaluation will be widened to include these services.

This scheme is monitored via the Better Care Board, which then feeds into the

Health and Wellbeing Board.
What are the key success factors for implementation of this scheme?
Key success factors include: • Partnership/collaborative working arrangements in place; • Appropriate funding in place; • Appropriate infrastructure in place, e.g.workforce, IT, etc.; • Effective communication and marketing strategy in place to ensure people in Halton use the services available.

Treatment		Local value	Eng. value	Eng. worst*	England Range	Eng. best*
Treatment and early intervention can help to minimise the impact of mental illness and improve overall wellbeing. A high number of people in contact with mental health services may indicate a particularly high prevalence in your geography, but it may also reflect good recognition and diagnosis of conditions and availability of appropriate treatment services. Therefore some of the indicators in this domain show high or low significance (using blue lines) rather than best and worst judgements (using red and green lines).						
15	Directly standardised rate for hospital admissions for mental health, 2009/10 to 2011/12	351	243	1,257		99
16	Directly standardised rate for hospital admissions for unipolar depressive disorders, 2009/10 to 2011/12	75.4	32.1	84.8		4.7
17	Directly standardised rate for hospital admissions for Alzheimer's and other related dementia, 2009/10 to 2011/12	226	80	226		5
18	Directly standardised rate for hospital admissions for schizophrenia, schizotypal and delusional disorders, 2009/10 to 2011/12	89	57	233		5
19	Allocated average spend for mental health per head, 2011/12	213	183	147		257
Levels of Mental Health and Illness						
At any one time, roughly one in six of us is experiencing a mental health problem. mental health problems are also estimated to cost the economy £105 billion per year It's important to monitor and investigate the levels of mental health in order to target and improve mental health services at a local level.						
11	Percentage of adults (18+) with dementia, 2011/12	0.56	0.53	0.95		0.21
12	Ratio of recorded to expected prevalence of dementia, 2010/11	0.55	0.42	0.27		0.69
13	Percentage of adults (18+) with depression, 2011/12	14.66	11.68	20.29		4.75
14	Percentage of adults (18+) with learning disabilities, 2011/12	0.57	0.45	0.21		0.77

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
11
Scheme name
Positive Behaviour Support Service (PBSS)
What is the strategic objective of this scheme?
In order to reduce the need of Long-term placements, the Directorate is adopting a multi-agency and multi- disciplinary approach to a) preventing out of borough placements and b) bringing people back to Halton from out of borough placements. This work spans both transition and adult services and the PBSS service (behaviour analysts) support this work through working with children and adults with severe learning disability and through reducing the frequency, intensity and duration of behaviour that challenges services.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The PBSS service is a specialist service with the primary purpose of reducing the frequency, intensity and duration of behaviour that challenges services. The team of professionals are Board Certified Behaviour Analyst (BCBA). The service works across four domains of activity: a) Early intervention b) Crisis prevention c) Technical support d) Placement development The service takes a peripatetic lifespan approach working with individuals with Learning Disabilities and/or Autism that challenge services. All interventions are person centred taking account both the natural informal support and paid support. The service works across Halton and with individuals in out of borough placements. The aim of the service is to improve an individual's life opportunities and enable them to remain living within their own community and accessing local services. A referred individual will end up with a Person Centred Intervention including: 1) Behaviour Support is based on holistic assessment (incorporating Functional Assessment) of the context in which the behaviours occur. 2) There is a written individual support plan 3) An Active Support model of care is generally put in place and staff members are trained accordingly. 4) The behaviour support plan includes: a description of behaviour that challenges; a summary of the reasons for this behaviour; proactive strategies and reactive strategies (that feeds in to a wider Person Centred Plan). 5) Monitoring and review arrangements. 6) Implementation arrangements. 7) The plan is implemented; monitored and evaluated (with data to evidence this).

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

This scheme is the responsibility of the Better Care ECB and the Operational Director for Complex Care.

The PBSS team is commissioned by Halton Borough Council and Halton Clinical Commissioning Group.

The PBSS team work as part of a multi-disciplinary team across a range of service areas depending on the individuals needs and services examples include:

Social work teams, Learning Disability Nursing team, CAMHS, schools and other education facilities, short break/ respite facilities, independent service providers (domiciliary, residential and activity based), community day services etc.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

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)
- The recent outcome of the Winterbourne View investigation highlights concerns about the quality and safety of such provision
- Such placements frequently occur as a reaction to crisis situation

The Mansell Report
- The Mansell Report (Revised edition: 2007) recommends specialist challenging behaviour services (a) work intensively with a small number of individuals and (b) help strengthen mainstream services so they can serve people locally.
- Research on specialist Challenging Behaviour services suggests effective services are likely to be:
- Peripatetic
- Psychology-led
- Have good case management procedures
- Clearly orientated to evidence-based approaches in behaviour analysis (Forrest et al. 1996).

Other relevant Department of Health publications:
- Valuing People (2001)
- Fulfilling and Rewarding Lives (2010)
- Winterbourne View Report (2012)
- Ensuring Quality Services (2014)

The service is reviewed on a quarterly basis by commissioners and an annual report is completed, this enable the service to review its impact, cost effectiveness and value for money.

The team captures data during all interventions that enables a comprehensive evidence base to be presented to commissioners outlining the impact for individuals and informal carers.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

2014/15	2015/16
£0	**£256,000**

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

This scheme contributes to:

- The maintenance of long-term care
- Improved quality of life.

This scheme also impacts on improving the quality of life of residents within Halton.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The multiagency approach is reviewed on a regular basis depending on the individual cases and the learning from the intervention is implemented into new practices. Data is collected for all cases to evidence the intervention and the impact, this is shared with informal carers, professionals and service providers to demonstrate the outcomes of the intervention.

This scheme is monitored by the Better Care Board

What are the key success factors for implementation of this scheme?

Key success factors:

- An MDT approach to reducing the number of individuals going to out of borough placements.
- Integrated partnership working across services.
- Funding committed from a range of stakeholder.
- Improving the quality of life of individuals and informal carers.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
12
Scheme name
Learning Disability Nurses and Therapy Services
What is the strategic objective of this scheme?
National reports and investigation (e.g. Winterbourne View) have strongly advocated the need to develop local models than can support people with varyng levels of need in the least restrictive way. In Halton we have developed a Model of Care for Adults with Learning Disabilities. The Model is focused on a stepped care approach, from mainstream health and community services to more intensive specialist support. The most effective intervention is offered with the aim of supporting the person in their own home and not being overly restrictive or intrusive, therefore ensuring people can live longer in their own home, reducing the need for long-term care and reducing the amount of non-elective admissions to hospital.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The model adopts a stepped care rather than progressive approach offering a range of care based on the premise that people with learning disabilities, including people with complex and challenging behaviour can lead fulfilling lives in the community. Stepped care recognises the range of levels of need from those less severe who manage and thrive with support of family, friends and mainstream health and community services to those requiring intensive specialist support. Stepped Care offers the most effective intervention which supports the person in their home without being overly restrictive or intrusive. It is crucial that support is person centred with a focus on maintaining the individual living in the community, available from a range of sources, both formal and informal and responsive to specific needs at any given time. Implementation of the Halton Prevention and Early Intervention Strategy is fundamental to this approach particularly for the learning disabled population not known to social care. In responding to changing need, crisis or circumstances the model must offer a speedy response with the ability to “step” up, down or across the range of support. Key elements of a safe and effective model are specialist crisis support, outreach and assessment and treatment, including in-patient care if appropriate, supported by cross-sector multi-agency working and care pathways. Where a person needs more specialist support, including that arising from complex and challenging behaviour, they will have access to skilled support staff and where necessary the support of specialist professionals including behaviour analysts to assist assessment and help plan more effective individualised support.

This model will support all Halton adults with learning disabilities and their family carers, plus young people with learning disabilities in transition to adult services and their family carers, including those with complex needs arising from an autistic spectrum condition:

- Who are "ordinary resident" in Halton including those in distant placements or
- Who are registered with a Halton GP
- When reach-down is needed from age 16+ for a young person that will be transitioning to adult services.

The additional resource from the Better Care Fund will increase staffing within the existing service

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

This scheme is the responsibility of the Better Care ECB and the Operational Director for Prevention and Assessment.

Halton Borough Council and the NHS Halton CCG are joint commissioners of this service and Halton Borough Council, 5 boroughs partnership and Bridgewater are the providers of the service.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The model of care is founded on the principles enshrined in Valuing People[4] and re-affirmed in Valuing People Now[5] that embraces 'Rights, Independent Living, Control and Inclusion', with services delivered in a person-centred way with access to mainstream services, including mainstream health services, wherever possible.

The model is founded on a person centred approach with a focus on people having fulfilling lives with opportunities for education, employment, leisure and social activities. Where additional support is needed it should be flexible, accessible, community based, close to home and consistent with identified best practice.

This approach will also facilitate reduction in the numbers of individuals requiring admission to hospital and of out of area placements (Winterbourne Review Interim and Final Reports 2012):

Where additional support is needed people's experience of care and support will be improved by adopting these principles and aims:

- Services for all, including those individuals presenting the greatest level of challenge
- High quality services for people with learning disabilities including those with

[4] Valuing People: A New Strategy for Learning Disability for the 21st Century (DH, 2001)

[5] Valuing People Now a new three year strategy for people with Learning Disabilities (DH, 2009)

behaviour which challenges
- Services which work around the individual – no one size fits all
- Services follow a life-course approach i.e. planning and intervening early, starting from early adulthood and incorporating crisis planning
- Services are provided locally
- Services offer timely responses
- Services focus on individual dignity and human rights
- Services are integrated/co-ordinated with good access to physical and mental health services as well as social care
- Where in-patient services are needed, planning to move back to community services starts from day one of admission.
- Services provide good value for money

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

2014/15	**2015/16**
£0	**£55,000.00**

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The main impact of this scheme is on improving the quality of life for residents of Halton. Working alongside people within the community will also contribute to the prevention of deterioration.

It is imperative that the partners responsible for delivering the model of care can keep track of progress and be confident that the model envisaged is the one being achieved. The performance framework set out below constitutes both qualitative and quantitative measures to monitor the range of activities across the whole model of care.

Some of the suggested indicators are collected nationally and these are referenced whilst others enable performance at the local level to be more closely monitored to trigger alerts to potential problems, offer analysis of the root cause from multiple perspectives and thus optimise performance of the whole system. All of the indicators contribute to delivering the national outcomes for the NHS, Public Health and Adult Social Care and have been linked to the relevant domains.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Performance of the model is monitored by the Better Care Board and forms part of the annual Self Assessment Framework externally assessed.

What are the key success factors for implementation of this scheme?

Key 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
- To reduce the number of placements in long-term care for people with learning disabilities.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
13
Scheme name
Integrated Services and Quality Assurance
What is the strategic objective of this scheme?
Integrated Adults Safeguarding Unit To deliver a consistent, proactive, outcome focused approach to safeguarding adults with an increased emphasis on prevention and quality assurance. The model also serves to support all partner organisations and care management teams within the Local Authority involved in safeguarding adults by reducing the impact on these services, enabling them to prioritise other work streams. **Integrated Care Homes Support** Building on the pilot work in 2013/14, develop and commission a model of support into care homes to improve access to treatment, care and support for all residents. This will incorporate 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. **Joint Quality Assurance Team** Establishment of a Joint Quality Assurance Unit and aligning performance systems across health and social care. Rather than having two systems, have one system in place.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Integrated Adults Safeguarding Unit The team a good skill mix and knowledge base to be effective at multi-disciplinary working. In leading on safeguarding across Health and Social Care, the team will be dealing with cases which have a complex safeguarding element to them providing support to care management teams who are dealing with safeguarding referrals. The Unit provides a personalised approach to safeguarding by following the principles of the Making Safeguarding Personal project. Service users are asked to identify what outcomes they would like to achieve at the beginning of the safeguarding process and at the end of the process, service users are asked to identify to what extent these outcomes have been achieved. The Integrated Adult Safeguarding Unit deals with safeguarding referrals for all adults aged 18 plus living in Halton. Where children are identified through safeguarding investigations, the Unit will also work closely with colleagues from the Children & Enterprise Directorate. **Integrated Care Homes Support** Additional nursing staff will be employed to:

- Coordinate with care home providers for the comprehensive assessment of all new residents within 4 weeks of admission. This will involve community therapy and dedicated older people's psychiatric provision as well as pharmacy. The resultant plans will be managed by the care homes with support from the team
- Work with care homes to maintain and improve their skills in early recognition of deterioration of health and well-being and support the delivery of early interventions
- Support the delivery of the early warning system being developed that supports the monitoring of the quality and safety of care within the homes
- Undertake intensive work with homes where standards of care require this

Additional pharmacy staff will be employed to:

- Work with homes on improving their systems for the ordering, storage, administration and disposal of medication
- Ensure timely medication reviews are undertaken

All residents of residential and nursing homes within the borough are the patient cohort

Joint Quality Assurance Team

The team will proactively monitor the contracts funded through social care, continuing care and funded nursing care budgets drawing in clinical expertise as required. The team will support providers to develop systems that monitor the quality and safety of the care delivered. The team will utilise a range of tools including site visits and service user feedback to ensure high quality safe care is delivered providing assurance to the local authority, CCG and the CQC.

All adults in receipt of care home and domiciliary care and support are the patient cohort

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Element of this scheme are the responsibility of the following groups:

- Halton Safeguarding Adults Board
- Better Care ECB

Halton Borough Council are the lead provider for the Integrated Adults Safeguard Unit with Bridgewater Community NHS Trust providing clinical staff into the team

The Care Home Support Team is provided by Bridgewater Community NHS Trust

Halton Borough Council are the lead provider for the Quality Assurance Team – NHS Halton CCG provide the clinical input.

The services are commissioned by the NHS Halton CCG and Halton Borough Council

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Integrated Adults Safeguarding Unit

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. The Unit will contribute to the safeguarding of adults across the borough by:-

- Providing support to the Halton Safeguarding Adults Board (HSAB) and its sub groups.
- Providing support to the Halton Dignity Champion's Network.
- Ensuring key linkages continue with the Domestic Violence coordinator and services.
- Ensuring key linkages with children's safeguarding.
- Supporting the development of effective Interagency Safeguarding Adults Policies and Procedures and Dignity Policies.
- Lead on prevention by responding to those cases that do not meet the Threshold for a safeguarding investigation.
- Supporting the local authority and its partner agencies to :-
    - Fully embed safeguarding adults policies and procedures and thus deliver consistent and robust outcomes for vulnerable adults
    - Monitoring the effectiveness of the delivery of their safeguarding adults activity
    - Providing advice and support regarding individual safeguarding adults cases.

The Unit is an example of best practice and provides effective safeguarding for adults. Through our continued involvement with the Making Safeguarding Personal project, the Unit will continue to focus on the outcomes the adult at risk would like to achieve following the safeguarding process and then to assess how far these outcomes have been achieved. This outcomes focused approach will be embedded across the Directorate and will be followed not only by the Integrated Adult Safeguarding Unit but also the Social Work Teams across the Directorate.

Integrated Care Homes Support

Making our health and care systems fit for an ageing population. Kings Fund 2014

Polypharmacy and medicines optimisation: making it safe and sound. Kings Fund 2013.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

2014/15	**2015/16**
£0	**£761,000**

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below
The main impact of this scheme is improved quality of life rather than financial benefits. There will be an improvement in clinical effectiveness. There may be a small reduction in non-elective admissions from this scheme. Other outcomes include: • Increase in the number of medication reviews for residents of care homes • Increase in the number of anticipatory and contingency plans for residents in care homes • Participation in training sessions from care home staff
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
The Integrated Adult Safeguarding Unit regularly provides reports to both the Communities Directorate Senior Management Team and also the Halton Safeguarding Adults Board. The Council's involvement with the Making Safeguarding Personal project will also be evaluated at regular intervals and reported to relevant Boards and Senior Management Team. Monitoring the safety and quality of care delivered in the care home sector is undertaken by the Adult Safeguarding Board and the NHS Halton CCG Quality Board. The over-arching performance is reported through the Better Care Board
What are the key success factors for implementation of this scheme?
The Integrated Adult Safeguarding Unit has provided effective safeguarding process for all adults at risk across the borough to help keep them safe and to provide a positive outcome and experience of the overall safeguarding process. The Integrated Adult Safeguarding Unit continues to expand and taking learning from local and national areas of best practice and to further improve our processes and procedures. • Increase in the number of medication reviews for residents of care homes • Increase in the number of anticipatory and contingency plans for residents in care homes • Participation in training sessions from care home staff Robust contract, safety and quality systems in place that promote high quality care and support and demonstrate improvement across the sector.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
14
Scheme name
Information Management and Technology (IM&T) Strategy
What is the strategic objective of this scheme?
Halton's IM&T strategy spans health and social care within Halton and will ensure that innovative technology is being utilised to improve communication, efficiency and data co-ordination across services. The strategy is aligned and part of the solution in meeting the overall objective of linking systems to support integrated pathways of care. This scheme is enabling improvements in whole system infra-structure.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
There is widespread recognition that patient care can be enhanced by making better use of technology. The development and implementation of an IM&T strategy is intended to ensure that as a population we are clear about what is needed from technology to deliver services, that are aware of the opportunities and innovation that Information Technology can offer and ensure that we are utilising this technology in the most effective way for our population. This strategy is intended to be Halton wide across covering both health and social care in and across both specialties and organisations It is envisaged that a strong emphasis of the strategy will be placed on interoperability between systems and supported by the development of appropriate supporting information governance tools including data sharing agreements to facilitate this, the detail of which will be informed as part of the development process. Along with drawing on the most up to date evidence and lessons learnt to develop an IM&T model that is appropriate for Halton, the development of the strategy will be progressed via facilitated workshops taking place during Q3 and Q4 of 13/14. Engagement with all stakeholders is a critical element of the strategy development in order to understand the current barriers to communication between services and how new and innovative models of IM&T can address this. The implementation of the strategy will then be managed by an IM&T Board with stakeholder representation from across Halton, including Informatics Specialists, Provider Representation, CCG Lead, LA lead and the wider health economy.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

This scheme is the responsibility of the IT Strategy Group and the Operational Director for Complex Care.

This strategy is an over-arching strategy in that all providers delivering care to Halton residents whether this is health or social care will need to be engaged in the process, inputting into the development of an effective IM&T strategy and then supporting its implementation. This will include:

- Secondary care providers
- Primary Care
- Community providers
- Social care providers
- Voluntary sector
- Halton CCG (and neighbouring CCG's where appropriate)
- Halton Borough Council

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

There is evidence that, where interoperability between patient systems is enabled, significant patient benefits have been realised, including; improved communications, enhanced integration between services and increased the efficiency and effectiveness within services. The evidence base will be further expanded upon as part of the strategy development process which will be progressed over the coming months to include local evidence of where improvements can be made.

It is also evident based on a number of CCG stakeholder events that there are a number of barriers that lack of appropriate technology creates in terms of sharing necessary information between services and how this is impacting on the patient pathway. Often the processes that have been put in place as an alternative have led to duplication and inefficiencies within services.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

2014/15	**2015/16**
£0	**£100,000**

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

It is anticipated that there will be a number of other 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 – via improved communication and reducing duplication between services and providers.
- Reduction in patient delays - via improved access to test results and up-to-date patient information
- Reduced admissions – particularly in services such as the palliative care in which

improved communication may avoid an out of hours admission.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

It is anticipated that the IM&T strategy will need to be carried out as a phased implementation throughout Halton. There are currently a number of different information systems being utilised amongst providers and as such it will be necessary to target areas which are likely to see the most benefit in the first instance and use these areas to inform roll-out across the wider health economy.

Progress will be monitored by the Better Care ECB

What are the key success factors for implementation of this scheme?

The implementation of the IM&T strategy will be dependent on two key factors:

1. Sufficient engagement form providers to develop the strategy. The strategy will be developed in collaboration with providers, via a number of stakeholder engagement events and as such support for the direction of travel will need to be established and supported.

2. The second key success factor is the availability of appropriate IT solutions to support our intentions which will be secured via robust specification of what we want our IM&T strategy to deliver. The supporting technology capability will underpin the success of the scheme.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
15
Scheme name
Early Intervention and Prevention
What is the strategic objective of this scheme?
The strategic objective of the scheme is the implementation of the Halton Borough Council Early Intervention and Prevention Strategy by: • Investing in prevention services that provide early support to people to maintain their own health and wellbeing. • Reducing the overall burden on primary and secondary care by helping people to manage and maintain a better quality of health This will be managed via Sure Start to Later Life who are co-ordinating the services of grant-funded organisations with the strategic aim of early intervention and prevention. Each organisation is working on different strands of prevention services and are listed below.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Halton Borough Council has made considerable investment in implementing our Early Intervention and Prevention Strategy. Our model of care and support provides a balance of provision across the three levels of prevention- primary, secondary and tertiary prevention. At the primary level The Sure Start to Later Life and Community Bridge Builders services provide support to people to engage in community activities, volunteering and trips out. They both provide information services. These services work in partnership, through the Partnerships in Prevention (PIP) group, with numerous prevention agencies including Age UK, The Red Cross, Sports Development, the Alzheimers Society, Stroke Association and many more. The target group here are people who have no particular social or health care needs. At secondary level our services aim to identify people at risk and to halt or slow down any deterioration and actively seek to improve their situation. Examples of this approach include our comprehensive falls prevention programme and loneliness intervention programmes. The former provides exercise classes and falls awareness presentations to staff and “at risk” groups which has resulted in a 14% reduction in hospital admissions due to falls in the borough. The latter is actively targeting lonely people in the borough and provides a range of interventions coordinated through the Sure Start to Later Life service. This service is shortly to be entered into the SCIE prevention library as an example of good prevention practice. Our overall loneliness strategy is aimed at tackling the complex needs of individuals and communities in relation to loneliness and social isolation.

At tertiary level, which is aimed at minimising disability or deterioration from established health conditions or complex social care needs, we have the award winning Rapid Access and Rehabilitation Service and Reablement service. Their focus is on maximising people's functioning and independence through interventions such as rehabilitation and joint case management of people with complex needs.

Our key approach is that interventions are required across the whole spectrum of need, to help older people who are healthy to continue to live independently for longer and to assist older people who are unwell to regain their independence or to prevent or delay the onset of further health problems. Thus even when working with people at the tertiary level, we will ensure that their primary level needs are addressed.

We seek to take a 'whole systems approach', involving a broad range of other council departments or statutory organisations with a responsibility to act and money to invest. However, whilst our prevention strategies identify that there is 'no shortage of low level services', there is a clear gap in the coordination of these services and in taking a "joined up" approach to ensuring information and advice about these services is readily available.

This involves:

- The development of an overarching advocacy hub that will act as a triage to all local advocacy services. This is designed for people who need help to get their voices heard or access key services or information.

- The development of information and advice network that will help people access the relevant information that they need to maintain their own independence. This will be developed with reference to the new Care Act that is due for implementation in April 2015 and has specific new duties on Local Authorities to deliver up to date and accessible information to the local population.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

This scheme is the responsibility of the Better Care ECB

The services will be commissioned through existing local authority and Clinical Commissioning Group arrangements. Each of the services will work towards an agreed specification, however there will also be separate networks established for two of the areas that fall under the prevention heading, Advocacy and Information.
The Advocacy network will include:

- SHAP Ltd
- Together Working for Wellbeing
- Registered Social Landlords
- Halton Speak Out
- The Carers Federation

- Halton Healthwatch

The Information network will be developed through the Citizens Advice Bureau and will include:

- The Carers Centre
- Age UK
- Red Cross
- Sure Start to Later Life
- Wellbeing Enterprises
- The Alzheimer's Society
- Halton and St Helens Community Voluntary Action

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The Government White Paper Care and Support published earlier this year was a direct response to the recommendations of the Dilnot Commission which concluded in July 2011. The Care Act 2014 outlines a significant shift in how services should be delivered with more of an emphasis on prevention, information and advocacy.

Locally a number of strategies have contributed towards the evidence base:

- Early intervention and prevention strategy
- Falls strategy
- Loneliness strategy
- Older people's commissioning strategy

Support provided via the British Red Cross has been reviewed by nef consulting (new economics foundation)[6] and published in the report "Taking Stock: assessing the value of preventative support" this report highlights that the costs to the state would have been between £700 To £10,430 per person for the support provided". In particular support provided to tackling the complex needs of individuals in the community in relation to loneliness or social isolation prevents depression from worsening, reduce the likelihood of suicide, reduces the need for GP, and social care services and can improve medicines compliance and hospital admissions[7] In one of the cases study quoted, a single avoided hospital admission could save between £586 and £2,514. (including the cost of ambulance call out)

Additional evidence for the need for the creation and delivery of a loneliness strategy is the Age UK paper "Loneliness and Isolation Evidence Review"[8] which highlighted the recommendations from the Audit Commissions 2008 report "Don't Stop me know" including;

- Councils should target services to tackle social isolation and support independent living.
- Targeted services should focus on the underlying causes of dependency in later life
- Councils should lead local statutory agencies and the community and

[6] http://www.redcross.org.uk/~/media/BritishRedCross/Documents/About%20us/Taking%20stock%20-%20assessing%20the%20value%20of%20preventative%20support.pdf

[7] Taking Stock:assessing the value of preventative support, pg3, para. 6

[8] http://www.ageuk.org.uk/documents/en-gb/for-professionals/evidence_review_loneliness_and_isolation.pdf?dtrk=true

voluntary sector in making the most effective use of resources

The Age Concern report also highlighted that between 6 and 13% of the UK population described as often or always lonely with a steep rise in reported loneliness amongst those aged 80+

Reducing age-specific dependency rates by 1 per cent per year would reduce public expenditure by £940m per year by 2031[9]

The Cabinet Office report "Making life better for Older People: An economic case for preventative services and activities" highlights both qualatively and quantatively the benefits of prevention and early intervention[10] including

- Local interventions by a local health communities collaborative reduced falls by 32% in the first year, and 37% in the second
- Individuals with more social ties had lower mortality rates over a nine year period
- Home accidents, particularly falls, burns and scalds cost the Health service around £3bn a year.

Falls Evidence

We know that hip fractures alone cost the NHS over £2.3bn per year. Evidence shows that falls prevention services are cost effective and could make substantial savings particularly in the number of hospital admissions due to falls(Fracture Prevention Services: An economic evaluation, Department of Health, November 2009.)

Annually, ambulance services respond to 700,000 calls from older people who have fallen, which accounts for 10 per cent of total calls. Around 25 per cent of these **do not need to go to hospita**l. Falls cost £115 per ambulance call-out. (J.L. Newton et al., 'The Costs of Falls in the Community to the North East Ambulance Service', *Emergency Medicine Journal*, 23: 479–81 (2006) doi:10.1136/emj.2005.028803).

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

2014/15	**2015/16**
£0	**£566,000.00**

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

.Anticipated outcomes of this service include a contribution toward:

- Reduction in primary care visits
- Increase in people accessing information
- Increase in the number of people supported to maintain their own independence

The Cabinet Office report "Making life better for Older People: an economic case for preventative services and activities" demonstrated the scale of the impact that can

[9] Age Concern: Loneliness and Isolation Evidence review pg17, para. 2

[10] http://webarchive.nationalarchives.gov.uk/20080910192639/http:/www.cabinetoffice.gov.uk/~/media/assets/www.cabinetoffice.gov.uk/social_exclusion_task_force/publications_1997_to_2006/making_older_people%20pdf.ashx

be made, in addition to the improvement in wellbeing and mortality rates there are real cash savings to be made. The POPPs project, Manchester[11] which included services providing information and advice about services a team to strengthen the voluntary sector and a network of services under a single framework would cost an estimated £1.5m a year, supporting people to live at home to a benefit of £3.1m a year, preventing the need for high intensity care by £1.4m a year and reducing avoidable, emergency admissions and bed days by £11k a year.
Research identified that for every £1 spent, there is a benefit of £2.20.
Schemes identified by the British Red Cross and Age Concern identified that by talking loneliness, emergency admissions can be reduced, saving between £586 and £2,514 per admission.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Each service will have a service specification with a range of outputs and outcomes that will be relevant to their own area of work. This will be monitored through commissioning via Quality Assurance on a quarterly basis and will be supported by half yearly monitoring visits to complete an audit of the commissioned service. Overall governance of the scheme will be through the Better Care Board.

What are the key success factors for implementation of this scheme?

The success factors will be linked specifically to the outcomes of the service and will show a contribution towards reduction in the use of primary and secondary care services. It will also see an increase in the use of prevention services, lifestyle advice and overall information provision in the borough. Other key success factors will be reduction in number of hospital admissions due to falls, number of staff and residents attending falls awareness programmes, reduction in percentage of people reporting feelings of loneliness and an increase in successful outcomes, as defined by service users, through the information and advocacy hubs.

[11] OPDM: Making life better for older people: An economic case for preventative services and activities; Slide 12

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
16
Scheme name
Minor and Major Adaptations and Equipment
What is the strategic objective of this scheme?
In Halton we are committed to provide service in and as close to people's homes as possible to improve the health and wellbeing of the population. Timely access to equipment and adaptations to enable individuals to continue to carry out everyday tasks and maintain their independence in the community is an essential enabler to achieve this. Equipment also supports the delivery of care and nursing needs in the community setting by either paid or family carers.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The key components to providing equipment and adaptations to enable people to remain independent are: xiii. Assessment of individuals need for specialist equipment or adaptation by an 'Approved Prescriber'. NHS staff may also prescribe equipment that supports the treatment or, maintains health or end of life care. Multi-professional collaboration may occasionally be required, where there is more than one prescriber from a different service area involved in dealing with the disabled person xiv. Selection and order of equipment or adaptation including specialist or bespoke by prescriber with regard to the level of disability xv. Procuring equipment as requested by Approved Prescribers to the standards and guidance as set out by the Medical and Healthcare Product Regulatory Agency (MHRA) and identified within the NHS Controls Assurance Standards; xvi. Delivering appropriate items of equipment for daily living or nursing equipment to people's homes or community settings, within specified timescales vii. Fitting, installing, adjusting and/or assembling equipment and demonstrating the safe use of. viii. Servicing, maintenance and repair of all items of equipment supplied in accordance with the manufacturer's recommendations, including regular service of hoists and while the equipment is on issue to individuals.

xix. Collecting equipment from people's homes or community setting when no longer required within timescales as instructed by the service specification.

xx. Cleaning and refurbishment of returned equipment to recycle as quickly as reasonably practicable in accordance with national guidelines.

xi. Safe disposal of all equipment collected from or returned by individuals where the equipment is unsuitable for re-use and beyond economic repair.

xii. Providing on-site technical advice, working with practitioners/clinicians, attending joint visits and advising clinicians on all aspects of minor adaptations and technicalities around equipment.

xiii. Providing and maintaining the Equipment Catalogue.

xiv. Providing and administrating the Disabled Facilities Grant to provided for works to adapt the homes of chronically sick or disabled persons to enable them to continue to live independently in their homes

These arrangements are available to children and adults of all ages where it appears that a person has a permanent and substantial disability :

- as defined by the Equality Act 2010
- A child in need as defined by The Children Act 1989
- Someone who is "ordinary resident" in the local authority area and meets the relevant criteria
- Registered with a Halton GP

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

This scheme is the responsibility of the Better Care ECB and the Operational Directors for Complex Care and Prevention and Assessment.

These are jointly commissioned services.

Assessments are completed by nurses, therapists and rehabilitation officers working across health and social care.

Bridgewater Community NHS Trust are commissioned to deliver the integrated community equipment service through a partnership agreement and pooled budget arrangement between Halton CCG and Halton Borough Council.

The minor adaptations service is commissioned by Halton Borough Council and provided by Helena Partnerships Ltd

The Disabled Facilities Grant works are managed by Halton Borough Councils Home Improvement Agency

The evidence base

Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

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.

In Halton, more than 1 in 5 people (21.4%) are living a greater proportion of their lives with an illness or health problem that limits their daily activities.

In November 2012, 7,780 (9.4%) working age adults were claiming Incapacity Benefit (now Employment Support Allowance). This is higher than the North West and England averages and most of these people have been receiving this benefit for more than three years.

As more services are being delivered in people's own homes then it is self evident that changes to the physical environment and the provision of equipment is required to support this

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

2014/15	**2015/16**
£0	**£1,644,000**

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

This scheme contributes to:

- Improved quality of life
- Increasing a person's independence
- Maintaining independence
- Assisting recovery
- Support carers to provide safe care
- Reduction in falls and associated hospital admissions
- Delaying need for more formal care
- Improved wellbeing and mental health
- Improved dignity and respect

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Monitoring of efficacy will be through monthly performance reports to the Better Care ECB including:

- Total number of adaptations
- Number/% completed within target timescales
- Total number of equipment items delivered

- Number/% delivered within target timescales
- Total number of equipment items collected
- Value of items collected

Alongside these direct performance measures local metrics include data on numbers of people helped to live at home.

Providers also conduct their own customer satisfaction surveys which are reported to Commissioners.

Prescribers from across health and social care and operational managers meet regularly to ensure best practice is followed, the equipment catalogue remains current and to address any process issues.

What are the key success factors for implementation of this scheme?

Ensuring the delivery of responsive services to demographic pressures and increased demand for support to live at home.

Managing increased complexity in the community

Managing the equipment market to ensure cost inflation is kept to a minimum

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
17
Scheme name
Integrated Wellness Service
What is the strategic objective of this scheme?
Review the current approach to the delivery of Health and well-being services delivered by both health and local authority providers with a view to aligning systems and services with the overall aim of contributing to the reduction long-term care and prevention of deterioration. The integrated wellness model will initially aim to integrate those services which support people in adopting healthier lifestyles. In addition, they will recognise the fundamental impact of some of the wider health determinants that are likely to be a barrier to improving health by supporting and signposting to appropriate services.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
This proposal aims to further develop the joint delivery role into a single streamlined service called a wellbeing hub which will bring together the various strands of wellbeing and lifestyle services across Halton, recognise the current strengths of individually commissioned services and broaden the involvement and scope of the services though greater input from the third sector agencies also working on similar agendas through Halton. Central to delivery will be well-being advisers who will be made up from existing health trainers and wellbeing service team. The Wellbeing Hub would consist of both a physical and virtual presence. The team members would be able to receive referrals either by phone, e-mail, webpage or through physical presence at a number of key locations throughout the borough (eg one stop shops, community venues etc.) The service will provide a single point of access for the entire population of Halton to access a range of services, advice, interventions and assistance to help identify and resolve potential problems and improve their physical, emotional and social health and wellbeing. The service will also provide professionals, from any background, with a single access point for their clients or patients and assist with the Making Every Contact Count Agenda. a. Deliver a community wide approach to health and well-being; b. Develop holistic solutions to improve health and well-being outcomes and address health inequalities (across health, social care and public health) within Halton; and c. Embrace the full range of local services e.g. health, housing, leisure, transport, employment, social care, education and children's services.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

This scheme is the responsibility of the Public Health Senior Management Team and Operational Director of Public Health.

Providers to be part of the delivery chain include teams from Halton Borough Council: Health Improvement Team, Sure Start to Later Life, Community Bridge Builders, Halton Falls Prevention service, Community Development and Sports Development, along with the voluntary sector organisation Wellbeing Enterprises CIC.

Through our Partnerships in Prevention (PIP) group a host of statutory and third sector organisations will be closely involved in the delivery of the initiative. These include: CAB, Age UK, The Red Cross, Stroke Association, Halton Housing Trust, Liverpool Housing Trust, Halton Carers Centre, Halton Community Transport, Vision Support, Halton Speak Out, Halton Older People's Empowerment Network, Halton People into Jobs, Halton Libraries service, Halton Community Wardens and Telecare services, Halton Leisure services, Five Boroughs Partnership NHS Trust, Halton Rapid Access and Rehabilitation service and Reablement service.

To achieve best value we currently demonstrate an integrated approach to commissioning across health and social care whilst moving towards a model of co-produced commissioning of services.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

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,

The benefits to the service user
• Promote positive health that can empower individuals, enabling them to maintain and improve their own health.
• Providing, safe, natural means to boost physical and mental health without unpleasant side-effects. For example: tools, techniques, assistive technology and education.
• Wellness services can work in conjunction with traditional medical services or prevent or reduce the need for medical interventions
• Where necessary services and programmes facilitate lifestyle adjustments to enable individuals to gain wellness.
• The focus is on promoting quality of life not just length of life.
• Rather than considering just the diseased part, the service considers the whole person: mind, body and spirit and the wider determinants of health such as lifestyle, social environment, living conditions and so forth where there can be imbalances in an individual's life – that are preventing them from reaching their optimum health.

- Wellness services take into consideration inequalities of health and where possible actively seeks out those individuals that do not usually benefit from mainstream health services.
- Specific wellness services can increase patient choice by linking patients up to non-medical facilities and services available in the wider community that can address psychosocial factors that influence wellbeing.
- There have been a range of reported positive mental health outcomes including: enhanced self-esteem, improved mood, opportunities for social participation, increased self-efficacy, various transferable skills and greater confidence that all enhance quality of life.
- Some of these wellness services can make available new opportunities for patients for meaningful activities.
- Preventive health programmes based on Occupational Therapy may mitigate against the health risks of older adulthood.
- Wellness services can provide contact with others facing similar challenges. This provides a sense of not being alone and opportunities to learn from others' coping strategies.
- Peer support or "buddying" can provide on-going mutual support for self-help strategies beyond the professional intervention.
- Some services can enable some individuals to improve self-management of a long-term health condition and return to work.
- By tackling the causes of ill-health, wellness services have demonstrated a broad understanding of the links between life circumstances and health. For example "the Women's mental health demonstration project" in Glasgow, has found that significant impacts can be made in the lives and health of women with complex underlying problems in a relatively short period of time.
- Improved outcomes for older people appear to be achieved through integrated, co-located health and social care teams.

While many programmes do not undertake a rigorous cost effectiveness analysis, there are many examples of cost benefits as a result of reduced prescribing, secondary care interventions, improved household income and improved social productive described for a large number of 'holistic' interventions (highlighted in the Liverpool Public Health Observatory Report in 2010)

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

2014/15	**2015/16**
£0	**£20,000**

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

This scheme will contribute to:

- Prevention of Deterioration, which in turn contributes to a lower level of higher levels of care
- Improved quality of life.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to

understand what is and is not working in terms of integrated care in your area?
A whole system approach to measuring structure process and outcome will be inbuilt to reduce the need for new survey and data collection. The evaluation will be based on the key service standards which will ensure continuous improvement and learning. This will be reported through the Better Care Board
What are the key success factors for implementation of this scheme?
In the last few years, the national drivers for improving lifestyle risk factors have been focussed predominantly on topic based strategies rather than holistic approaches to achieve healthy individuals and healthy communities. This included targets around individual behaviours that have driven local programmes for stopping smoking, achieving healthy weight etc. Despite this Halton has a positive history in the development of more holistic approaches to address the wider determinant and improve overall health and well-being. One such example being the Advice on Prescription Service, a Primary Care Trust initiative in collaboration with Citizens Advice Bureau (CAB) which aimed to fast-track people visiting their GP with mental health problems, which may be exacerbated by social welfare issues, to appropriate support services rather than prescribing medication or referring to psychological therapy services. The service has also been shortlisted as a finalist in the HSJ 2010 finals under mental health innovation. There are many other examples which have been successfully managed across Cheshire and Merseyside and the North West, including nationally accredited and award winning services; Knowsley NHS Holistic Service and Ellesmere Port and Neston Primary Care Trusts Health and Social Welfare Service which shown significant improvements in mental health, reductions in antidepressant prescribing, increased household income and improved housing conditions for those accessing the service, in addition to support within lifestyle services to promote health gains.

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Halton
Name of Provider organisation	St. Helens & Knowsley Hospitals NHS Trust
Name of Provider CEO	Ann Marr
Signature (electronic or typed)	*Ann Marr*

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	7559
	2014/15 Plan	7370
	2015/16 Plan	6992
	14/15 Change compared to 13/14 outturn	-2.5%
	15/16 Change compared to planned 14/15 outturn	-5.1%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	189
	How many non-elective admissions is the BCF planned to prevent in 15-16?	378

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	The Trust can confirm that the intentions within the BCF plan are aligned with the Trust IBP/LTFM. However, given that the health and social care economy has never delivered a sustained reduction in urgent care demand the Trust cannot at this stage be confident that the BCF plan will bring about the improvements as per the stated intention. Further work is required across the whole system to provide assurance that the plan will have an impact at the scale and pace required.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	The BCF submission includes a comprehensive list of schemes which are intended to improve services although several of these are described as a “continuation of” or “maintenance of” and as such these are not

		new. Where new schemes are identified these lack clarity with regard to scheme specific methodology, milestones, programme management plan, performance metrics etc. The Trust is also as yet unclear as to how the proposed governance system will function; who will be represented on what committees, what decisions will be made etc. The Trust would welcome further discussion with regard to this.
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	If the BCF plan does not deliver at scale and pace the impact upon the Trust will be considerable as pressures in the urgent care pathways will continue to rise. In the last three years the Trust has been operating at full capacity with many occasions when demand exceeded available beds. During this period admissions to "specialty beds" have continued to rise. Even if activity levels remain the same as the last two years there will be many occasions when capacity will be exceeded. In late 2013 the Trust initiated a Medicine Redesign Programme without funding and made a significant investment into AED, nursing, and ward based discharge planning teams all of which has underpinned service delivery. These services cannot be continued if they are not funded and this is the highest priority for the Trust this winter and beyond

PLEASE SEE ATTACHED ANNEX 2 (PDF)

Support from Acute Providers

Both acute providers are fully committed members of the System Resilience Group. Terms of Reference can be found at Annex 8. Attached are letters of support from both providers in terms of our BCF Plan.