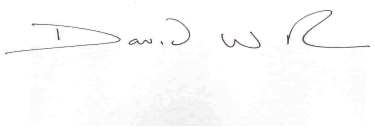
Public Document Pack

Health and Wellbeing Board

Wednesday, 11 March 2015 2.00 p.m.
Karalius Suite, Stobart Stadium, Widnes



Chief Executive

Please contact Gill Ferguson on 0151 511 8059 or e-mail gill.ferguson@halton.gov.uk for further information.
The next meeting of the Committee is on Date Not Specified

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

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HEALTH AND WELLBEING BOARD

At a meeting of the Health and Wellbeing Board on Wednesday, 14 January 2015 at Karalius Suite, Stobart Stadium, Widnes

Present: Councillors Polhill (Chairman),Philbin, Woolfall and Wright and S. Banks, M. Cleworth, M. Creed, K. Fallon, G. Ferguson, S. Henshaw, D. Lyon, A. McIntyre, E. O'Meara, M. Pickup, N. Rowe, I. Stewardson, R. Strachan, D. Sweeney and J. Wilson.

Apologies for Absence: S. Boycott, D. Parr, N. Sharpe, A. Waller and S. Yeoman

Absence declared on Council business: None

ITEM DEALT WITH
UNDER DUTIES
EXERCISABLE BY THE BOARD

Action

HWB32 MINUTES OF LAST MEETING

The Minutes of the meeting held on 11th November 2014 having been circulated were signed as a correct record. Under Minute HWB23 Integrated Sexual Health Service it was noted that the tender had been led by Warrington and Halton Hospitals NHS Foundation Trust in partnership with St Helens and Knowsley Teaching Hospitals NHS Trust.

HWB33 FAMILY NURSE PARTNERSHIP - PRESENTATION

The Board received a presentation from Julie Rosser which provided background information on the role of the Family Nurse Partnership (FNP) in Halton, including its aims and anticipated outcomes.

FNP was a preventative programme aimed at improving the life chances of the most disadvantaged children and families in society. The main aims of the programme were to work with first time mums under 19 years of age as follows:

- to improve pregnancy outcomes, so that the baby had the best start in life;
- to improve the child's health and development by

developing parenting knowledge and skills; and

- to improve parents' economic self-sufficiency, by helping them to achieve their aspirations (such as employment or returning to education).

Members were advised that there was a Government commitment to increase the number of FNP places in England at any one time to 16,000 by 2015. Local Authorities would take on responsibility for commissioning FNP In 2015.

It was noted that in Halton, FNP had been commissioned by NHS England. Four nurses had now been recruited and started seeing patients in November 2014. The provider organisation was Bridgewater Community Healthcare NHS Foundation Trust, who was licensed to deliver the programme.

It was also noted that a Halton FNP Board had been established which included representatives from NHS England, CCG, Bridgewater, Public Health and Partner Organisations.

RESOLVED: That the report and presentation be noted.

HWB34 DEVELOPING A NHS HALTON CCG RESPONSE TO THE NHS FIVE YEAR FORWARD VIEW

The Board considered a report of the NHS Halton Clinical Commissioning Group (CCG) which informed Members that on the 23rd October 2014, NHS England, in partnership with five other national organisations involved in setting the strategic direction and regulatory framework for the NHS, had published Five Year Forward View. The purpose of the Five Year Forward View was to:

- articulate why change was required, what that change might look like and how it could be achieved;
- describe various models of care which could be provided in the future, defining the actions required at local and national level to support delivery;
- recognise the challenges and outlined potential solutions to the big questions facing and health and care services in England; and
- define the framework for further detailed planning about how the NHS needed to evolve over the next five years.

The Board was advised that on the 4th December

2014 NHS Halton CCG had commenced a two month dialogue with local people and partners in regard to a Halton response to Five Year Forward View. Strategic decisions would need to be made by NHS Halton CCG Governing Body, particularly in regard to new models of care.

As a result, a template had been produced which took the key statements made of actions suggested in the Five Year Forward View to apply a "Halton lens" to enable comparisons to be made. Contributions to this document were invited from all partners and a final document would be returned to the CCG Governing Body on 5th February 2015. The Governing Body were invited to contribute to the development of this document as strategic decisions would need to be made following the Five Year Forward View, particularly in regard to new models of care.

RESOLVED: That the Board be invited to review and contribute to the document produced by NHS Halton CCG.

HWB35 HALTON SUICIDE PREVENTION STRATEGY 2015-2020

The Board considered a report of the Director of Public Health, which presented the final draft of the Halton Suicide Prevention Strategy 2015-20. The Halton Suicide Prevention Strategy had been written in partnership and set out evidence-based actions, based upon national policy, research and local insight, to prevent suicide and support those bereaved or affected by suicide in Halton. The Strategy was supported by a detailed action plan outlining actions, responsible leads, timescales and outcomes to be achieved.

It was noted that the plan would be monitored by the Halton Suicide Prevention Partnership and outcomes reported to the Safer Halton Partnership, Health and Wellbeing Board and all other relevant bodies. Members were also advised on the vision, areas for action, outcomes and objectives of the Suicide Prevention Strategy.

The Board highlighted the importance of signposting individuals to access services to prevent suicide or to support those affected by suicide and if there were sufficient levels of signposting available in Halton. It was suggested that beer mats could also be made available with contact details of suicide prevention services.

RESOLVED: That

(1) the contents of the report be noted; and

Director of Public

Health

(2) the Strategy outcomes, objectives and actions be supported.

HWB36 DEVELOPING A NHS HALTON CCG RESPONSE TO NEXT STEPS TOWARDS PRIMARY CARE CO-COMMISSIONING

The Board was advised that on the 10th November 2014 NHS England, in partnership with NHS Clinical Commissioners, as representatives of the English Clinical Commissioning Groups (CCGs), published Next Steps Towards Primary Care Co-commissioning. The document aimed to provide clarity and transparency around co-commissioning options, providing CCGs and area teams with the information and tools they needed to choose and implement the right form of co-commissioning for their local health economy. NHS Halton CCG needed to decide by the 9th January 2015, the level of primary care co-commissioning the organisation wished to undertake with NHS England. It was noted that there were three primary care co-commissioning models CCGs could take forward:-

- Greater involvement in primary care decision-making;
- Joint commissioning arrangements; and
- Delegated commissioning arrangements.

Members were advised that at the NHS Halton CCG Governing Body meeting on the 4th December 2014, it was recommended that an expression of interest would be submitted for the organisation to assume delegated commissioning for 2015/16. Comments from member practices and key partners were invited by 19th December 2014 and the document had been submitted on 9th January 2015, following approval by the NHS Governing Body on 8th January 2015.

It was noted that NHS England recognised that it would be challenging for some CCGs to implement co-commissioning arrangements, especially delegated arrangements, without an increase in running costs. Whilst there would be no increase in running costs in 2015/16, NHS England would keep this situation under review.

It was highlighted that the area teams and the CCGs would agree the full membership of their joint committees and that a Local Authority representative would have the right to join the joint committee.

RESOLVED: That the Board review the report and

verbal update from NHS Halton CCG.

HWB37 MATERNITY SERVICES

The Board considered a report of the NHS Halton Clinical Commissioning Group (CCG) which informed Members that Cheshire and Merseyside CCGs had agreed to undertake a review of maternity services across the sub-region. The review was being undertaken with the support of provider organisations and the Cheshire and Merseyside Strategic Clinical Network (SCN). It was reported that the involvement of the SCN was crucial as it ensured that the clinicians were engaged in and leading this work.

It was noted that work was currently under way to develop a baseline understanding of the nature and shape of maternity services in Cheshire and Merseyside. Using all available data this was specifically looking at:-

- Clinical outcomes;
- Patient experience and choice;
- Education and training of the current and future workforce;
- Co-dependencies with other services including neonatal intensive care, co-surgical support, critical care, A & E and other specialist services;
- Safeguarding;
- Capacity and size of current provision;
- Current and future demographics and geographical access;
- Epidemiology of the population; and
- Current commissioning and financial arrangements.

The Board was further advised that the next phase of the work would involve developing options for improvement, using evidence of national and international best practice. Any options for change would be subject to engagement and consultation with patients and the public in Cheshire and Merseyside.

RESOLVED: That the report and comments raised be noted.

HWB38 PHARMACEUTICAL NEEDS ASSESSMENT

The Board considered a report of the Director of Public Health, which provided a final version of the Pharmaceutical Needs Assessment (PNA) and briefing on the results of the statutory 60-day consultation. The PNA

was a statutory document that stated the pharmacy needs of the local population. This included dispensing services as well as public health and other services that pharmacies may provide. It was used as the framework for making decisions when granting new contracts, and approving changes to existing contracts as well as for commissioning pharmacy services. At its meeting on the 17th September 2014 the Board authorised the commencement of the statutory 60 day consultation which was part of the process of developing the PNA.

It was reported that following the consultation process, 6 responses were received. One response referred to the previous 2011 PNA and was so omitted from the responses detailed in the report. It was noted that, overall, the respondents were very positive and the majority agreed with the findings. Full details of comments made and the Steering Group response to each were outlined to Members of the Board.

Members were advised that the PNA must be published no later than 1st April 2015 and the Steering Group would meet, periodically and as needed to produce supplementary statements during the lifetime of the PNA.

RESOLVED: That –

(1) the PNA be approved for publication; and — Director of Public Health

(2) the Steering Group be delegated to deal with production of supplementary statements needed throughout the lifetime of the PNA.

HWB39 GENERAL PRACTICE STRATEGY

The Board received a report from the Chief Officer of NHS Halton CCG which provided an update and next steps on the progress with the development of the General Practice Strategy and other key agendas that influenced the Strategy. The Strategy had been developed through local discussion, feedback and research. The draft summary document had been shared with practices and partners and formed the basis of a discussion at the Service Development Committee in November. There were four key elements to the General Practice Strategy:-

- Case for Change: setting out the range of National and Local Drivers that collectively resulted in the conclusion that general practice in its current guise was not sustainable in Halton. This was evidence-

based and where available, local data had been used;

- Principles: ten principles that were considered fundamental to the future design, configuration, commissioning and delivery of local General Practice;

- Service model: It was proposed that a new model was established with services centred around people in the community, ensuring everyone's needs were met through an integrated health and social care delivery model;

- Community Hubs: The model would see services and teams aligned to a community "hub". The aim was for each hub to contain approximately 20,000 to 25,000 residents, therefore, across Halton, there would be between 6 to 8 hubs.

It was proposed that the final strategy would be circulated to Board Members and presented to the CCG Governing Body in March 2015. S. Banks

RESOLVED: That the report and timescales be noted.

HWB40 PRIME MINISTER'S CHALLENGE FUND

The Board considered a report of the Chief Officer, NHS Halton CCG, which provided an update on Wave Two of the Prime Minister's Challenge Fund: Improving Access to General Practice and on the submission being co-ordinated by NHS Halton CCG.

In October 2013, the Prime Minister announced a new £50m Challenge Fund to help improve access to General Practice and stimulate innovative ways of providing Primary Care Services. Twenty pilot schemes were selected that would benefit over 7 million patients across more than 1,100 practices. On the 30th September 2014, the Prime Minister announced a new second wave of access pilots, with further funding of £100m for 2015/16. The Government asked NHS England to lead the process of inviting practices to submit innovative bids and oversee the new pilots.

NHS England invited applications from practices or groups of practices that wished to test new models for providing general practice services, with potential benefits not only for patients accessing general practice, but also with benefits to the wider NHS. NHS Halton was working on

an application with local practices, partners and CCG staff and would be liaising closely with the Merseyside Area Team over the coming weeks to get their input and consideration to ensure the application was as robust as possible.

The deadline for Wave Two applications was the 16th January 2015 and the successful Wave Two Pilots would be announced in February 2015 with pilot mobilisation from March 2015 onwards.

RESOLVED: That

(1) the contents of the report and timescales be noted; and

(2) the Board considers any risks not identified and potential mitigations.

HWB41 CHILDREN IN CARE ANNUAL REPORT

The Board considered a report of the Strategic Director, Children and Enterprise, which presented the Annual Report on the Health of Children in Care (CIC) for the period 1st April 2013 to 31st March 2014.

The Children in Care Annual Report looked at health issues of CIC in Halton and CIC from other Local Authorities who lived in Halton.

Members were advised that when a child or young person came into care they had a health assessment by the Community Paediatrician. Once they had seen the doctor, the children and young people would each have a nurse who would see them later in the year for health checks and help with their Health Care Plan. The CIC would also see all Care Leavers for a health check before they left care.

The report concluded that there had been considerable improvement in children receiving a timely service to ensure that their health needs were identified and addressed. However, there was still room for improvement and healthcare partners needed to continue to work together, to ensure that CIC were offered a service of the highest quality to meet each child/young person's needs.

RESOLVED: That the report be noted.

HWB42 MEETING DATES 2015/16

The following dates of Health and Wellbeing Board Meetings in 2015/16 were noted:

2015
11 March
13 May
8 July
16 September
4 Nov

2016
13 Jan
9 March

All meetings will be held on a Wednesday at 2 pm in the Karalius Suite, Stobart Stadium, Widnes.

RESOLVED: That the meeting dates be noted.

Meeting ended at 3.20 p.m.

REPORT TO: Health and Wellbeing Board

DATE: 11th March 2015

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Wellbeing

SUBJECT: Delivering improved health and wellbeing through the Widnes Vikings Rugby Club

WARDS: Borough wide

1.0 PURPOSE OF THE REPORT

A presentation will be given to the Board from the Chief Executive of the Widnes Vikings. The presentation will illustrate to the Board how the Vikings are working with the local community and schools to promote health and wellbeing.

2.0 RECOMMENDATION: That the Board note the contents of the presentation

REPORT TO:	Health and Wellbeing Board
DATE:	11th March 2015
REPORTING OFFICER:	Simon Banks, Chief Officer
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Strategy for General Practice Services in Halton
WARDS:	Borough Wide

1.0 PURPOSE OF THE REPORT

This report follows that of 17th September 2014, where the Health and Wellbeing Board were notified of the development of a Strategy for General Practice Services in Halton. This Strategy was presented to the NHS Halton CCG Governing Body on 8th January 2015 as a final draft; this is the document that is attached to this report. The final Strategy will be presented for ratification to the NHS Halton CCG Governing Body on 5th March 2015.

2.0 RECOMMENDATION: That the Health and Wellbeing Board note the report and accompanying documentation.

3.0 SUPPORTING INFORMATION

General practice is often described as the cornerstone of the NHS, with roughly one million people visiting their general practice every day. NHS England is responsible for commissioning the core primary medical services that general practice provides. Clinical Commissioning Groups (CCGs) have a duty to support NHS England in promoting quality in general practice services.

The basic delivery model of general practice has evolved over time but not radically changed. There have been seismic shifts and environmental pressures in health and social care in recent years that have challenged the sustainability of general practice. General practice faces challenges from:

- An ageing population, growing co-morbidities and increasing patient expectations.
- Increasing pressure on NHS financial resources and increased regulation.
- Persistent inequalities in access and quality of general practice.
- Growing reports of workforce pressures, including recruitment and retention problems.
- Political pressure to change.

At the time of writing of this report, NHS Halton CCG is awaiting from NHS England the outcome of a formal expression of interest to undertake co-commissioning arrangements for general practice services in the borough. This means that NHS England may, from 1st April 2015, delegate responsibility for the commissioning of general practice services in the borough to NHS Halton CCG. NHS Halton CCG and NHS England agree that strong sustainable general practice is needed in Halton to support commissioning *and* service provision. This needs a co-ordinated and engaged approach to deliver this, which is why NHS Halton CCG has worked with general practices and other partners in the borough to develop a co-commissioning strategy for general practice services in Halton.

4.0 POLICY IMPLICATIONS

NHS England has stated their ambition for general practice services to operate at greater scale and be at the heart of a wider system of integrated out-of-hospital care. This will require a shift of resources from acute to out-of-hospital care. These ambitions are congruent with NHS Halton CCG's 2 Year Operational Plan and 5 Year Strategy and also with the Better Care Fund delivery plan developed with Halton Borough Council. NHS Halton CCG, engaging with NHS England, local practices and other partners has developed a co-commissioning strategy to meet these ambitions by focusing transformational activity in six areas:

- Improved access and resilience.
- Integrated care.
- New services in the community.
- Community development.
- Quality improvement.
- Enabling work streams (i.e. governance, finance, estate, contracting, information technology and workforce).

5.0 OTHER IMPLICATIONS

The strategy will impact on how general practice services, and ultimately all out of hospital services in the borough, are commissioned and delivered.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children and Young People in Halton

Children and young people will benefit from transformed general practice services.

6.2 Employment, Learning and Skills in Halton

None as a result of this report.

6.3 A Healthy Halton

A coherent strategy for general practice services in Halton, with an associated implementation and evaluation plan, will contribute to improving the health of the borough and reducing inequalities.

6.4 A Safer Halton

None as a result of this report.

6.5 Halton's Urban Renewal

None as a result of this report.

7.0 RISK ANALYSIS

The programme is collating a risk register as it progresses. A lack of engagement in the programme by practices and other partners is a potential risk, which is being mitigated by dedicated management resource.

8.0 EQUALITY AND DIVERSITY ISSUES

There are no equality and diversity issues arising as a direct result of this work.

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

Addicott, R. and Ham, C. (2014) *Commissioning and funding general practice: Making the case for family care networks*, London: The King's Fund.

British Medical Association (BMA), (2013) *Developing General Practice today: Providing healthcare solutions for the future*, [Online], Available: http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/gpc-vision.

Department of Health (2014), *Transforming Primary Care: Safe, proactive, personalised care for those who need it most*, London: Department of Health.

Dyson, B. (2014), *Improving General Practice: A Call To Action Phase 1 Report*, London: NHS England.

Health and Social Care Information Centre (HSCIC) (2013) *NHS Staff 2002-12:General Practice*, [Online], Available: http://www.hscic.gov.uk/article/2021/Website-Search?productid=10382&q=NHS+Staff+2002-12+General+Practice&sort=Relevance&size=10&page=1&area=both#top.

NHS England (2013), *Improving General Practice: A Call to Action*, [Online], Available: http://www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/igp-cta/.

NHS Improving Quality (2013), *An introduction to the NHS Change Model*, [Online], Available: http://www.changemodel.nhs.uk/pg/dashboard [28 May 2014].

Rosen, R. and Parker, H. (2013), *New models of primary care: practical lessons from early implementers,* London: Nuffield Trust.

Roughton, R. and Hakin, B. (2014), *Co-commissioning of primary care services: Publications Gateway ref. Number 01599*, NHS England, Leeds.

Halton Clinical Commissioning Group

NHS Halton CCG

A strategy for General Practice services in Halton

Creating sustainable out of hospital care for the people of Halton

2014/15 – 2019/20

January 2015

FINAL DRAFT 1.0

Version control

Version number	Purpose/change	Author	Date
0.1	Initial draft – to share with chief officer to discuss structure, sections and flow	Rob Foster, Programme Lead	19/9/14
0.1a	Includes structural changes	Rob Foster	30/9/14
0.2	Final working draft	Rob Foster	12/12/14
0.3	Amended working draft	Simon Banks	17/12/14
1.0	Final draft	Rob Foster	23/12/14

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1. EXECUTIVE SUMMARY

General Practice is the cornerstone of NHS care, yet the demands placed upon General Practitioners (GPs) and their teams have never been greater. NHS England's *Improving general practice – a call to action*[1] was intended to stimulate debate in local communities as to how best to develop General Practice services and enable them to play an even stronger role at the heart of more integrated out-of-hospital services that deliver better health outcomes, more personalised care, excellent patient experience and the most efficient possible use of NHS resources. This Strategy has emerged from our direct response to this call to action in August 2013.

NHS Halton CCG has achieved much in its primary care services since its inception in 2013. There are a range of Local Enhanced Services (LES) schemes in place, a number of projects or plans being developed and working relationships already established. At the same time we realised that General Practice services in the borough were not sustainable, for all the reasons outlined in *Improving general practice – a call to action.* This Strategy recognises the challenges General Practice services face but also seeks to address them within Halton by building upon the foundations of good work that are already in place.

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

The principle approach throughout the programme of work to develop this Strategy has been about engagement with local practices, NHS England, providers and partners and the public and a range of patient groups. Initially we worked to develop a shared understanding of the problem we wished to solve and then worked on co-designing and co-producing what a sustainable model of General Practice looks like for Halton.

There are a range of national drivers that have influenced the work including NHS E's co-commissioning agenda[2] and the *Five Year Forward View*[3]. We believe that

[1] NHS England (2013), *Improving General Practice: A Call to Action*, [Online], Available: http://www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/igp-cta/

[2] NHS England and NHS Clinical Commissioners (2014), *Next steps towards primary care co-commissioning*, [Online], Available: www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2014/11/nxt-steps-pc-cocomms.pdf

[3] Care Quality Commission, Health Education England, Monitor, NHS England, Public Health England and Trust Development Authority (2014). *Five Year Forward View*, [Online], www.england.nhs.uk/ourwork/futurenhs/

the timing of these national programmes complements and accelerates our local work and we have considered and aligned the approach accordingly.
The future model of service outlined in this Strategy, Multispecialty Community Provision, owes much to the Multispecialty Community Provider approach in *the Five Year Forward View*. We have deliberately referred to Multispecialty Community Provision rather than of a Multispecialty Community Provider as it is important we define the functions we want our model to deliver (provision) before we discuss who it will be provided by and how. This approach is widely supported within Halton and the emergent model has been discussed and created through the local engagement and co-production across range of organisations.

Our Strategy will require General Practices to work more in partnership, ensuring that every resident of Halton has access to the same high quality and standardised services. This will involve harnessing the skills, experience and knowledge of the professionals in Halton. This will require work at four levels – borough wide, town wide, across community hubs of more than one practice and at individual practice level. The advent of community hubs will ensure we are focussing on local communities and we will engage with those local communities as services are developed.

Finally, regardless of whether additional funding is made available or not, NHS Halton CCG and NHS England, through co-commissioning arrangements, will drive the implementation of this Strategy. We are looking to secure non-recurrent funding in 2015/16 through the Prime Ministers Challenge Fund that will support more rapid implementation and the pump-priming of a series of projects that will start to shape the future model of services across Halton.

Dr Cliff Richards
Chair, NHS Halton CCG

Simon Banks
Chief Officer, NHS Halton CCG

2. INTRODUCTION

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

NHS England's *Improving general practice – a call to action* was a start to stimulate debate in local communities – amongst GP practices, NHSE area teams, CCGs, Health and Wellbeing Boards and other community partners - as to how best to develop general practice services and enable them to play an even stronger role at the heart of more integrated out-of-hospital services that deliver better health outcomes, more personalised care, excellent patient experience and the most efficient possible use of NHS resources.

In response to *Improving general practice – a call to action* and to inform the challenges facing primary care and provide a sustainable future for membership practices, NHS Halton CCG began working with its member practices and key stakeholders to undertake a review of General Practice services in the borough and their sustainability. To meet the increasing challenges faced by General Practice there is a need to reshape the range of services offered in out of hospital care, including General Practice, thereby enhancing sustainability whilst preserving the local roots of General Practice that are valued highly by patients.

NHS Halton CCG has achieved much in its primary care services since its inception in 2013 and wishes to build on this to ensure that they reflect the needs of its population. There are a range of LES schemes already in place, a number of projects or plans being developed and working groups already established. This Strategy aims to embrace this work and build upon the foundations that are already in place.

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

It also considers key enablers that are fundamental and underpin successful and sustainable general practice services, including: the use of informatics, high quality and appropriate estates, workforce development and new, more integrated ways of working between practices and across pathways and the role of co-commissioning by introducing more innovative and outcome based commissioning.

The vision of NHS Halton CCG is **"Involving everybody in improving the health and wellbeing of the people of Halton"** with key values focused on **Partnership, Openness, Caring, Honesty, Leadership, Quality** and **Transformation**

This vision and these values have been at the core of the approach the CCG has taken throughout and this will be demonstrated throughout the Strategy.

3. BACKGROUND

About us

NHS Halton CCG is responsible for planning NHS services across the borough, and work with other clinicians and healthcare providers to ensure they meet the needs of local people.

This includes:

- Elective hospital care
- Rehabilitation care
- Urgent and emergency care
- Most community health services
- Mental health and learning disability services

Creation of CCGs formed part of the Government's wider desire to create a clinically-driven commissioning system that is more sensitive to the needs of the local patients.

The organisation works with patients and healthcare professionals, as well as in partnership with local communities and Halton Borough Council to make sure that health and social care is linked together for people whenever possible. In addition to GPs, the Governing Body will have at least one registered nurse and a doctor who is a secondary care specialist.

NHS Halton CCG is overseen by NHS England, which ensures that they have the capacity and capability to commission services successfully and to meet all financial responsibilities.

What is General Practice?

General Practice is an essential part of medical care throughout the world. General Practitioners (GPs) are the first point of contact for most patients. GPs provide a complete spectrum of care within the local community; dealing with problems that often combines physical, psychological and social components. They increasingly work in teams with other professions, helping patients to take responsibility for their own health.

The wide mix of General Practice is one of the major attractions. There can be huge variation in the needs of individual patients during a single surgery. No other specialty offers such a wide remit of treating everything from pregnant women to babies and from mental illness to sports medicine. General practice gives the opportunity to prevent illness and not just treat it.

Outside normal surgery hours, an Out Of Hours (OOH) service is offered. OOH services usually operate from 6.30pm to 8.00am on weekdays and all day at weekends and on Bank Holidays. GPs can choose whether to provide 24-hour care

for their patients or to transfer responsibility for out-of-hours services another provider.

NHS England currently commissions General Practice, with CCGs being required to support NHS E in ensuring that these services provide good quality for the local population. This relationship is now changing as co-commissioning between NHS England and CCGs gathers momentum.

Most GPs are independent contractors to the NHS. This independence means that in most cases, they are responsible for providing adequate premises from which to practice and for employing their own staff.

The diagram below was produced by NHS England following the changes resulting from the NHS Health and Social Care Act 2012. It demonstrates how people and communities are at the heart of the new NHS system with a range of services wrapped around them. This includes General Practice.

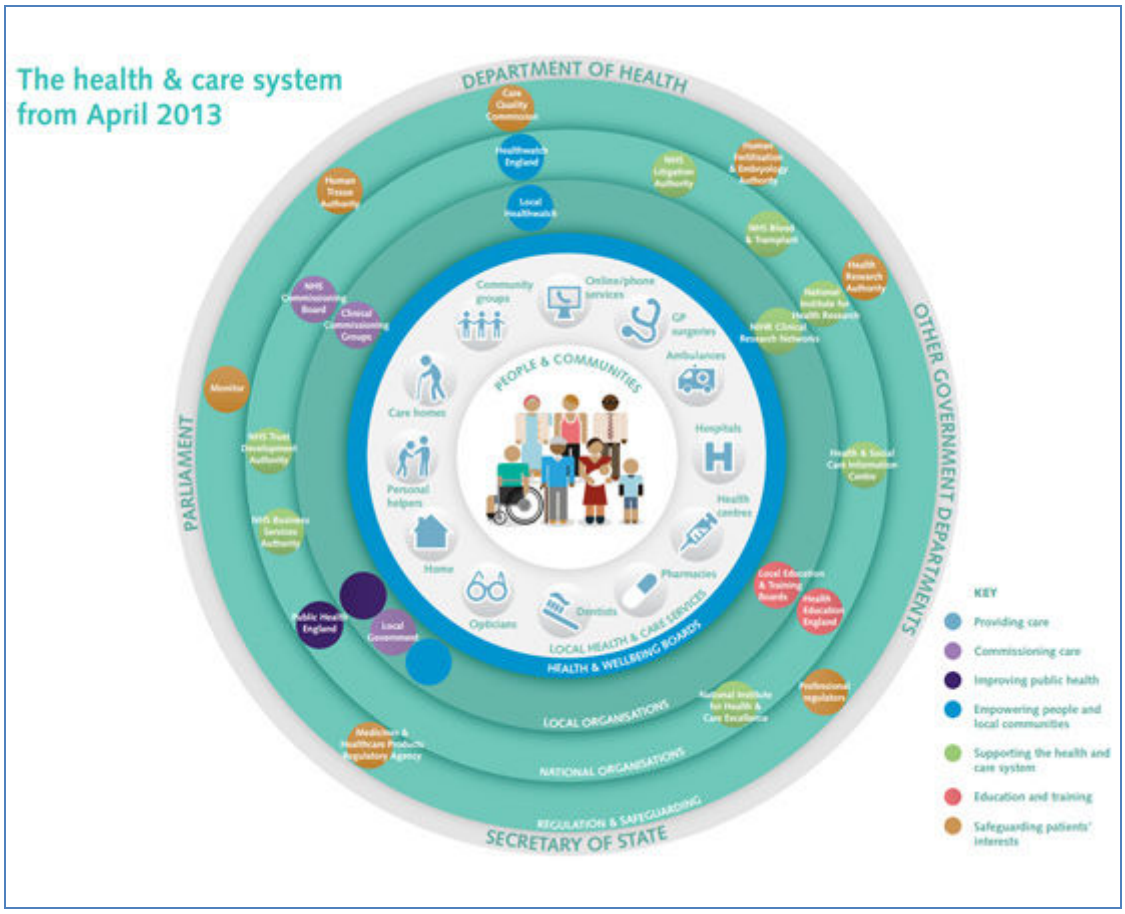

Figure One: The health and care system from April 2013[4]

[4] Department of Health (2012), *The health and care system from April 2013*, [Online], Available: http://webarchive.nationalarchives.gov.uk/20130805112926/http://healthandcare.dh.gov.uk/system-overview-diagram/

Halton in Numbers – summary

- There are 17 GP practices in Halton, serving a population of approximately 128,000. The practices range in size (determined by population list size) from just over 2,000 through to the largest practice which has a list size of over 14,000.
- Across the 17 practices, there are 74 GPs (Headcount) and 52 Practice Nurses (Headcount). 6 of the practices have 2 or fewer GPs.
- There are 8 practices in Runcorn and 9 in Widnes. 8 of the practices are training practices. 14 of the practices have a Personal Medical Services (PMS) contract, 2 have a General Medical Services (GMS) contract and 1 has an Alternative Provider Medical Services (APMS) contract.
- The opening times of the practices are largely standard although Enhanced Services arrangements mean there are subtle variations.
- All of the practices partake in a range of nationally determined and locally set Enhanced Services.
- 16 of the 17 practices operate the same IT clinical system in their practices; EMIS Web, with the other practice using Vision.

Appendix 1 contains a series of tables that set out further details of the shape of General Practice services in Halton.

4. THE APPROACH

The underlying approach in developing the strategy has been based on the stages described within the NHS Change Model[5].

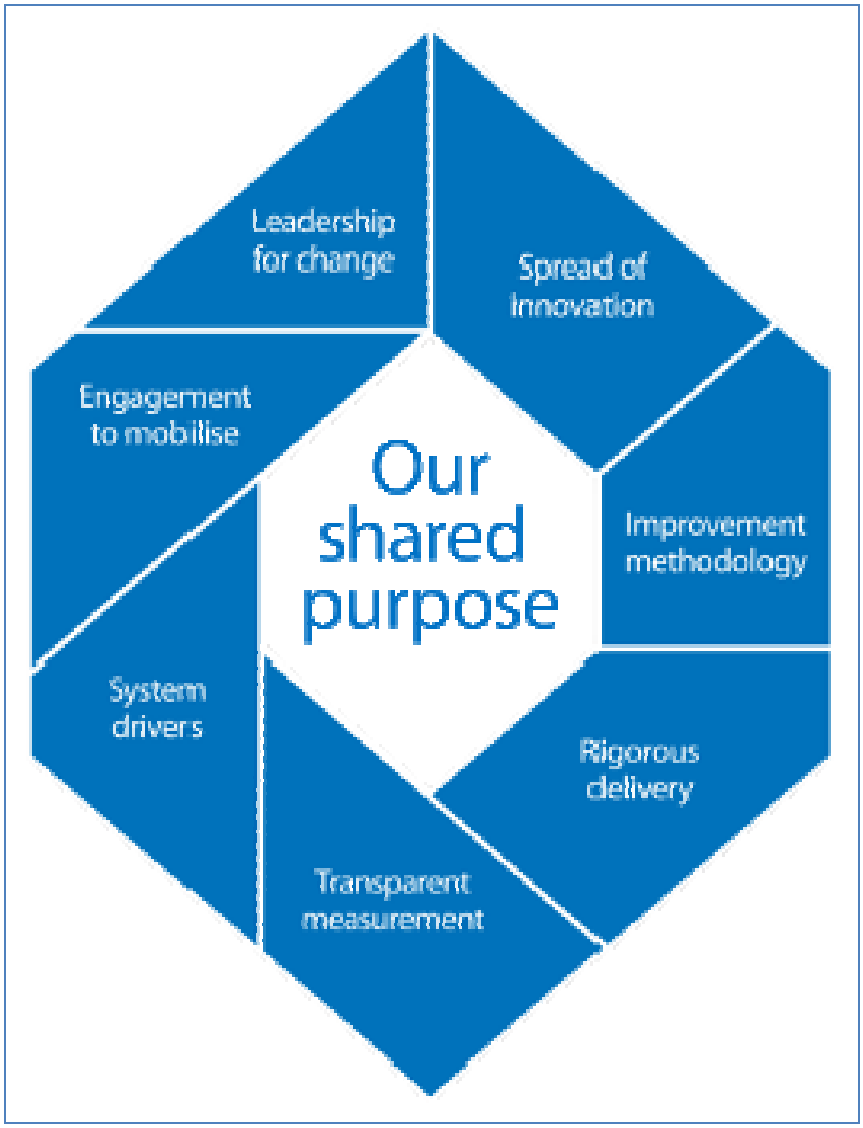

Figure Two: NHS Change Model

The development of the shared purpose has been essential, carefully considered, widely debated and not rushed. A compelling and locally-oriented case for change was developed that considered the drivers and issues that collectively, helped all parties derive a common conclusion; General Practice in its current guise is not sustainable.

[5] NHS Improving Quality (2013), *An introduction to the NHS Change Model*, [Online], Available: http://www.changemodel.nhs.uk/pg/dashboard

NHS Improving Quality (NHSIQ) was also commissioned to support our change programme. NHSIQ are experts in supporting large scale change and the programme of support they offer is drawn from an experience and understanding of how large scale change happens, informed by tools and techniques of improvement science. The key features of this approach are that:

- It is designed to support CCGs in progressing a locally identified large scale challenge priority, whilst also building capability, competence and confidence to apply learning from this to other initiatives.
- It is based upon the premise that most large scale change, of the degree now required in the NHS, will require collaboration in leadership between one (or maybe more) CCGs and their relevant commissioning partners, e.g. local authority(ies), the Health and Wellbeing Board, commissioning support providers and representation from the NHS England area team.
- It is designed to help CCGs "ringmaster" this collaboration, to help the system achieve transformational change, through engaging, mobilizing, building trust, undertaking a shared development journey, and by jointly focusing on a shared challenge.
- It will help establish solid foundations for this and other priorities, with frameworks for undertaking change, anchored on a clear shared purpose and joint narrative."

They supported the development of an approach that considered all elements from the NHS Change Model.

The principle approach throughout the programme of work has been an integrated approach engaging everyone, including practices, NHS England, providers and partners and the public and a range of patient groups and working groups. We have been actively discussing this whole agenda with a range of local organisations and individuals including Halton Healthwatch, Halton People's Health Form, Patient Participation Groups, the CCGs AGM and local engagement events. We have also run specific events around Care Homes, Cancer and Hypertension. All of these meetings, discussions and sessions have been used to gather opinion, views and intelligence, both quantitative and qualitative, to help form and influence the emerging strategy.

The emerging and draft Strategy has been shared and discussed with General Practice, partners and providers and the public to test the proposed principles, approach and model. This is an example of the continual feedback and engagement that has been established from the outset of the programme of work.

A Communication, Engagement and Consultation plan is currently being developed and this is being supported and monitored by the CCGs Consultation Steering Group. Following ratification of the Strategy by the CCGs Governing Body, a

population-wide information campaign will begin to inform them of the direction of travel and it is anticipated that consultation will then take place to determine how to best implement and develop the proposed model of service.

Headline milestones

Milestone	Timescale
Communication, Engagement and Consultation plan to Engagement & Consultation Steering Group.	February 2015
Launch public awareness campaign about new approach.	February 2015
Consultation commencing in (where needed) at Community Hub level.	March 2015

5. THE CASE FOR CHANGE

National context

As set out in *Improving general practice – a call to action,* future trends threaten the sustainability of our health and care system: an ageing population, an epidemic of long-term conditions, lifestyle risk factors in the young and greater public expectations. Combined with rising costs and constrained financial resources, these trends pose the greatest challenge in the NHS's 65-year history.

Key facts – national context
• 86 per cent of respondents to the GP Patient Survey say that their overall experience is good or very good • A quarter of patients do not rate the overall experience of making an appointment as "good". • 26 per cent of people do not find it easy to get through to the surgery by telephone and this figure varies from 8 per cent to 48 per cent in different parts of the country. • The NHS faces a projected funding gap of £30 billion by 2021/22. • Between 2003/04 and 2011/12 the number of emergency admissions for acute conditions that should not usually require hospital admissions increased by 34 per cent. • While the numbers of full time equivalent GPs has grown over the past ten years, the GP workforce has grown at only half the rate as other medical specialties and has not kept up with population growth.

Source: Improving general practice – a call to action

In *Improving General Practice: A Call To Action Phase 1 Report*[6], NHS England set out five ambitions to improve General Practice for "today's population" and also "to ensure…excellent services for the future." These ambitions are:

- *Ambition one*: proactive, coordinated care: anticipating rather than reacting to need and being accountable for overseeing your care, particularly if you have a long-term condition.
- *Ambition two*: holistic, person-centred care: addressing your physical health, mental health and social care needs in the round and making shared decisions with patients and carers.
- *Ambition three*: fast, responsive access to care: giving you the confidence that you will get the right support at the right time, including much greater use of telephone, email and video consultations.
- *Ambition four*: health-promoting care: intervening early to keep you healthy and ensure timely diagnosis of illness - engaging differently with communities to improve health outcomes and reduce inequalities.

[6] Dyson, B. (2014), *Improving General Practice: A Call To Action Phase 1 Report*, London: NHS England, [Online], Available: http://www.england.nhs.uk/wp-content/uploads/2014/03/emerging-findings-rep.pdf

- *Ambition five*: consistently high-quality care: removing unwarranted variation in effectiveness, patient experience and safety in order to reduce inequalities and achieve faster uptake of the latest knowledge about best practice.

Improving General Practice: A Call To Action Phase 1 Report set out 7 areas of work where NHS England wanted to take forward change to deliver these ambitions:

Areas of work	Summary
Empowering patients and the public	Enabling patients and carers to play a more active role in their own health and care, involving local communities in shaping services, giving greater choice over the general practice they register with, and transforming patient access to GP services
Empowering clinicians	Ensuring high quality support for innovation and improvement, developing networks to allow more rapid spread of innovation, supporting General Practice in developing new models of provision, and releasing time for patient care and service improvement
Defining, measuring and publishing quality	Improving information about quality of services both to strengthen accountability to the public, clarity on what the public can expect, and to support clinical teams in continuous quality improvement
Joint commissioning	Working with CCGs to develop a joint, collaborative approach to commissioning General Practice services, with a stronger focus on local clinical leadership and ownership and allowing more optimal decisions about the balance of investment across primary, community and hospital services
Supporting investment and redesigning incentives	Supporting a shift of resources towards general practices and 'wrap around' community services, developing the national GP contract to support our five ambitions, and developing innovative new forms of incentives that reward the best health outcomes
Managing the provider landscape	Ensuring that all General Practices meet essential requirements, responding effectively to unacceptably low quality of care, and enabling new providers to offer their services to the public
Workforce, premises and IT	Working with national and local partners to develop the General Practice workforce, promote improvements in primary care premises and sustain improvements in information technology solutions

Personal Medical Services (PMS) contract review

NHS England has begun reviewing PMS contracts to ensure that additional funding meets a set of consistent principles and criteria, agreed as part of the review. This approach has been determined following a national data collection exercise NHS

Employers ran with area teams to help understand PMS contract expenditure and identify its component parts.

The criteria that area teams will apply are that additional funding must:

- reflect local strategic plans for primary care agreed jointly with clinical commissioning groups (CCGs);
- secure services or outcomes that go beyond what is expected of core general practice or improve primary care premises;
- help reduce health inequalities;
- give equality of opportunity to all GP practices;
- support fairer distribution of funding at a locality level.

The data collection exercise identified that the premium element of PMS expenditure nationally is £325 million. That is the value of how far PMS expenditure exceeds the equivalent items of GMS expenditure. This means that NHS England pays, on average, a premium of £13.52 for patients registered with PMS practices. The premium will reduce to around £235 million over the seven years to 2021/22, as the GMS Minimum Practice Income Guarantee (MPIG) is gradually phased out. This reduces the average premium per registered PMS patient to £9.80.

Of the £325 million, around £67 million was identified as linked to defined enhanced services or key performance indicators (KPIs). The remaining £258 million may be associated with enhanced services or populations with specific needs, but it has not been notified as such. Analysis of the data revealed there is no obvious relationship between current PMS expenditure and deprivation.

Given the number of Practices with a PMS contract in Halton, this review presents a potential challenge to the level of practice income. The CCG has been advised that the current amount of funding allocated to practices in total will remain within Halton, however, the outcome of the PMS review may mean that the way in which this total level of funding is allocated amongst individual practices may vary from the current levels.

Co-commissioning

On 10th November 2014 NHS England, in partnership with NHS Clinical Commissioners, published *Next steps towards primary care co-commissioning*. The document aimed to provide clarity and transparency around co-commissioning options, providing CCGs and area teams with the information and tools they need to choose and implement the right form of co-commissioning for their local health economy.

Co-commissioning is a seen as a key enabler in developing seamless, integrated out-of-hospital services based around the diverse needs of local populations. It will

also drive the development of new models of care such as multispecialty community providers and primary and acute care systems.

There are three primary care co-commissioning models CCGs could take forward:

- Greater involvement in primary care decision making.
- Joint commissioning arrangements.
- Delegated commissioning arrangements.

The scope of primary care co-commissioning in 2015/16 is General Practice services only. For delegated arrangements this will include contractual GP performance management, budget management and complaints management. However, co-commissioning excludes all functions relating to individual GP performance management (medical performers' lists for GPs, appraisal and revalidation). Furthermore, the terms of GMS contracts and any nationally determined elements of PMS and APMS contracts will continue to be set out in the respective regulations and directions.

NHS Halton CCG is, at the time of writing of this Strategy, is preparing a submission to express an interest in undertaking delegated commissioning for General Practice services from April 2015.

Five Year Forward View

The *Five Year Forward View* was published on 23rd October 2014 and sets out a vision for the future of the NHS. It has been developed by the partner organisations that deliver and oversee health and care services including NHS England, Public Health England, Monitor, Health Education England, the Care Quality Commission and the NHS Trust Development Authority. Patient groups, clinicians and independent experts have also provided their advice to create a collective view of how the health service needs to change over the next five years if it is to close the widening gaps in the health of the population, quality of care and the funding of services.

The purpose of the *Five Year Forward View* is to articulate why change is needed, what that change might look like and how we can achieve it. It describes various models of care which could be provided in the future, defining the actions required at local and national level to support delivery. Everyone will need to play their part – system leaders, NHS staff, patients and the public – to realise the potential benefits for us all. It covers areas such as disease prevention; new, flexible models of service delivery tailored to local populations and needs; integration between services; and consistent leadership across the health and care system.

A small number of radical new care delivery options will be supported, these options include:

- Multispecialty Community Provider
- Primary and Acute Care Systems
- Urgent and Emergency Care Networks
- Viable Smaller Hospitals
- Specialised Care
- Modern Maternity Services
- Enhanced Health in Care Homes

Whilst new care models will be developed and supported, Five Year Forward View states that the foundation of NHS care will remain list-based primary care. As part of this commitment there will be a 'new deal' for GPs.

At a North Tripartite Event on 4th November 2014, organised by NHS England, Monitor and the Trust Development Authority, there was clear message that 5 Year Forward View requires a period of reflection but that this should be short. Delivery is expected from April 2015, with demonstrable congruence with our existing strategies and plans.

Local Context

As at the 2011 Census, Halton's population was 125,700 (rounded to nearest 100) with 48.8% male and 51.2% female. The population registered with Halton GPs is 128,446 (July 2012) and there are 17 general practices in Halton.

Halton is ranked as the 27th most deprived local authority in England (out of 326 local authorities). [7]

Life expectancy has risen steadily over time. In 2010-12 average life expectancy in the borough was 77.4 years for men and 80.7 years for women. However, the borough is consistently lower than its comparators (about 3 years lower than the England figures).

There are also internal differences in life expectancy, ranging from 71.1 years for males in Windmill Hill to 82.1 years in Daresbury. For females the differences range from 76.4 years in Riverside to 89.7 years in Birchfield ward: a difference of 10.4 years for males and 13.3 years for females.

This is a slight narrowing of internal inequalities for men from 11.4 years and widening for women from 9.4 years during the previous reporting period 2008-10.

The table below summarises key demographic forecasts and changes:

[7] Halton Borough Council (2013), Joint Strategic Needs Assessment
Available: http://www4.halton.gov.uk/Pages/health/JSNA/JSNASummary.pdf

Demographics [8]

- The population in Halton will **increase in size by 2.8%** (3,500 people) between 2012 and 2030
- Over this time period, the **number of people aged over 80 will more than double** (from 4,300 to 8,700) and **the number aged between 65 and 80 will increase by over 40%**
- During the same time period, this will see **a reduction of 3.8% in the under 19 population** and a **reduction of 8.6% in the 20-59 population**

Long Term conditions and co-morbidities

The table below presents the headline figures of QOF prevalence in Halton against six key QOF disease groups [9]. It demonstrates the prevalence rates compared to the England average and also highlights variation in the levels of prevalence across the GP practices in Halton:

Condition	Halton average	England average	Halton maximum	Halton minimum
Asthma	6.9%	6.0%	9.7%	5.6%
CHD	4.4%	3.3%	5.0%	2.4%
Diabetes (over 17)	7.3%	6.0%	8.0%	4.1%
COPD	2.5%	1.7%	4.0%	1.5%
Hypertension	14.8%	13.7%	17.6%	8.8%
CKD (over 17)	4.5%	4.3%	5.8%	2.5%

According to results from the General Lifestyle survey [10], people with long term conditions account for:

- 50% of all GP appointments;
- 64% of outpatient appointments;
- 70% of all inpatient bed days;
- In total around 70% of the total health and care spend in England (£7 out of every £10) is attributed to caring for people with LTCs;
- This means that 30% of the population account for 70% of the spend.

In a consultation response from people living with long term conditions [11], they said:

[8] Office for National Statistics (2014), Population projections
Available: http://ons.gov.uk/ons/taxonomy/index.html?nscl=Population+Projections#tab-data-tables

[9] Halton Borough Council (2014), Quality Outcomes Framework 2012/13

[10] Office for National Statistics (2009), General Lifestyle Survey
Available: http://www.ons.gov.uk/ons/rel/ghs/general-lifestyle-survey/2009-report/index.html

[11] Department of Health (2006), Our health, our care, our say: a new direction for community services – consultation responses from people with long term conditions
Available:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/272238/6737.pdf

- They want to be involved in decisions about their care – they want to be listened to;
- They want access to information to help them make those decisions;
- They want support to understand their condition and confidence to manage – support to self-care;
- They want joined up, seamless services;
- They want proactive care;
- They do not want to be in hospital unless it is absolutely necessary and then only as part of a planned approach;
- They want to be treated as a whole person and for the NHS to act as one team.

In the Department of Health's Long Term Conditions Compendium of Information [12]states that age is a major factor in prevalence of LTCs but also in those who have multiple LTCs and that the number of people with one long term condition is projected to be relatively stable over the next ten years. However, the number of people with multiple LTCs is set to rise to 2.9 million in 2018 from 1.9 million in 2008. This is based on a national population forecast that by 2034 the number of people aged 85 and over is projected to be 2.5 times larger than in 2009, reaching 3.5 million and accounting for 5% of the population. The document sets out that the additional cost to the NHS and social care for the increase in co-morbidities is likely to be £5 billion in 2018 compared to 2011. It recommended that plans need to be put in place immediately to address the health and social care issues facing people with multiple long term conditions.

Patient experience

The feedback from the national General Practice patient survey published in July 2014 set out that the general satisfaction of respondents locally was lower than the national average and peer group (industrial hinterland) average against a number of the questions.

Patient experience[13]
• Q, Overall experience of making an appointment. Answer - Very good Halton - 24%, Eng av – 34%, Peer av – 32% • Q, Ease of getting through to someone at GP surgery on the phone. Answer – Very easy

[12] Department of Health (May 2012), Third edition of Long Term Conditions Compendium Available: https://www.gov.uk/government/news/third-edition-of-long-term-conditions-compendium-published

[13] NHS England (July 2014), GP Patient Survey Results. Available: http://www.england.nhs.uk/statistics/category/statistics/gp-patient-survey/

Halton – 15%, Eng av – 26%, Peer av – 25%

- Q, Is the GP surgery currently open at times that are convenient for you? Answer - Yes
  Halton – 72%, Eng av – 75%, Peer av – 77%
- Additional opening times that would make it easier to see or speak to someone:
  After 6:30 – 73%, On Saturday – 73%

However, within the first three questions presented above, there was wide variation in the satisfaction response rate between practices:

Questions	Halton av.	Halton max.	Halton min.
Overall experience of making an apt – very good	24%	80%	14%
Ease of getting through to someone at GP surgery on the phone – very easy	15%	75%	3%
Is the GP surgery currently open at times that are convenient for you? Yes	72%	94%	56%

Urgent care rates

Advancing Quality Alliance (AQUA) data [14] sets out that the Non-Elective admissions aged 65+ per 1000 population in Halton are in the top 19-23 quartile (where a lower rate is considered better) for CCGs across the North West. The average NW admission rate was 295 per 1000 population and the Halton rate was 319. Looking at similar data (for the over 75s population), the average admission rate in Halton for the over 75s population is 412 per 1000 population. However, there is a significant variation in the levels between practices with the lowest admission rate at 279 per 1000 population and the highest admission rate at 647 per 1000 population.

Referral rates

Data provided the acute providers identify the GP referral rates from 2013/14 for all specialties. It demonstrates that average referral rate per 1000 weighted population across all practices was 179. However, there is significant variation at a practice level with the highest level at 310 referrals per 1000 weighted population and the lowest level at 111 per 1000 weighted population.

Practice variation

[14] Advancing Quality Alliance (June 2014), Quality and Efficiency Scorecard for Frail Elderly

There is a range of information available that demonstrates variation across General Practice [15]. Variation can be a positive reflection of decision-making and services aligned to the needs, desires or expectations of a specific population and individual. There are also instances of unwarranted variation and the causes of this include:

- Variation in the supply of resources, more facilities in one population than another;
- Different definitions of appropriateness for intervention and referral, either by individual clinicians, sometimes even within one institution, or between different groups of clinicians working in the different populations;
- Variations that may be due to attitudes, both individual and population based, for example differences in use of services to different ethnic groups or different age groups. The Inverse Care Law was first described in 1971 and indicates that care may be provided inversely in relation to need because of beliefs and attitudes both on the part of the population itself and professionals serving it.

No conclusions have been drawn from the above information, other than the demonstration of variation across the practices. Part of the strategy moving forward will be a need to clarify the difference between warranted and unwarranted variation and where unwarranted, consider interventions to reduce it.
Interventions for dealing with variation in clinical practice include:

- Peer review and audit between practices;
- Point of care decision support systems, prompts and reminders;
- The use of explicit care pathways;
- The use of information technology;
- The use of guidelines and audit to measure adherence to guidelines.

Workforce

Data sourced from the Health and Social Care Information Centre [16] demonstrates that as of 30th September 2013, Halton had the following number of GPs (excluding Registrars and Retainers):

Full Time Equivalent

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

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

[15] Right Care (September 2011), Unwarranted variation: a reading list produced by QIPP Right Care. Available: http://www.rightcare.nhs.uk/downloads/ER_unwarranted_variation_aug_2011.pdf

[16] Health and Social Care Information Centre (2014) [Online]. Available: http://www.hscic.gov.uk/workforce

Furthermore, according to the Seventh National GP Work life Survey [17], an increasing number of GPs (nationally) are considering their 'Intention to Quit' within the next five years.

Considerable/high intention to leave direct patient care within five years	All GPs	GPs aged under 50	GPs aged over 50
2005	19.4%	6.1%	41.2%
2008	21.9%	7.1%	43.2%
2010	21.9%	6.4%	41.7%
2012	31.2%	8.9%	54.1%

Forecast future demand

In May 2014, Capita (commissioned by four local CCGs and NHS England) produced an End to End Care Assessment Report designed to provide a retrospective, current and future view of health and social care activity, spend and patient flows across the Mid Mersey area. Capita identified that NHS Halton CCG operates within a complex health environment that is served by four main providers – 5 Boroughs Partnership NHS Foundation Trust, Bridgewater Community Healthcare NHS Foundation Trust, St Helens and Knowsley Teaching Hospitals NHS Trust and Warrington and Halton Hospitals NHS Foundation Trust. Whilst secondary care provision is "dominated" by the latter two organisations, Capita identified that there is a significant amount of competition from specialist NHS providers on Merseyside as well as local private hospitals.

Based on population forecasts alone, the "Do nothing" scenario when considering the financial implications across the four main care settings for the CCG are set out below:

Care Setting	% change to 2016/17	% change to 2018/19	% change to 2023/24
Acute	+3.2%	+5.2%	+10.2%
Community	+2.5%	+4.0%	+7.7%
Mental Health	+2.5%	+4.0%	+7.7%
Social Care	+2.5%	+4.0%	+7.7%

Tackling health inequalities – our missing 40%

NHS Halton CCG, on the recommendation of Halton Borough Council's Director of Public Health, has looked into health inequalities in the borough. Professor Chris

[17] Institute of Population Health (August 2013), Seventh National GP Worklife Survey. Available: http://www.population-health.manchester.ac.uk/healtheconomics/research/FinalReportofthe7thNationalGPWorklifeSurvey.pdf

Bentley, an expert on health inequalities and a former head of the Department of Health's Health Inequalities National Support Team, supported us in looking at health inequalities, premature mortality and the impact we could have on addressing these areas in our borough. His work left us with two really important headline messages:

- The data demonstrates that people accessing General Practice in Halton are being looked after well;
- However, the data also identifies that about 40% of the population who need to be looked after in primary care, have conditions and co-morbidities, and are not accessing General Practice soon enough. The data identified cancer and hypertension as the two areas where, when compared to a peer population, interventions and changes could make a real difference to the local population. At present, approximately 40% of this cohort of our population are presenting at local A&Es with developed symptoms and conditions of cancer and hypertension, often at a late stage in the disease/condition progression, having not accessed General Practice in the first instance or when symptoms first presented.

Therefore, an essential strand of the approach within this Strategy is to:

- Identify the areas, pathways and conditions where, with further intervention and focus, changes could make a real difference to the health and life expectancy of the local population.
- Undertake engagement and insight work across our community, working with partners and providers and the voluntary sector, as well as the existing patient groups, to understand why so many patients are not accessing General Practice and to work with them to develop new, and possibly innovative approaches to better engage with this cohort of the local population.

Feedback from public engagement

As described previously, NHS Halton CCG has made a significant efforts to engage with the local population to seek its views and experiences with General Practice. To support this approach, as well as visits to the local practice Patient Participation Groups, the CCG worked in partnership with the Halton People's Health Forum, a group of local public ambassadors, to shape two events in the community that would be informative for attendees but with a real focus on discussion and feedback from the public.

Key feedback themes included:

- Access can be a challenge;

- Care continuity with professionals is very important;
- Working with the younger population now is essential;
- We need to focus on Mental Health services;
- Local services need to be maintained;
- Services working more closely together in the community will help to make a difference;
- Every resident and practice should have access to the same services across the borough;
- Good local transport is essential.

Healthwatch Halton - 'GP access and out of hours provision survey

Between March and June 2014, Healthwatch Halton carried out a survey looking at 'GP access and out of hours provision' across the borough. The survey was distributed to 1200 Healthwatch Halton members by post and email. It was also shared with GP Patient Participation Groups. In total 491 responses were received.

In the main the results are very positive. Whilst people really value a high quality and easily accessible service from their General Practice, there is variation in accessibility across the borough.

Key feedback themes and recommendations included:

- Communication
- Appointment triage
- Opening hours and appointments
- Patient records
- Complaints
- Urgent Care Centres

In response to the survey, an action plan has been produced by the Primary Care Quality & Development Working Group, drawing on the recommendations. The implementation of the actions identified will be closely monitored and aligned to the emerging themes included within this Strategy.

6. THE POLICY CONTEXT

NHS Halton CCG Commissioning Priorities and Principles

As stated above, the catalyst for the discussions that has had during the development of this Strategy was NHS England's *Improving general practice – a call to action*. This supported a conversation in which we were able to consider all the information and evidence and develop facts through engagement with our member practices and other stakeholders. This enabled us to create a shared problem statement, that General Practice in Halton was not sustainable in its current form. Subsequently we agreed together that we wanted to develop a strategy for General Practice services in Halton by January 2015 that would create sustainable out of hospital care for the people of Halton.

We wanted to ensure that our approach to develop a strategic approach to commissioning General Practice was also congruent with the themes in our existing 5 Year Strategy, 2 Year Operational Plan and Better Care Fund. The priorities that we developed from this are:

- *Improved access and resilience* - Commissioning services to ensure the population of Halton can access the right services, at the right time, in the right place. Listening to and working with the population, we want to commission services that are convenient to them both in hours and out of hours.

- *Integrated care* - Commissioning services to bring organisations together and integrate care pathways to wrap around individual patient's needs through improving care coordination and multi-disciplinary team working.

- *New services in the community* - Commissioning and providing more services in the community to support care closer to home. Developing specialist skills in the community and investing in community facilities.

- *Community developments* - Local practices, pharmacies, community health services, voluntary agencies and the local authority work as a group to engage with their community, collaborating with them in asset-based approaches to improving health and wellbeing.

- *Quality improvement* - Commissioning for quality improvements in all services and a reduction in unwarranted variation through a range of measures including the developing of a culture of peer-to-peer challenge and learning, continued personal developments and funding service improvement capacity. Listening to the local population and their feedback and acting and responding to this.

When considering the case for change, population feedback, national and local priorities, it was considered important to identify a series of key principles that would be fundamental to the future design, configuration, commissioning and delivery of the local General Practice system in Halton. All principles are as important as each other. They are:

- 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 and improved experience, 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.

Five Year Forward View – New models of care

The *Five Year Forward View* sets out the intention of NHS England and the other key national organisations working across the NHS to stimulate the creation of a number of major new care models that can be deployed in different combinations locally across England. Whilst not seeking to impose a one-size-fits-all model, nor to allow "a thousand flowers to bloom", *Five Year Forward View* does commit to an approach that identifies the characteristics of similar health communities across England, and then jointly work with them to consider which new options signalled in the document constitute viable ways forward for health and care services in that area.

The *Five Year Forward View* commits to several immediate steps to stabilise General Practice, through what it refers to as "A new deal for primary care". General practice, with its registered list and everyone having access to a family doctor, is one of the great strengths of the NHS, but it is under severe strain. Even as demand is rising, the number of people choosing to become a GP is not keeping pace with the growth in funded training posts – in part because primary care services have been under-resourced compared to hospitals. The *Five Year Forward View* commits to invest more in primary care and take the following steps:

- Stabilise core funding for general practice nationally over the next two years while an independent review is undertaken of how resources are fairly made available to primary care in different areas.

- Give GP-led Clinical Commissioning Groups (CCGs) more influence over the wider NHS budget, enabling a shift in investment from acute to primary and community services.
- Provide new funding through schemes such as the Challenge Fund to support new ways of working and improved access to services.
- Expand as fast as possible the number of GPs in training while training more community nurses and other primary care staff. Increase investment in new roles, and in returner and retention schemes and ensure that current rules are not inflexibly putting off potential returners.
- Expand funding to upgrade primary care infrastructure and scope of services.
- Work with CCGs and others to design new incentives to encourage new GPs and practices to provide care in under-doctored areas to tackle health inequalities.
- Build the public's understanding that pharmacies and on-line resources can help them deal with coughs, colds and other minor ailments without the need for a GP appointment or A&E visit.

The *Five Year Forward View* is also clear that General Practice needs to be at the heart of out of hospital care. It suggests that there are two main models, above the status quo, that NHS England will be promoting in England over the next five years to make this a reality.

The first new care model is ***Multispecialty Community Providers (MCPs)***. This envisages that smaller independent GP practices will continue in their current form where patients and GPs want that. However, as the Royal College of General Practitioners has pointed out, in many areas primary care is entering the next stage of its evolution. As GP practices are increasingly employing salaried and sessional doctors, and as women now comprise half of GPs, the traditional model has been evolving.

Primary care of the future will build on the traditional strengths of 'expert generalists', proactively targeting services at registered patients with complex on-going needs such as the frail elderly or those with chronic conditions, and working much more intensively with these patients. Future models will expand the leadership of primary care to include nurses, therapists and other community based professionals. It could also offer some care in fundamentally different ways, making fuller use of digital technologies, new skills and roles, and offering greater convenience for patients.

To offer this wider scope of services, and enable new ways of delivering care, NHS England will make it possible for extended group practices to form – either as federations, networks or single organisations. These Multispecialty Community Providers (MCPs) would become the focal point for a far wider range of care needed by their registered patients:

- As larger group practices they could in future begin employing consultants or take them on as partners, bringing in senior nurses, consultant physicians, geriatricians, paediatricians and psychiatrists to work alongside community nurses, therapists, pharmacists, psychologists, social workers, and other staff.
- These practices would shift the majority of outpatient consultations and ambulatory care out of hospital settings.

- They could take over the running of local community hospitals which could substantially expand their diagnostic services as well as other services such as dialysis and chemotherapy.
- GPs and specialists in the group could be credentialed in some cases to directly admit their patients into acute hospitals, with out-of-hours.
- Inpatient care being supervised by a new cadre of resident 'hospitalists' – something that already happens in other countries.
- They could in time take on delegated responsibility for managing the health service budget for their registered patients. Where funding is pooled with local authorities, a combined health and social care budget could be delegated to Multispecialty Community Providers.
- These new models would also draw on the 'renewable energy' of carers, volunteers and patients themselves, accessing hard-to-reach groups and taking new approaches to changing health behaviours.

The second new care model is ***Primary and Acute Care Systems (PACS)***. A range of contracting and organisational forms are now being used to better integrate care, including lead/prime providers and joint ventures. NHS England will now permit a new variant of integrated care in some parts of England by allowing single organisations to provide NHS list-based GP and hospital services, together with mental health and community care services.

The leadership to bring about these 'vertically' integrated Primary and Acute Care Systems (PACS) may be generated from different places in different local health economies:

- In some circumstances – such as in deprived urban communities where local general practice is under strain and GP recruitment is proving hard – hospitals will be permitted to open their own GP surgeries with registered lists. This would allow the accumulated surpluses and investment powers of NHS Foundation Trusts to kick start the expansion of new style primary care in areas with high health inequalities. Safeguards will be needed to ensure that they do this in ways that reinforce out-of-hospital care, rather than general practice simply becoming a feeder for hospitals still providing care in the traditional ways.
- In other circumstances, the next stage in the development of a mature Multispecialty Community Provider (see section above) could be that it takes over the running of its main district general hospital.
- At their most radical, PACS would take accountability for the whole health needs of a registered list of patients, under a delegated capitated budget – similar to the Accountable Care Organisations that are emerging in Spain, the United States, Singapore, and a number of other countries.

In developing this Strategy we have considered both these approaches. The Strategy recommends the development of a model for Halton that owes much to the Multispecialty Community Provider model.

7. THE FUTURE MODEL OF CARE

The future model of care

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

Our future model of care will be established with services being centred around people in the community. Delivery may be across the whole CCG on a Halton-wide footprint; by bringing more than one GP practice together to service distinct communities through a 'hub' based approach; by sustaining individual practices wherever appropriate and by giving local people and communities more opportunities to self-care and create resilience. The constant in the model is to ensure that everyone's needs are met through an integrated health and care delivery model. Integration will involve practices working together with acute care, community and mental health providers as well as social care, the voluntary and community sector and a host of other organisations and individuals, as described in the diagram below.

Figure Three: Integrated health and delivery model

NHS Halton CCG in our co-commissioning with NHS England and Halton Borough Council intends to commission and contract for the following services within this model:

Community nursing	School nursing	District nursing
Community midwives	Health visitors	Social care services
Mental health teams	Well-being services	Sexual health services
Health improvement teams	Urgent Care Centres	Family nursing
Children's Services	Out of Hours provider	Urgent Care Centres
Promotion, Prevention and Screening	Community pharmacy	Outpatient services
Diagnostic services	Voluntary and community groups	

What potential benefits will this integrated approach bring…for patients?

- Better and clearer access to local health and care services.
- Better co-ordination of care, especially for elderly patients, patients with complex needs and those with Long Term Conditions.
- Improved experience.
- Improved communication and information.
- Reduced duplication.
- Reduced number of unplanned admissions.

What potential benefits will this integrated approach bring….for professionals?

- Better access to local services and experts for their patients.
- Increased level of peer support and access to expertise.
- Reducing unwarranted variation within services.
- Better opportunity to lead and influence commissioning decisions and strategy for the local population.
- Reduction in crisis management.
- Opportunity to offer more services at scale whilst maintaining local presence.
- Reducing pressure on the workforce.
- Improved use of technology.
- Increased financial sustainability.

Community Hubs

The model will see local services and teams wrapped around a series of 'community hubs'. Each hub will comprise of membership including General Practice, ideally made up of more than one practice, as well as the providers of the services listed above. It is recognised that in certain circumstances, it will be advantageous to continue to commission and deliver services across the whole borough of Halton, but this would necessarily engage with each 'hub'.

Four levels of commissioned services

We believe that we need to commission services as part of this new model at four levels of services within this new approach. This will be determined on a service by service basis and will be influenced by need and resources. These are levels:

- Level 1, practice level – services that are provided within, to or by one practice.
- Level 2, hub level – services are provided across more than one practice, across wards and communities.
- Level 3, town level – hubs work together around the Urgent Care Centres or other delivery points across Runcorn or Widnes.
- Level 4 – borough level – services are developed on a whole-borough basis, with one team or service serving the whole population.

In terms of service delivery, we will set clear commissioning criteria to be met in service provision, but each 'hub' will need to determine how to best configure itself to meet the needs of its local population and commissioning intentions. We will support this with advice and guidance not only on service delivery, but also on governance, population engagement, performance management, contracting and strategic planning.

NHS Halton CCG and our co-commissioning partners will work with provider organisations and partners to reflect this approach through its contracts and service specifications. We have already begun this work Bridgewater Community Healthcare NHS Foundation Trust through a joint review of adult community nursing. We will develop a phased approach to rolling out this model with all other providers, including General Practice.

NHS Halton CCG recognises that it cannot mandate practices to work together or join in community hubs. Nonetheless, this is how we intend to commission services in the future and we know that many practices are keen to work together better with each other and with other service providers. NHS Halton CCG considers that the benefits for a practice to join with a community hub outweigh those to not join.

At present, there are 17 practices operating in Halton as 17 separate delivery organisations. Having looked at approaches adopted elsewhere, we aim to create hubs with a population size of 20,000-25,000 registered patients. Our new care model is predicated on the practices starting to work together to create a number of community 'hubs', although the specific configuration of this will be for the General Practices and staff to determine. This approach means the formation of between 6 and 7 community hubs across Halton.

Future practice operating models

Practices in Halton will need to consider how they respond individually and collectively as providers within the new care model. Practices may want to explore a number of organisational operating models that may support them in responding to this commissioning approach, drawing on examples from elsewhere in England and beyond. These operating models include:

- The current as-is model.

- Networks or federations.
- Super-partnerships.
- Regional multi-practice organisations.
- Community Health organisations.

Aside from the 'as is' approach, all of these models use greater organisational scale to extend the range of services offered and to diversify income streams, thus enhancing the sustainability of practices. They develop more sophisticated management support to undertake strategic planning and service development, and create new professional, management and leadership roles that offer a new range of career opportunities for professional, managerial and support staff in primary care. Each approach is underpinned by a shared desire to improve and extend primary care services, develop management and leadership capacity, and assume a more significant role in the local health system – particularly in regard to out of hospital care.

As recognised by the King's Fund and the Nuffield Trust [18], all operating models emphasise the need to balance the benefits of organisational scale with preserving the personal and local nature of general practice. Each model seeks to preserve local practices as the first point of contact for patients, strengthen networks of wider advice and support, use organisational scale to enhance (and not undermine) the local accessibility and nature of primary care.

Headline milestones

We recognise that we need to develop a full implementation and evaluation plan for this Strategy. Nonetheless, there are some immediate milestones for the roll out of the new model of care.

Milestone	Timescale
Practices to have determined whether to join a community hub and if so, have agreed community hub configurations	January 2015
Public engagement and consultation on strategy and approach to take place	February and April 2015
Phased approach to service and provider roll-out to new approach agreed	April 2015
Hubs to be established with agreed initial working arrangements (governance, performance management) agreed	June 2015
Hub working arrangements to be in place and operating	October 2015
Hub specific Joint Strategic Needs Assessment (by Halton Public Health team) to be completed	October 2015
Adult Community Nursing services to be	2015/16

[18] Kings Fund and Nuffield Trust (July 2013), Securing the future of General Practice, New Models of Primary Care. Available: http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/130718_securing_the_future_summary_0.pdf

Milestone	Timescale
operational within new approach	

Priority areas of focus

As well as considering the organisational forms, it has been essential to consider which functional areas, when further addressed, would have the greatest impact on the health of the population of Halton. When considering commissioning for outcomes, it was essential to identify and work on the areas with the highest priority for the local population and the Halton Borough Council Public Health Directorate has supported this process. As a result, the following have been identified as priorities:

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

Using the Joint Strategic Needs Assessments (JSNAs) developed by Halton Borough Council's Public Health Directorate for Area Forums and individual practices and the information shared with us by Professor Bentley, we will undertake further analysis with each 'hub' to determine the priority areas, as in some cases they will not be the same across the whole borough. The solution to tackling each area will be for the community hub to determine, although it would need to congruent and compliant with the commissioning intentions and contracting approach of NHS Halton CCG and our co-commissioners. The principles of sharing experience and peer review to identify best or successful practice will be encouraged.

NHS Halton CCG has partnered with a company called The Experienced Led Commissioning Programme (ELC) to generate insight into what matters to people in Halton about the range of pathways and disease groups identified above. This involves engagement through co design that will see local people shape the commissioning agenda and service design for each area.

An initial workshop was held in December 2014 for cancer and hypertension because they are the two largest causes of premature mortality in Halton. We also know that significant proportions of people with these conditions do not access primary care services early enough (the "missing 40%"); often end up in A&E and have worse outcomes because of this. We need to understand why people are not coming forward so we can address this.

Experience Led Care (ELC) is a new approach to health system management that puts people and their experiences at the centre of every stage of the process. ELC works in the context of any health and care system. It can be applied to any commissioning challenge because it is person-centred. ELC enables clinical commissioners to drive improvement by putting people and their experiences of care at the heart of commissioning and service redesign.

We will look to run a series of workshops, focussing on each priority area, throughout 2015/16 to co design services and pathways with our local people.

Initial working groups

As part of the work to develop this Strategy, four areas were identified where work had begun. These areas were identified based on information gathered throughout the process and the strong evidence base of where we can make a difference with additional focus and intervention. The areas were:

- Cancer.
- Hypertension.
- Access to services over 7 days.
- Care Homes.

Cancer

The overall aim of the cancer project was to reduce late presentation of patients and improve patient care. NHS Halton CCG has an established Cancer Action Team, managed by a lead GP and the Director of Public Health.

It was decided that this project would integrate into the existing work programme of the Cancer Action Team who have been working with all 17 practices to undertake and complete a Cancer Audit, focussing on all instances of Cancer in 2013. This will provide a rich source of information and evidence to work with and support practices about their current approach and pathways and also identify where cohorts of the population are not accessing General Practice.

Targeted campaigns will then follow, working in collaboration with regional bodies, to raise awareness of the local population on themes including the importance of screening and where to access services.

Hypertension

There were 2 overall aims for this project:

1. Optimise treatment of patients with Hypertension; and
2. Identify and find the missing cohort of patients not accessing General Practice.

To this end, a pilot scheme is being implemented whereby a group of practices have identified patients over the age of 18 years who have not had a blood pressure recorded in the last 3 years. They have planned a campaign to support healthy living, good blood pressure control and the risks associated with uncontrolled hypertension. They are then running weekend clinics, both in practice and in a local community centre, for health checks for this cohort of patients.

The patients will be written to in the first instance. If they do not respond, the practice will work with the voluntary sector to proactively target people in their communities to stimulate interest.

The scheme is due to run through to March 2015, when the impact and results will be analysed and shared with all other practices to determine potential roll-out.

Access to services over 7 days

Given the recent political drive to offer extended hour services in General Practice, it was deemed important to establish a project that focussed on this. There were a wide range of views about how this agenda could be addressed and a key feature was the potential role of the soon to be opened Urgent Care Centres (UCCs) in Widnes and Runcorn.

The UCCs will be fully open from April 2015, they will operate from 7:30am to 10pm, 7 days a week and have a GP on-site. A significant programme structure is already in place to support the development and opening of the centres and this has involved a broad range of local stakeholders.

Furthermore, there has been a need to carefully consider how the UCC align and integrate with General Practice and the local acute providers. To this end, an approach with four levels of resilience and access across the community has been considered.

Level 1 – A focus on the self-care agenda and care at home where the 'wrap around' services focus on keeping people as fit and healthy as possible within their own home environment.
Level 2 – The development of General Practice with extended evening and weekend services. NHS Halton CCG will pilot a number of schemes and monitor their effectiveness to determine which best meet the needs of the patients and public, which are most sustainable and which have the greatest impact on the health and wellbeing of the population. We will share the impacts and results with all practices and hubs to allow them to determine which approaches will work best for their populations moving forward.
Level 3 – Extending community resilience through the opening of the two Urgent Care Centres to support the reduction of demand on local hospitals. The Urgent Care Centres will also provide additional community based diagnostic services, accessible to General Practice and the wider 'wrap around' services.

Level 4 – Supporting the sustainable future and development of the local acute services for when our population are most in need of urgent and acute intervention. Further discussions are taking place about this approach.

Care Homes

Building on existing work that NHS Halton CCG and Halton Borough Council have been running with a lead clinician, this project was designed to propose a sustainable model of primary care (and associated services) that improves outcomes, care quality and safety for frail older people in care homes. To support this, the NHS Halton CCG worked in partnership with Healthwatch Halton to run an engagement event with care home residents and staff, key providers and partners and other interested parties. Key feedback themes from the workshop included:

- Variation in the way GP surgeries are contacted or issue prescriptions should be standardised to make it a simpler process for care home staff.
- Dedicated phone line for care homes or single point of contact thus making it easier for GPs to be contacted.
- Relationship building of cares home staff and other health professionals.
- Clear faster pathways for referral processes, promotion of the services that are available such as the audiology housebound service.
- Mapping exercise for the professionals to avoid duplication in the service that is being provided.
- Improved links with the voluntary sector- for provision of activities within the care homes

This is now being documented, alongside an implementation and action plan and will be presented for approval and roll-out.

Enabling support

In addition to the commissioning priority areas and existing working groups, there are four underpinning key enablers that NHS Halton CCG will drive forward, with partners such as Health Education England, to support a sustainable solution. The areas are:

- Workforce.
- Estates.
- IT and Informatics.
- Contracting.

Each of the four areas brings its own challenges and opportunities. Working with General Practice and the experts in each area, NHS Halton CCG will develop a long term approach to each that will support the development and evolution of services.

Workforce

A paper was presented in October 2014 to NHS Halton CCG's Service Development Committee (SDC) setting out the principles of workforce planning. It stimulated

discussion and debate with General Practice around the need to undertake a Halton-wide approach to workforce planning. There was collective recognition of the challenges described in the paper (as well as in this Strategy) and an agreement that further discussions are needed to consider what can be done to address the range of issues.

Essential to those further discussions is the consideration of how the future model of service delivery will affect and influence both the current and future workforce needs, including staffing numbers, staffing types and skill mix.

Estates

Working with local partners and considering the future model of service delivery, the intention of the Strategic Estate Planning process is to support real change in the local estate and to generate strategic estate solutions that drive system wide savings, integration and new service models. Significant savings are achievable through a structured and targeted programme to support the strategic planning of the estate, which will deliver:

- **Increased efficiencies**, through the better use of high-quality primary and community care estate.
- **Better service integration**, driving improvements in service efficiency and better health outcomes for patients.
- **New service models**, supporting the drive to move services into the community from hospitals, replacing outmoded and inadequate premises and releasing capital through a structured programme of disposals.

Information Management and Technology (IM&T)

An IM&T strategy is being developed to reflect the overall strategy, values and aspirations for the future and highlights how Health Informatics and IT can be a significant enabler and driver of improved information flows. This will help effectively measure what we do now, how we communicate and most importantly, how to improve it. It is ensuring that fit for purpose systems are in place which allows streamlined processes and data sharing supported by robust governance arrangements to support clinicians to provide high quality care.

The IM&T strategy is designed to focus on the opportunities and innovation that Information Technology and information/data management can offer and will set out how NHS Halton CCG, practices and partners can deal with rapid changes both in respect of the internal and external environment.
We must ensure that the use of information and information technology to improve patient care, access to care, the patient experience, delivery of clinical outcomes, health record keeping and value for money should be, and will be, a fundamental part of all future of General Practice.

Contracting

To support a number of points made above, it is recognised that "…a new alternative contract for primary care is required (in parallel to the current General Medical

Services contract). The contract needs to be crafted by NHS England in a way that encourages groups of practices to take on a collective responsibility for population health (and ideally also social) care across a network of practices, without specifying the detail of implementation – this should be a matter for local determination" (The Kings Fund & Nuffield Trust, Securing the future of general practice)

8. FINANCIAL SUMMARY

Financial stability is essential moving forward. As set out by NHS England in the *Five Year Forward View*, they will stabilise core funding for general practice nationally over the next two years while an independent review is undertaken of how resources are fairly made available to primary care in different areas. Furthermore, NHS England is currently in the process of providing all CCGs with the current expenditure levels on General Practice. This will include expenditure on General Practice contracts, premises costs, enhanced services and Quality and Outcomes Framework (QOF)

In addition, delegated co-commissioning would means that NHS Halton CCG would have the opportunity to design a local incentive scheme as an alternative to the Quality and Outcomes Framework or Directed Enhanced Services. This would allow NHS Halton CCG to determine how to use resources could be used differently, considering which elements add real value and need to be maintained and even strengthened, and which could add more value.

The approach to wrap services around community hubs means, in the first instance, the aim is to use existing resources more effectively and efficiently. As the system develops and the community hubs mature, consideration about how the overall shape of services and the associated funding can and will be carefully considered as part of the overall commissioning strategy.

In October 2013, the Prime Minister announced a new £50 million Challenge Fund to help improve access to general practice and stimulate innovative ways of providing primary care services. In September 2014, the Prime Minister announced a new second wave, with further funding of £100 million non-recurrent money for 2015/16. To be successful, organisations will need to outline programmes of work to improve access including:

- Longer opening hours;
- Joining up of services;
- Sustainable solutions;
- Greater flexibility about how people access general practice; and
- Greater use of technology.

In addition, NHS England will welcome applications from practices or more likely, groups of practices that wish to test new models for providing general practice services, with potential benefits not only for patients accessing general practice, but also with benefits to the wider NHS.

NHS Halton CCG is making an application for this non-recurrent money in 2015/16 to support the more rapid implementation of this strategy and a number of supporting projects. The deadline for the application is 16th January 2015 and the CCG is actively working with the practices to collate a bid.

At present, projects included in the application include:

- Project management to support the development and implementation of the community hubs and wrap around model.
- Extended hours pilot schemes for General Practice.
- Insight and engagement work.
- Pharmacy schemes.
- IM&T schemes to both support improved access and also interconnectivity between practices and partner organisations.
- Practice and provider development support.

NHS Halton CCG and our co-commissioners will implement this strategy whether we are successful or not with the Prime Ministers Challenge Fund application. It is important to note that the pace of implementation will be affected if not successful, however, alternative sources of non-recurrent monies will sought to support a more rapid implementation.

9. GOVERNANCE APPROACH

To support the development and implementation of this strategy, including successfully delegated co-commissioning status from NHS England, we have identified five key elements involved in the commissioning and contracting of General Practice:

Figure Four: NHS Halton approach to co-commissioning

Each of these interdependent areas requires clear and distinct governance arrangements. NHS Halton CCG will continue be responsible for continuous quality improvement with General Practice and other providers through established governance arrangements, particularly the Primary Care Quality and Development Working Group. This Group will be responsible for establishing the relevant impact assessment monitoring arrangements to track the progress each hub is making towards achieving improved outcomes for its local population.

Co-commissioning will be guided by this Strategy and by existing NHS Halton CCG commissioning strategies. New governance arrangements will be established, consistent with guidance from NHS England for co-commissioning and contract management performance. NHS England will initially support this with resources that they will retain within their structure. NHS Halton CCG will also look to resource support for co-commissioning and contracting and put in place new conflicts of interest policies and a new committee, without GP or member practice representation, to make decisions about commissioning and contracting with General Practice.

Provider Development will focus on supporting practices and the community hubs develop as organisations and assist the development of services and standards.

Individual GP performance management (medical performers list for GPs, appraisals and revalidation) will continue to be executed by NHS England.

10. CONCLUSION

Throughout our programme of work to develop this Strategy we have adopted an integrated approach of co-production, engaging everyone, including practices, NHS England, providers and partners and the public and a range of patient groups and working groups.

There are a range of national and local drivers that collectively create a compelling and evidence based case for change in that General Practice in current guise not sustainable in Halton.

Ten key principles have been derived that are considered fundamental to the future design, configuration, commissioning and delivery of the local General Practice system in Halton.

The future model as set out, Multispecialty Community Provision, fully aligns to the approach as set out in NHS England's Five Year Forward View. The establishment of Community Hubs will further strengthen this model and also bring with it, a much greater focus on the communities of Halton. They will also result in General Practice working together in a more integrated and supportive way, with peer review and buddying actively encouraged creating a learning culture.

Co-commissioning will give the CCG a greater role and responsibility in supporting the establishment of this new approach. There will undoubtedly be challenges but the opportunities are significant.

The use of the Prime Ministers Challenge Fund, if successful, will support an accelerated implementation programme and there a number of projects developing that will support and embed this. Sharing the learning from these projects will be fundamental.

Finally, as important as everything else, continuing the engagement is key. This strategy has been co-produced with practices, partners, providers and the public. This has to continue. Insight work will commence to understand why certain cohorts of the population do not access services early enough. We will consult with our population on the new models and how they are best implemented and we will run co-design events around our areas of greatest focus to ensure the local patients and public co-produce the services in partnership with us.

If successful, the principles outlined earlier will be adhered to and will have sustainable General Practice and out of hospital services for many years to come that will support the improvement of the health and wellbeing of the people of Halton.

APPENDIX 1 HALTON IN NUMBERS

General Practice in Halton – fact file

The table below presents key facts on each of the 17 practices in Halton. The data included is valid at the time of producing this strategy.

Practice	Runcorn/ Widnes	Contract type	Population size	No of GPs	Pts per GP	No of nurses	Pts per Nurse	Training practice?	Nursing homes *
Brookvale	Runcorn	PMS	8,141	3	2,714	6	1,357	Y	7
Weaver Vale	Runcorn	PMS	9,149	6	1,525	3	3,050	Y	7
Heath Road	Runcorn	GMS	2,573	1	2,573	1	2,573	N	3
Grove House	Runcorn	PMS	10,677	5	2,135	3	3,559	N	7
Tower House	Runcorn	PMS	13,167	7	1,881	4	3,292	Y	9
West Bank	Widnes	PMS	2,473	2	1,237	2	1,237	N	5
Beeches	Widnes	PMS	7,857	7	1,122	3	2,619	Y	13
Hough Green	Widnes	PMS	3,503	2	1,752	1	3,503	N	5
Upton Rocks	Widnes	PMS	2,800	2	1,400	2	1,400	N	4
Appleton Village	Widnes	PMS	10,859	6	1,810	2	5,430	Y	11
Beaconsfield	Widnes	PMS	11,200	7	1,600	4	2,800	Y	14
Peelhouse	Widnes	PMS	14,140	6	2,357	4	3,535	N	10
Newtown	Widnes	PMS	8,026	4	2,007	3	2,675	Y	7
Oaks Place	Widnes	PMS	2,978	2	2,978	1	2,978	N	9
Castlefields	Runcorn	PMS	11,785	9	1,309	9	1,309	Y	8
Windmill Hill	Runcorn	APMS	2,024	2	1,012	2	1,012	N	3
Murdishaw	Runcorn	PMS	7,268	4	1,817	3	2,423	N	7
		Totals	**128,620**	**74**	**1,738**	**52**	**2,711**		
					Av.		*Av.*		

Key:

Information obtained from a variety of sources

Contract[19]	Detail
General Medical Services (GMS) contract	This is a nationally directed contract between NHS England and a practice. The new GMS contract was introduced in April 2004. Currently, about 60 per cent of practices nationally are on GMS contracts
Personal Medical Services (PMS) contract	This is a local contract agreed between NHS England and the practice, together with its funding arrangements. In England, approximately 40 per cent of practices nationally are on PMS contracts. The GMS contract has a strong influence on the content and scope of this contract.
Alternative Provider Medical Services (APMS) contract	This allows NHS England to contract with 'any person' under local commissioning arrangements

Training practice – a practice officially approved to teach and train GPs, Nurses and Medical Students

Nursing homes – the number of homes each practice had patients residing in. A snapshot audit undertaken in 2014

[19] British Medical Association (2014),

General Practice in Halton - opening times (un-validated)

	Mon AM	Mon PM	Tue AM	Tue PM	Wed AM	Wed PM	Thur AM	Thur PM	Fri AM	Fri PM	Additional opening	Total hours
Brookvale	8:30 - 18:30		07:30 - 19:00		08:30 - 19:00		08:30 - 18:30		07:30 - 18:30			53.00
Weaver Vale	8:15 - 18:00		8:15 - 18:00		8:15 - 18:00		8:15 - 18:00		8:15 - 18:00		Mon 18:30 - 20:15	50.50
Heath Road	9:00-10:40	16:00-17:30	9:00-10:40	16:00-17:30			9:00-10:40	16:00-17:30	9:00-10:40	16:00-17:30		12.66
Grove House	8:15 - 18:00		8:15 - 18:00		8:15 - 18:00		8:15 - 18:00		8:15 - 18:00			48.75
Tower House	8:30 - 18:00		8:30 - 18:00		8:30 - 18:00		8:30 - 18:00		8:30 - 18:00			47.50
West Bank	8:30 - 18:00		8:30 - 18:00		8:30 - 12:00		8:30 - 18:00		8:30 - 18:00		Mon 18:30 - 20:00	41.50
Beeches	9:00-12:15	15:00-17:30	9:00-12:15	15:00-17:30	9:00-12:15	15:00-17:30	9:00-12:15		9:00-12:15	15:00-17:30		26.25
Hough Green	8:45 - 19:30		8:45 - 18:30		8:45 - 12:30		8:45 - 18:30		8:45 - 18:30			43.75
Upton Rocks	8:00-19:30		8:00-18:30		8:00-18:30		8:00-18:30		8:00-18:30			53.50
Appleton Village	8:30-12:45	13:15-18:00	8:30-12:45	13:15-18:00	8:30-12:45	13:15-18:00	8:30-12:45	13:15-18:00	8:30-12:45	13:15-18:00	Wed 18:30-19:15, Fri 7:00-8:00	46.75
Beaconsfield	8:30-18:30		8:30-18:30		8:30-18:30		8:30-18:30		8:30-18:30		Wed 7:00 - 8:00	51.00
Peelhouse	8:00-20:00		8:00-18:30		8:00-18:30		8:00-18:30		8:00-18:30			54.00
Newtown	9:00-20:30		9:00-18:30		9:00-18:30		9:00-12:00		9:00-18:30			43.00
Oaks Place	9:00-18:30		9:00-18:30		9:00-18:30		9:00-12:30		9:00-18:30			41.50
Castlefields	8:00-13:00	13:00-19:00	8:00-13:00	13:00-19:00	8:00-13:00	13:00-19:00	8:00-13:00	13:00-18:30	8:00-13:00	13:00-18:30	Sat 8:00 - 12:30	54.00
Windmill Hill	8:00-18:30		8:00-18:30		8:00-18:30		8:00-18:30		8:00-18:30		Sat 9:00-13:00, Sun 9:00-13:00	60.50
Murdishaw	8:00-18:30		8:00-18:30		8:00-20:30		8:00-18:30		8:00-18:30			53.50

Information sourced from practice websites and NHS Choices web sites.

General Practice in Halton - Enhanced Services

Practice	NHS England Enhanced Services																		CCG Enhanced Services			
	Alcohol	Learning disabilities	Dementia	Patient participation	Violent patient	Minor surgery	Avoiding unplanned admissions	Childhood flu	Hepatitis B (newborn babies)	Meningococcal C (Men C) Freshers	MMR (aged 16 and over)	Pertussis	Pneumococcal Child PCV	Pneumococcal Adult & At risk	Seasonal Flu	Shingles Routine	Shingles Catch-up	Rotavirus for infants	Extended hours	Unplanned Admissions DES Monthly MDTs	Anti-Coag Levels 1-4	Anti- Coag Level 4+	NPT
Brookvale	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Weaver Vale	N	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	N	Y
Heath Road	N	N	N	N	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	N	N	Y
Grove House	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Tower House	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
West Bank	Y	Y	Y	N	N	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	Y
Beeches	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	N	N	Y
Hough Green	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	Y
Upton Rocks	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Appleton Village	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Beaconsfield	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Peelhouse	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Newtown	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N
Oaks Place	Y	Y	Y	Y	N	Y	Y	Y	N	N	Y	Y	N	N	Y	Y	Y	N	N	Y	N	N	N
Castlefields	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Windmill Hill	Y	Y	Y	Y	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	N	Y
Murdishaw	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y

Information sourced from CCG Primary Care Commissioning Team

General Practice in Halton – IT summary

			HIS/CCG Programme													
Practice	Clinical Sys.	Version	GPSoC	COIN	VOIP	Docman	ICE Path	ICE Rad	Elg	EPS 2	SCR	Patient Partner	Medical Messenger	WiFi	BYOD	Win 7 Off 2010	EMIS IQ
Brookvale	EMIS	EMIS web	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y
Castlefields	EMIS	EMIS web	Y	Y	Y	Y	Y	Y	P	Y	Y	P		Y	Y	Y	Y
Grove House	EMIS	EMIS web	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	P
Heath Rd MC	INPS	Vision VES	Y	Y	N	Y	Y	Y	P	Y	Y			Y			n/a
Murdishaw HC	EMIS	EMIS web	Y	Y	Y	Y	Y	Y	P	B	Y	Y		Y			Y
Tower House	INPS	Vision VES	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y			n/a
Weaver Vale	EMIS	EMIS web	Y	Y	Y	Y	Y	Y	B	Y	Y			Y		Y	Y
Windmill Hill	EMIS	EMIS web	Y	Y	Y	Y	Y	Y		B	Y			Y			Y
Appleton Village	EMIS	EMIS web	Y	Y	Y	Y	Y	Y	Y	N	Y		Y	Y	Y	Y	Y
Beaconsfield	EMIS	EMIS web	Y	Y	Y	Y	Y	Y	N	Y	Y	Y		Y	Y		Y
Beeches MC	EMIS	EMIS web	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y		Y	Y
Newtown HCC	EMIS	EMIS web	Y	Y	Y	Y	Y	Y		B	Y			Y		Y	P
Oaks Place	EMIS	EMIS web	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y			Y
Peelhouse Medical Plaza	EMIS	EMIS web	Y	Y	Y	Y	Y	Y		Y	Y			Y	Y	Y	Y
Hough Green Health Park	EMIS	EMIS web	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y			Y
Upton Rocks Primary Care	EMIS	EMIS web	Y	Y	Y	Y	Y	Y	Y	B	B			Y			Y
West Bank MC	EMIS	EMIS web	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y		Y	Y

General Practice in Halton – IT summary

Information provided by the Health Informatics Service (HIS)

Key

Glossary

GP SoC - GP Systems of Choice
COIN - Community of Interest Network
VOIP - Voice over Internet Protocol Telephony
DOCMAN - Scanning System
ICE - Pathology electronic ordering and results system
ICE - Radiology
Elg - Electronic Archiving and Retrieval system for Lloyd George records
EPS2 - Electronic Prescribing solution
SCR - Summary Care Record
PP - Patient Partner - Automated telephophony appt booking system
MM - Medical Messenger Texting Service
Wi Fi - Wifi connectivity in practice premises
Windows 7 /Office
2010
Emis IQ searches and reports - currently being activated

Key

Y	Live
N	Practice declined
B	Date Booked
P	Planning stage

REPORT TO: Health and Wellbeing Board

DATE: 11th March 2015

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Wellbeing

SUBJECT: Healthy Halton Performance Report Q3 2014/15 & Health and Wellbeing Priorities 2015/16

WARDS: Borough wide

1.0 PURPOSE OF THE REPORT

1.1 This report introduces, through the submission of a structured thematic performance report, the progress of key performance indicators, milestones and targets relating to Health in Quarter 3 of 2014-15. This includes a description of factors which are affecting the service. The thematic report is attached as Appendix 1 to this report.

1.2 The report also sets out information relating to the annual review of Health and Wellbeing Strategy priorities.

2.0 RECOMMENDATION: That the board

1. **receive the Quarter 3 Priority Based report;**

2. **consider the progress and performance information and raise any questions or points for clarification;**

3. **highlight any areas of interest or concern for reporting at future meetings of the Board; and**

4. **consider if the Health and Wellbeing Board priorities set out in 3.2 below are still relevant for 2015/16**

3.0 SUPPORTING INFORMATION

Q3 Performance Report

3.1 This Healthy Halton thematic performance report highlights information relating to performance in Quarter 3 2014/15. The performance framework enables the Health and Wellbeing Board to monitor progress against key health priorities, provide early identification of emerging issues and to take remedial action where necessary. Performance monitoring is also in line with Health and Wellbeing Board Terms of Reference and CCG audit processes.

Health and Wellbeing Board priorities 2015/16

3.2 In 2013 the Health and Wellbeing Board agreed a Health and Wellbeing Strategy for 2013-16 which outlined five key priority areas. These were:

- **Prevention and early detection of cancer.**
- **Improved Child Development.**
- **Reduction in the number of fall in adults.**
- **Reduction in the harm from alcohol.**
- **Prevention and early detection of mental health conditions.**

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

3.3 The Health and Wellbeing Board now need to consider if these priorities continue to be fit for purpose for 2015/16 (the remainder of the period covered by the Health and Wellbeing Strategy).

4.0 POLICY IMPLICATIONS

4.1 There are no direct policy implications arising from this report

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 None

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children and Young People in Halton

Improving the health of children and young people is a key priority in Halton. Therefore, this thematic report also includes performance information relating to the health and wellbeing of children.

6.2 Employment, Learning and Skills in Halton

This report does not contain performance information relating to the above priority, however, it is worth noting that employment, learning and skills are key health determinants. Therefore improving outcomes in this area will have an impact on improving the health of Halton residents.

6.3 A Healthy Halton

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

6.4 **A Safer Halton**

Reducing the incidence of crime, improving Community Safety and reducing fear of crime has an impact on health outcomes particularly on mental health. Whilst the majority of indicators for Safer Halton, form the basis of a separate priority based report, this report contains information on alcohol harm as a shared priority.

6.5 **Halton's Urban Renewal**

This report does not contain any performance data relating to this priority, however, it worth noting that the environment in which we live and the physical infrastructure of our communities has a direct impact on our health and wellbeing. Therefore, any improvements under this priority should ultimately also improve health outcomes.

7.0 RISK ANALYSIS

Not applicable.

8.0 EQUALITY AND DIVERSITY ISSUES

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

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

None under the meaning of the Act.

Health and Wellbeing Board Performance Priority Based Report Oct – Dec 2014

1.0 Introduction

This report provides an overview of issues and progress against Health and Wellbeing priorities, objectives, milestones and performance targets from October to December 2014 from the following areas:

- Improved mental health
- Reduced harm from alcohol
- Improved child development
- Prevention and Early detection of cancer.
- Reduced number of falls in older people.

2.0 Key Developments

There have been a number of developments which include:

Mental Health Services

Operation Emblem was originally set up following a successful trial across Halton and Warrington, as a pilot in late 2013. This project, operated jointly between Cheshire Police and the 5BoroughsPartnership NHS, funded by NHS Halton CCG and supported by Halton Borough Council. The scheme was designed to reduce the large number of inappropriate detentions under section 136 Mental Health Act 1983 (this gives the police the power to detain anyone found in a public place who appears to be mentally disordered and in need of care or treatment). There had been a particular problem in the Northern Division of the Cheshire Police force (which covers Halton), with substantial numbers of people being detained but only relatively low numbers of people then going on to be offered psychiatric help.

Under this scheme, police officers were supported by specialist mental health nurses to assess and triage people who were liable to be detained; this was initially for specified shifts for four days a week. After 12 months, it is clear that Operation Emblem has been extremely effective; the numbers of people being detained under this legislation has dropped by up to 90%, and of those, around 90% are now receiving the psychiatric help that they need. This indicates that the right people are now receiving the appropriate support, and it is proving an effective means of fast tracking people in crisis to specialist help.
The project has now been extended from four days a week to provide full time cover, and it is being rolled out across the whole of Cheshire.

Mental Health Crisis Care Concordat: this policy directive was published by Central Government in February 2014, and requires all relevant organisations to work together to reduce the impact of mental health crisis on individuals and their families, and to ensure that appropriate services and supports are in place. Each locality was required to submit a declaration by the end of December 2014, committing itself to achieving the aims of the Concordat, and then to have an action plan in place by April 2015.

As a whole, the Halton mental health system has signed up to the declarations submitted across the local authority areas in both Cheshire and Merseyside; this is because, for planning and commissioning reasons, Halton straddles both areas. An integrated Halton approach is actively engaged in supporting the Cheshire partners in developing its action plan; in addition, however, Halton has made its own separate declaration and is developing a local action plan, which will be designed to reflect fully the plans developed across Cheshire and Merseyside. This will be reported on more fully in the next Quarterly Monitoring Report.

GP pilot: for twelve months, the Mental Health Outreach Team has been operating a pilot programme with three local GP surgeries, taking referrals about and working with people with lower level mental health needs, intervening at an earlier stage and aiming to reduce the need for more complex support in the future. This continues to show very promising results and measures are now being taken, in partnership with NHS Halton CCG, to develop this as a Borough-wide service.

Full Mental Health Review: A major review of mental health services has been commissioned covering 5 regional CCGs and LAs. This review will take an in-depth look into the successes, gaps, and opportunities around the acute care pathway (ACP). This work will also take into consideration mental health acute psychiatric beds. The results and recommendations will be completed by June 2015.

New planning and governance arrangements for mental health services: a new Mental Health Oversight Group - consisting of senior managers from key stakeholders - has now been developed, with responsibility for leading the strategic development of local mental health services, and monitoring and holding to account all organisations responsible for the delivery of those services. A Mental Health Delivery Group, accounting to the above group, has also been set up, with the primary responsibility of delivering the Halton Mental Health Action Plan.

Prevention and early detection of cancer

A local Cancer Strategy has recently been developed and sets out key actions to address this priority and improve outcomes. The national Be Clear on Cancer campaign is being rolled out with a team of volunteers working with local people. Halton CCG has prioritised cancer as a key area for the new Primary Care Model. A project plan and working group are taking this forward. Weight Management is important to reduce levels of bowel cancer. A range of weight management services are delivered for children and adults on an individual or group level, such as the fresh start programmes, active play and introduction to solid food parties. The Halton Healthy Weight management care pathways for children and adults have been reviewed and opportunities to enhance provision identified. We are also working with the CCG to improve uptake in bowel cancer screening and again this is part of the Primary Care Model work. HPV Vaccination protects girls from cervical cancer in later years. Uptake remains good for HPV vaccination. Changes to the national schedule for HPV vaccination may further improve opportunities to improve uptake locally.

Improving child development

The Family Nurse Partnership team has been recruited and began to start work with first time teenage mothers in November 2014. Work is underway to ensure the safe transition of the Health Visiting service to be commissioned by the Local authority by October 2015.

To date we have had a successful workshop with all providers and partners on the 0-19 child pathway.

3.0 Emerging Issues

Mental Health Services

Mental Health Act Code of Practice: a full and detailed review of the Code of Practice to the Mental Health Act has been conducted by the Department of Health, and Halton Borough Council made a substantial contribution to the national consultation. The revised Code will be issued in Quarter 4 and will then be the subject of detailed training for key staff; relevant policies and procedures will also need to be revised.

Review of the Acute Care Pathway (ACP): the ACP was developed within the 5Boroughs in 2013 as a model for the delivery of services to people under the age of 65 with complex mental health problems. The CCGs across the footprint of the 5Boroughs - supported by the Local Authorities - are now taking forward a review of the ACP as a whole, to establish the level of positive outcomes that have been achieved.

Redesign of Borough Council services for people with mental health problems: given the positive results coming from the pilot programme run by the Mental health Outreach Team with GP surgeries, the decision has been made to review in detail the way that social services as a whole are provided for local residents with mental health problems. Although there will always be a need to provide comprehensive support to people with the most complex needs and levels of risk, the intention is to establish the extent to which social services can engage at an earlier stage with people and reduce the need for complex interventions. This should result in greater opportunities to support partner agencies – particularly the police, children's services and the local housing bodies – to manage and support people whose needs can be very challenging, but who do not fit the criteria for referral to the specialist psychiatric services. This review will also involve a detailed examination of the pathways into step-down services with lower levels of support, to ensure that the right services are provided to people at the right time. The Review is designed to complement the review of the ACP, described above.

5Boroughs locality-based service: following an internal restructure, the 5Boroughs are moving to develop a more borough-based approach to the delivery of their services, so as to match local commissioning requirements more exactly. This is welcomed by the Borough Council and it should continue the effective engagement by the 5Boroughs in local strategic planning processes.

Child development

Current child development status shows an improvement from 37% in 2013/14 to 46% this quarter. We expect this figure to continue to improve.

Since 2010/11 breastfeeding has increased by 11.3%. Halton has a Child Poverty Strategy and Action Plan and is part of the City Region Child Poverty Commission. There is a wide range of work underway to address this area including Children's Centres Programmes, healthy eating, working with food banks, increasing breastfeeding, increasing free school meal uptake, plain packaging for cigarettes, smoking prevention,

work with mums and tots, Credit Crunch Cooking, work with Housing Trusts around welfare reforms and work with the Citizens Advice Bureau supporting clients with mental health issues to access benefits.

Reducing alcohol harm

Local Alcohol Action Area (LAAA) update
We continue to receive support from the Home Office and Public Health England through being a Local Alcohol Action Area (LAAA). Good progress is being made against all LAAA objectives. In December we were appointed a diversity advisor. An initial scoping meeting was held to discuss developing a local action plan. In addition an overnight assessment will be organised and a wider meeting on the topic of diversification arranged.

Halton Alcohol Inquiry: Talking drink taking action
Local residents have been recruited to take part in the Halton Alcohol Inquiry. The Inquiry entitled "Talking Drink: Taking Action" will take place between January and April 2015. As part of The Halton Alcohol Inquiry residents will answer the question 'What would make it easier for people to have a healthier relationship with alcohol?' The group will meet for 9 sessions and hear from local experts who work on this agenda locally in order to create local recommendations for action on the issues that matter to them. The recommendations will then be used to inform and advise what is done to reduce alcohol-related harm in Halton.

Ensuring the local licensing policy supports alcohol harm reduction agenda
Work is underway to work in partnership to ensure Halton's local licensing policy supports the local alcohol harm reduction agenda. It has been agreed that Halton's Statement of licensing policy (SOLP) will be updated in collaboration with all Responsible Authorities. Public health (supported by Community Safety colleagues, Public Health England and Drink Wise) are briefing the Licensing Regulatory Committee in February around alcohol-related harm in Halton and the role licensing can play in promoting public health.
Initial discussions have also been undertaken as part of the Community Safety Sub Regional Programme at looking at licensing tools and powers (including the Late Night Levy) on a sub-regional basis.

6.0 Performance Overview

The following information provides a synopsis of progress for both milestones and performance indicators across the key areas that have been identified by the Health and Wellbeing Board. The way in which the Red, Amber and Green, (RAG), symbols have been used to reflect progress to date is explained at the end of this report.

Key Objectives / milestones

Ref	Milestones	Q3 Progress
PH 01	Work with the public and service providers to raise awareness of the early signs and symptoms of bowel, breast and lung cancer so we can identify it an early stage in the population. **March 2015**	✓
PH 01	Reduce obesity rates in the local population, thereby reducing the incidence of bowel cancer through promoting healthy eating and screening programmes for adults and children via a range of services. **March 2015**	?
PH 01	Meet the 95% target for the take up of HPV vaccination in girls 11-13, to reduce cervical cancer rates by working proactively with the School Nursing Service and GPs. **March 2015**	✓
PH 01	Work proactively with GPs, all service providers, Alcohol Liaison Nurses, teachers in schools to reduce the number of people drinking to harmful levels and alcohol related hospital admissions given the rise in pancreatic and liver cancer rates. **March 2015**	✓
PH 02	Facilitate the Early Life Stages development which focusses on a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, and health, well-being and parenting advice for ages 2½ years and 5 years. **March 2015**	✓
PH 03	Working with all service providers, implement the action plan to reduce falls at home in line with the Royal Society for the Prevention of Accidents (ROSPA) guidance as outlined in the new Falls Strategy **March 2015**	✓
PH 05	Implement the Mental Health and Wellbeing Programme in all schools and provide training for GP Practices and parenting behaviour training in the Children's Centres. **March 2015**	✓

Supporting Commentary

PH 01 Raise awareness of Bowel, Breast and Lung Cancer
This remains a priority for Halton Health & Wellbeing Board and sits within its underlying action plans. The national Be Clear on Cancer campaign continues to be rolled out with a team of volunteers working with local people. We are working closely with Halton CCG to develop additional early detection programmes along the lines of a Cancer Rehabilitation programme. We are still working towards improving access to staging data from the local hospitals.

PH 01 Reduce Obesity Rates
A range of weight management services are delivered for children and adults on an individual or group level, such as the fresh start programmes, active play and introduction to solid food parties. The Halton Healthy Weight management care pathways for children and adults is under review and opportunities to enhance provision being identified. Community Food Workers have been reviewed and the dietetic service is out to tender .

PH 01 Reduce Cervical Cancer Rates
Uptake remains good for HPV vaccination. Changes to the national schedule for HPV vaccination (reduction from 3 to 2 dose schedule) may further improve opportunities to improve uptake locally.

PH 01 Reduce the number of people drinking to harmful levels
An Alcohol Harm Reduction Strategy for Halton has been developed and was launched during alcohol awareness week (17-23 November). The strategy was developed in partnership with colleagues from health, social care, education, voluntary sector, police and the community safety team. The strategy sets out actions across the life course to reduce alcohol related harm and reduce hospital admissions. Good progress has been made related to reducing Under 18 admission alcohol rates locally and Halton is now at the same level as the North West.. Alcohol health education sessions are being delivered in all local schools

PH 02 Facilitate Early Life Stages development
The healthy child programme continues to be delivered across Halton, conducting screening, immunisations and health reviews. The Family Nurse Partnership team started recruiting first time teenage mothers from November 2014. Work continues to ensure the safe transition of the Health Visiting service and Family Nurse Partnership to be commissioned by the Local authority by October 2015.

PH 03 Falls Reduction Action Plan
Implementation of the falls strategy is on track, the main emphasis remains workforce development, public awareness and training and the development of an integrated pathway. All of these elements have seen either a completion or increase in activity. The next stage of development is to agree a new falls business case that will see an increase in prevention work to support the positive rehabilitation work that has been carried out as part of the strategy.

PH 05 Mental Health and Wellbeing Programme
The children's mental health service went out to tender and the announcement of the service provider is awaited. A new mental health and wellbeing action plan has been refreshed.

Key Performance Indicators

Ref	Measure	13/14 Actual	14/15 Target	Q3	Current Progress	Direction of travel
PH LI 01 (SCS HH 7)	Mortality rate from all cancers at ages under 75	145.1 July 13 to June 14	140	126	✓	↑

PH LI 02	A good level of child development	37%	40%	46%	✓	↑
PH LI 03 New SCS Measure Health 2013-16)	Falls and injuries in the over 65s	2,850.4 (Jan 13 – Dec 13)	2,847	2,796.3	✓	↑
PH LI 04	Admissions which are wholly attributable to alcohol AAF=1, rate per 100,000 population.	947.5 (2013/14)	1,038	Data unavailable	?	N/A
PH LI 05	Mental Health: Self-reported wellbeing	N/A	69%	N/A	N/A	N/A

Supporting Commentary

PH LI 01
There is some progress with a slight decrease in the mortality rate from cancers. It is too early to identify an ongoing trend, although the activity against the Cancer Action Plan will maximise reduction going forward.

PH LI 02
Quarter 3 has shown an increase in the number of children reaching a good level of child development by school age. There has been a lot of work in this area, for example piloting an integrated assessment between education and health and parenting programmes that contribute to this improvement.

PH LI 03
Although there has been a slight rise in the rate of falls and injuries, it is not significantly higher. Also the figure is still considerably lower than the 2013/14 figure. The slight increase can be attributed to a higher level of people being present in either hospital or residential care settings, both of which see a higher level of falls compared to people who live at home. Work is ongoing to address this area of concern.

PH LI 04
Data for 2014/15 is not available until later this year.

PH LI 05
No data available yet.

APPENDIX 2 – Explanation of Symbols

Symbols are used in the following manner:

Progress		Objective	Performance Indicator
Green		Indicates that the objective is on course to be achieved within the appropriate timeframe.	*Indicates that the annual target is on course to be achieved.*
Amber		Indicates that it is uncertain or too early to say at this stage, whether the milestone/objective will be achieved within the appropriate timeframe.	*Indicates that it is uncertain or too early to say at this stage whether the annual target is on course to be achieved.*
Red		Indicates that it is highly likely or certain that the objective will not be achieved within the appropriate timeframe.	*Indicates that the target will not be achieved unless there is an intervention or remedial action taken.*

Direction of Travel Indicator

Where possible performance measures will also identify a direction of travel using the following convention

Green		*Indicates that* **performance is better** *as compared to the same period last year.*
Amber		*Indicates that* **performance is the same** *as compared to the same period last year.*
Red		*Indicates that* **performance is worse** *as compared to the same period last year.*
N/A		*Indicates that the measure cannot be compared to the same period last year.*

REPORT TO: Health and Wellbeing Board

DATE: 11th March 2015

REPORTING OFFICER: Dave Sweeney

PORTFOLIO: Health and Wellbeing

SUBJECT: Better Care Fund (BCF)

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To inform the Board that as of January 2015 NHS Halton CCG and Halton Borough Council met all the necessary elements of the BCF and are therefore approved. Also to approve the change to the original targeted reduction in 2015 Non-elective activity as submitted in the Halton Better Care Fund Plan.

2.0 **RECOMMENDATION: That the Board note the positive assurance of BCF** *(see appendix 1)* **and approve the reduced planned reduction in Non-Elective activity to meet NHSE governance & timescales.** *(see appendix 2)*

3.0 **SUPPORTING INFORMATION**

3.1 NHS Halton CCG Better Care Fund January 2015 Survey submission document

4.0 **POLICY IMPLICATIONS**

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

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 The financial implication of reducing the target has not been stated by NHS England.

5.2 The Impact of missing the target for 2015 has already been factored into the CCG budget for 2014/15, there is no impact on the 2015/16 budget.

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

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

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

6.3 **A Healthy Halton –** By reducing the target reduction this will have

the effect more people having a non-elective admission to hospital than was otherwise expected, the number is small, (in the region of 40 additional admissions than otherwise planned for)

6.4 **A Safer Halton -** None

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

7.0 **RISK ANALYSIS**

7.1 *The financial risk of the 40 additional admissions to hospital has been absorbed in 2014/15. The financial impact of any reward payment from NHS England on reaching the reduced target is not yet known, no sanctions were applied on submission of the January updated. Should the financial implications of this amendment be significant any potential loss of reward would be factored into an amended submission with additional planning undertaken on a cost-benefit analysis.*

8.0 **EQUALITY AND DIVERSITY ISSUES**

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

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

None within the meaning of the Act.

Halton Clinical Commissioning Group

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

23rd February 2015

1. The 2015 Better Care Fund (BCF) originally planned for a 3.5% reduction in Non-Elective admissions to Hospital from a 2014 baseline. The 3.5% was made up of a 1% reduction in the 2014/15 financial year and a 4.4% reduction in the 2015/16 Financial year.

2. Only Q4 of 2014/15 fell into the 2015 calculation for the BCF ¼ of -1% = -0.25% to be factored into the BCF.
3. Q1 to Q3 of 2015/16 fell into the 2015 calculation for the BCF. ¾ of -4.4% = -3.3% to be factored into the BCF

4. One of the schemes embedded within the BCF which will provide a significant amount of this reduction is the development of the Urgent Care Centres. However the delays in fully opening the Widnes site and analysis of the initial Q4 data suggests that the reduction expected in 2014/15 will not take place and non-elective activity will be similar in 2014/15 to 2013/14.

5. This leaves a total reduction which could still be achieved in 2015 of -3.3%

6. In late January 2015 NHS England issued an e-mail asking all CCG's as part of their 2015/16 planning programme to revisit the target for non-elective care in light of likely 2014/15 performance. The turnaround for submitting this document was very short and it was not possible for this to go through HWBB prior to submission back to NHS England. However senior representatives from both the CCG and the LA were consulted prior to submission.

7. As part of the CCG 2015/16 planning submission the CCG have been asked to ensure that any changes to the originally submitted BCF target for Non-elective admissions have been seen and approved by the HWBB.

8. This paper seeks approval for this reduction from the original submission of -3.5% to the revised -3.3%

9. The difference between the -3.25% submitted in the January Survey and the -3.3% which will appear in the BCF is related to formatting in the BCF submission which only allows the use of 1 decimal place.

Better Care Fund Survey - January 2015

HWB name	Halton	Date	29/01/2015

Background

The non-elective admissions reduction ambition linked to payment for performance in BCF plans was for the period Q4 14/15 – Q3 15/16, compared to a baseline of actual out-turn in Q4 13/14 and forecast out-turn for Q1-3 14/15 (taken from operational plans). The technical guidance explained that the level of ambition would be adjusted once actual out-turn for Q1-3 14/15 was known. Since then the NHS planning guidance for 15/16 indicated that local areas can revisit their non-elective admissions plan through 15/16 operational planning to take into account: actual performance in the year to date (particularly through winter), likely outturn for 14/15 full year, and progress with contract negotiations with providers – with any proposed changes to be signed off by local partners in including the HWB.

In light of the recent rise in urgent activity, and as we approach the NHS planning round where we know everyone will be working together especially with providers to ensure appropriate capacity is in place for next year, we would like to gauge any potential revisions local areas might want to make to the ambition for non-elective admissions reductions. We understand that this will be worked out more fully over the coming weeks ahead of the first draft plan submission on 27 February, however, we are looking for an early indication of whether you have yet considered if you expect a change in the level of ambition for reductions.

Survey

	Question	Response	Narrative *Free text up to 200 characters*
1	Have you considered the impact of actual performance in the year to date (particularly through winter), likely outturn for 14/15 full year, and progress with contract negotiations with providers, on your local ambition for reducing non-elective admissions?	Yes	*An original plan for a 1% reduction is unlikely to be met due to factors outside our control leading to an unexpected delay in opening the Urgent Care Centre in Widnes.*
2	If you answered 'Yes' to question 1, do you expect a change to your level of ambition?	**Yes**	*The reduction planned for 15/16 remains the same at 4.33%, however the net effect of not meeting the 1% 14/15 target reduction will result in a overall reduction in the 2015 BCF calendar year target*
3	If you answered 'Yes' to question 2, what do you estimate your revised level of ambition will be in percentage terms, for reducing non-elective admissions (G&A) over Q4 14/15 – Q3 15/16?	**0.1 - 0.5% reduction**	*We estimate that the effect of not achieving a 1% reduciton in 2014/15 will be a net change of -0.25% in the BCF figure for 2015, resulting in a change from -3.5% to -3.25%*

Publications Gateway Ref. No. 02396

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To:
Halton Health and Wellbeing Board
NHS Halton CCG

Copy to:
Halton Borough Council

21 January 2015

Dear colleague,

Thank you for submitting further evidence to clear the conditions on your Better Care Fund (BCF) plan. We know that the BCF is an ambitious programme and preparing the plans at pace has proved an immensely challenging task. However, your plan is now part of an ongoing process to transform local services and improve the lives of people in your community.

It is clear that your team and partners have worked very hard over the last few months, making valuable changes to your plan in order to improve people's care.

NHS England is now able to approve plans following the publication of the 2015/16 Mandate. As a result I am delighted to let you know that, following the recent assurance process, your resubmitted plan has been classified as **'Approved'**. Appended to this letter is your NCAR Outcome Report for your information. Essentially, your plan is strong and robust and we have every confidence that you will be able to deliver against it. This puts you in a strong position for delivering the change outlined above.

Your BCF funding will be made available to you subject to the following standard conditions which apply to all BCF plans:

- The Fund being used in accordance with your final approved plan and through a section 75 agreement;
- The full value of the element of the Fund linked to non-elective admissions reduction target will be paid over to CCGs at the start of the financial year. However, CCGs may only release the full value of this funding into the pool if the admissions reduction target is met as detailed in the BCF Technical Guidance[1]. If the target is not met, the CCG(s) may only release into the pool a part of that funding proportionate to the partial achievement of the target. Any part of this funding that is not released into the pool due to the target not being met must be dealt with in accordance with NHS England requirements. Full details are set out in the BCF Technical Guidance

The conditions are being imposed through NHS England's powers under sections 223G and 223GA of the NHS Act 2006 (as amended by the Care Act 2014). These allow NHS England to make payment of the BCF allocation subject to conditions. If the conditions are not complied with, NHS England is able to withhold or recover funding, or direct the CCG that it be spent in a particular way.

We are confident that there are no areas of high risk in your plan and as such you should progress with your plans for implementation.

Any ongoing oversight of your BCF plan will be led by your NHS England Regional/Area Team along with your Local Government Regional peer rather than the BCF Taskforce from this point onwards.

Non-elective (general and acute) admissions reductions ambition

We recognise that some areas may want to revisit their ambitions for the level of reduction of non-elective admissions, in light of their experience of actual performance over the winter, and as they become more confident of the 2014/15 outturn, and firm-up their plans to inform the 2015/16 contracting round. Any such review should include appropriate involvement from local authorities and be approved by HWBs. NHS England will assess the extent to which any proposed change has been locally agreed in line with BCF requirements, as well as the risk to delivery of the ambition, as part of its assurance of CCGs' operational plans.

Once again, thank you for your work and we look forward to the next stage.

Yours sincerely,

Dame Barbara Hakin
National Director: Commissioning Operations
NHS England

[1] http://www.england.nhs.uk/wp-content/uploads/2014/08/bcf-technical-guidance-v2.pdf

REPORT TO: Health and Wellbeing Board

DATE: 11 March 2015

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Wellbeing

SUBJECT: Pregnancy and Alcohol Social marketing campaign

WARD(S): Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To highlight a new social marketing campaign to educate women of the harm that drinking alcohol in pregnancy can cause, in order to reduce alcohol related harm to the unborn baby.

2.0 RECOMMENDATION: That the board support the campaign aims:

- To bring about a change in attitude and behaviour, towards drinking alcohol in pregnancy.
- Reduce the risk to the unborn baby due to drinking alcohol in pregnancy, and subsequently improve child development.

3.0 SUPPORTING INFORMATION

3.1 A child's experience pre-birth and during the early years is critical to the child's physical, cognitive and social development. During this development phase the foundations are put in place for the rest of that child's life and this period offers a once in a lifetime opportunity to give that child the 'best start in life'.

3.2 UK guidance recommends that pregnant women should avoid drinking alcohol, and if they do choose to drink, they should not drink any more than 1 or 2 units of alcohol once or twice per week and should not get drunk.

3.3 Alcohol-related harm during preconception and pregnancy is caused by alcohol passing freely across the placenta from mother to foetus. Potential outcomes of alcohol consumption during pregnancy may include miscarriage, stillbirth, low birth weight (LBW), learning disabilities and hyperactivity as well as foetal alcohol spectrum disorder (FASD). The highest risk period for harm is the first 3 weeks of pregnancy, before women may know they are pregnant.

3.4 Evidence is as yet unclear regarding how much alcohol is safe to drink during pregnancy. The healthiest and safest option is therefore for women not to drink when trying for a baby or when pregnant.

3.5 There is no local data showing the number of women who drink in pregnancy or the quantity they consume. When national drinking rates during pregnancy were modelled to Halton there are a higher proportion of women who stop drinking during pregnancy than the English average. This is due to Halton having a higher proportion of younger mothers and a lower percentage of women working in managerial and professional jobs.

3.6 Each year in Halton:

- Around 1,600 women become pregnant
- Of these women around 1,300 (80%) were drinking before pregnancy
- Of these women around 800 (60%) will give up drinking during pregnancy

3.7 **Foetal alcohol spectrum disorder (FASD)**
FASD is the umbrella term for a range of preventable alcohol-related birth defects. Risk factors for foetal alcohol spectrum disorder are drinking in very early and late pregnancy and binge drinking

3.8 FASD is a direct result of prenatal alcohol exposure and can be prevented if pregnant women do not drink alcohol. There is no routine data available on the number of local children affected, but anecdotal evidence from paediatricians suggested that FASD is increasing and is a condition that is under diagnosed.

3.9 The effects of FASD can be mild or severe, ranging from reduced intellectual ability and attention deficit disorder to heart problems and even death. Many children experience serious behavioural and social difficulties that last a lifetime.

3.10 Experts estimate that in Western countries, one child in 100 is born with FASD as a result of their mother's drinking alcohol while pregnant. Modelled to the Halton birth rate 16 children would be born with FASD each year.

3.11 Current activity in Halton to reduce alcohol consumption during pregnancy includes:

- All pregnant women are advised of safe drinking guidelines
- Halton midwives and health visitors have been trained in the early identification and support of pregnant women who misuse alcohol. This includes when and how to refer to local treatment services.
- There is a dedicated Alcohol and Substance Misuse Liaison Midwife who coordinates antenatal care services for pregnant women identified as misusing alcohol.

3.12 The Halton Alcohol Strategy (2014-19) identified the need to improve general awareness and understanding of safe drinking levels during pregnancy. The action plan recommended developing an awareness campaign aimed at the general population to increase awareness of the danger of drinking during pregnancy.

3.13 The Health Improvement social marketing team instigated the development of the campaign through baseline research to establish women's knowledge and their attitudes towards drinking in pregnancy. A set of questions were developed based on previous research and delivered via face to face interviews on the street, in children's centres and via an online questionnaire.

3.14 The findings were clear that FASD did not mean anything to the general population and that there was a general disengagement with the subject. Women did not identify themselves as a 'heavy drinker', although they were unclear as to what 1 unit of alcohol was, and FASD in their mind was an 'alcoholics' issue.

3.15 Most women were shocked that drinking alcohol at conception could be detrimental to the developing foetus, so this was clearly an indication that work needed to be done around the pregnancy planning preventative messaging.

3.16 A set of creatives were developed and road tested at the local Children's Centres, but were initially dismissed with residents requesting a harder hitting approach. A further set of designs were produced and road tested. This provided us with a clear direction for the pre pregnancy and pregnant preventative concepts to establish a two pronged approach moving forward.

3.17 The final campaign creative was taken to a midwife focus group, the community, partnership groups and was approved by the alcohol and

families specialist midwife.

3.18 The campaign was launched at the end of February, with a big bang outdoor media approach with billboards, supermarket posters at entrances, bus sides and internals.

3.19 The campaign also includes PR, social media advertising and messaging using the hashtag #boozefreebump to use on all social media communications. The Health improvement team, CCG, NHS and Halton Borough council websites amongst other partners will support the messages and will include the campaign data.

3.20 Midwives will use a new information leaflet, to provide more information to pregnant women when they book in with the midwife and at Early Bird ante natal sessions.

3.21 Posters and flyers will be distributed to all GP surgeries and in community locations across the borough.

3.22 The campaign will be evaluated by further insight work with the targeted audiences in July 2015; this will be compared to the previous insight to establish changes in attitude/behaviour. Alongside this a sample of women will be identified at booking in stage and followed through to birth to establish attitude and behaviour change after exposure to the campaign messages. The use of social media will also be measured to establish their effectiveness.

4.0 POLICY IMPLICATIONS

4.1 Halton's Health and Wellbeing Strategy identifies Improved Child Development as one of five key priorities for action. This priority was chosen for a number of reasons including; child development has a significant impact on child health and wellbeing which remains into adult life. This work aims to directly impact upon child development.

5 OTHER/FINANCIAL IMPLICATIONS

5.1 There are no additional financial implications above the cost of the campaign.

6 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children and Young People in Halton**
All issues outlined in this report focus directly on this priority and improving child development.

6.2 **Employment, Learning and Skills in Halton**
Population level reductions in alcohol consumption will contribute to reducing the number of children with learning difficulties and other related health conditions, and improve long term educational outcomes.

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

6.4 **A Safer Halton**
Part of the overarching alcohol strategy to reduce alcohol related issues in Halton.

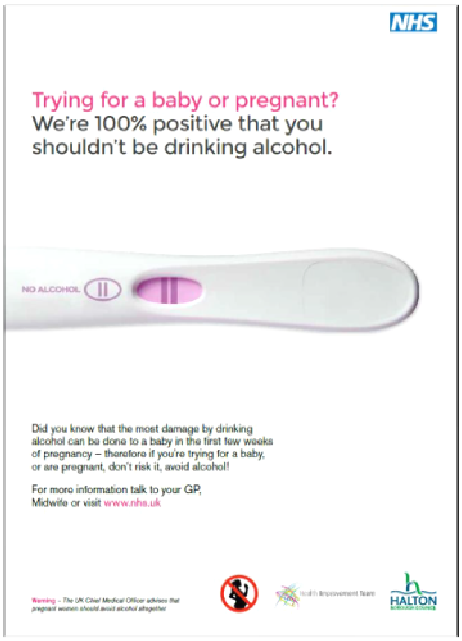
6.5 **Halton's Urban Renewal**
No direct implications have been identified.

7 RISK ANALYSIS
None

8 EQUALITY AND DIVERSITY ISSUES
This is in line with all equality and diversity issues in Halton.

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

Appendix 1



REPORT TO:	Health & Wellbeing Board
DATE:	11th March 2015
REPORTING OFFICER:	Strategic Director, Communities
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Halton Borough Council and NHS Halton Clinical Commissioning Group: Revised Joint Working Agreement
WARD(S)	Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To present and seek approval for the revised Joint Working Agreement between Halton Borough Council (HBC) and NHS Halton Clinical Commissioning Group (CGC), which now incorporates the Better Care Fund for 2015/16.

2.0 RECOMMENDATION: That the Board

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

2. **approve the revised Joint Working Agreement, attached at Appendix 1.**

3.0 SUPPORTING INFORMATION

3.1 In April 2013, HBC and NHS Halton CCG entered into a 3 year Joint Working Agreement for the commissioning of services for people with Complex Care needs. NB. This Agreement was previously presented and agreed at Executive Board on 28th March 2013.

3.2 The development of this Joint Working Agreement has been possible under Section 75 of the Health and Social Care Act 2006, which allows local authorities and health organisations to pool funds. This Agreement provides the legal framework in which HBC and NHS Halton CCG work together in order to achieve their strategic objectives of commissioning and providing cost effective, personalised, quality services to the people of Halton. As part of the Joint Working Agreement, HBC and NHS Halton CCG entered into a Pooled Budget arrangement, totalling just under £33 million. This pool contained the expenditure on delivering care and support services for adults with complex needs.

3.3 In the Summer of 2013, the government announced its intention to further promote integrated working across health and social care through the development of mandatory pooled budget arrangements between Local Authority Adult Social Care Services and Clinical Commissioning Groups. These new arrangements were intended to improve the quality of care delivered within localities and strengthen system capacity and demand management. These new pooled budget arrangements became known as

the Better Care Fund.

3.4 During 2014, partners within Halton worked collaboratively, within the national guidance and framework to develop Halton's Better Care Fund. It was agreed that the Better Care Fund should be incorporated into the existing Pooled Budget arrangements between HBC and NHS Halton CCG.

3.5 Halton's Better Care Fund plan was presented and approved for submission by Halton's Health and Wellbeing Board and received the necessary national approvals in January 2015.

3.6 The Joint Working Agreement has been revised to reflect the following changes:

- the Complex Care Board is renamed the Better Care Board
- the Executive Commissioning board is renamed the Better Care Executive Commissioning Board
- the budget schedule for 2015/16 has been revised to incorporate the additional Better Care Fund allocation for 2015/16

No changes have been made to the legal framework of the agreement.

4.0 POLICY IMPLICATIONS

4.1 None identified.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 HBC and NHS Halton CCG have agreed the spending arrangements of the revised Pooled Fund.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

None identified

6.2 Employment, Learning & Skills in Halton

None identified

6.3 A Healthy Halton

The Better Care Fund strengthens the existing arrangements in place to deliver high quality, effective and safe care for people with care and support needs. In addition the fund enhances the delivery of health promotion and preventative services designed to support people to live more years of healthy life.

6.4 A Safer Halton

None identified

6.5 **Halton's Urban Renewal**

None identified

7.0 **RISK ANALYSIS**

7.1 The Joint Working Agreement complies with the financial standing orders of HBC and NHS Halton CCG and the regulatory and monitoring arrangements contained within.

7.2 No specific risk assessment is required for this revision to the Joint Working Agreement.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 There are no Equality and Diversity implications as a result of the revision to the Joint Working Agreement.

9.0 **IMPLEMENTATION DATE**

The revised Joint Working Agreement would take effect from 1st April 2015.

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

Document	Place of Inspection	Contact Officer
Executive Board Report: 3 Year Joint Working Agreement: 28/03/2013	HBC Website	Damian Nolan Damian.nolan@halton.gov.uk
Executive Board Report: Better Care Fund Submission: 27/03/2014	HBC Website	Damian Nolan Damian.nolan@halton.gov.uk

HALTON BOROUGH COUNCIL

AND

NHS HALTON CLINICAL COMMISSIONING GROUP

JOINT WORKING AGREEMENT

1st APRIL 2013 – 31st MARCH 2016

Relating to

Complex Care Services in Halton
Revised March 2015

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THIS AGREEMENT dated day of 2013

MADE BETWEEN the following parties:-

(1) HALTON BOROUGH COUNCIL (HBC), Municipal Building, Kingsway, Widnes.

(2) NHS HALTON CLINICAL COMMISSIONING GROUP (NHS HCCG), Runcorn Town Hall, Heath Road, Runcorn.

1. **DEFINITIONS**

1.1	"the 2006 Act"	means the National Health Service Act 2006
1.2	"Budget Manager"	Means any manager in HBC or NHS HCCG with responsibility for a budget (not Pool Fund)
1.3	"Better Care Fund"	means the total pooled fund comprising the existing pooled fund and the additional amounts for 15/16.
1.4	"Capital Assets"	means (but not by way of limitation) the purchase, construction or replacement of a tangible asset which has a life of more than 12 months
1.5	"Capital Expenditure"	means such sum exceeding Five Thousand Pounds (£5,000) expended from the Pooled Fund upon the purchase construction or replacement of the Capital Assets
1.6	"the Client"	means a person who satisfies the requirements of the Eligibility Criteria and is a member of the Client group.
1.7	"the Client Group"	means any person (adults) registered with a Halton GP and is a Halton resident, with care being provided for a disability or illness due to a physical, mental health or learning disability and is in line with the requirements of the Eligibility Criteria.
1.8	"Complex Care"	means care provided for a disability or illness due to physical, mental health or learning disability.

1.9	"the ECB"	means the Complex Care Executive Commissioning Board whose constitution functions and rules of procedure are set out in Schedule 3 of this agreement
1.10	"Eligibility Criteria"	means the Criteria agreed between the Parties as to the conditions to be satisfied for a Client to be a member of the Client Group and which is more particularly set out in Schedule 1.
1.11	"Exempt Information"	means "such information which the Parties resolve that the remainder of their meetings be held in private because publicity would be prejudicial to the public interest or the effective conduct of public affairs etc…." [Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960] (See Appendix One for full information)
1.12	"a Financial Year"	means a year commencing on 1st April and ending on the following 31st March
1.13	"HBC"	means Halton Borough Council
1.14	"NHS HCCG"	means NHS Halton Clinical Commissioning Group
1.15	"health related functions"	means such of the functions of HBC as are prescribed in Regulation 6 of the Regulations as far as they relate to the Client Group
1.16	" the host party"	means the organisation responsible for the accounts and audit of the pooled fund arrangements as prescribed in Regulation 4 of the Regulations
1.17	"NHS functions"	means such of the functions of NHS HCCG as prescribed in Regulation 5 of the Regulations as far as they relate to the Client Group
1.18	"the Parties"	means HBC and NHS HCCG (and "Party" means either one of the Parties)
1.19	"the Complex Care Board"	now renamed Better Care Board whose role function and constitution are set out in Schedule 2 hereto

1.20	"the Pooled Fund"	means the fund administered by HBC from contributions by the Parties in accordance with the terms hereinafter appearing and in pursuance of the Pooled Fund Arrangements
1.21	"the Pooled Fund Arrangements"	means the arrangements agreed by the Parties for pooling their resources and to be expended upon the costs of the Services and to be maintained in accordance with the requirements of clause 6 hereof
1.22	"the Pool Manager"	means the officer appointed by the Parties for the purposes of administering the Pooled Fund and authorising payments from the Pooled Fund in respect of the costs of the Services. Pooled Manager is an Operational Director, HBC.
1.23	"the Regulations"	means the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 SI No.617 and any amendments and subsequent re-enactments
1.24	"the Revenue Payments"	means such sum as contributed by the Parties to the Pooled Fund at the commencement of the Term and thereafter on the 1st April of each subsequent year in respect of the costs incurred or to be incurred in paying for the Services
1.25	"the Service Contracts"	means the Contracts entered into by either one or all of the Parties for the purposes of providing Complex Care Services. Such contracts may be in the form of service level agreements and entered into with voluntary, independent and statutory sectors
1.26	"the Services"	means the Services provided for the benefit of the Client Group in accordance with the Service Contracts including inter alia the aims and set out in Clause 3 hereto
1.27	"the Term"	means the period beginning 1st April 2013 and ending 31st March 2016 subject to review as hereinafter set out

2. RECITALS

2.1 Pursuant to Section 75 of the 2006 Act and the Regulations and Regulation 7, SI 2000 No.617, the Parties have agreed to enter into a Pooled Fund Arrangement to establish and maintain a Pooled Fund made up of contributions by the Parties out of which payments may be made towards the exercise of the health related and NHS functions.

2.2 The objectives of the Pooled Fund Arrangements are to improve the services for clients through closer working between the NHS HCCG and HBC and which is pursuant to the obligations upon the Parties to co-operate with each other as referred to in the Section 75 of the 2006 Act.

2.3 The Pooled Fund Arrangements have been established pursuant to Section 75 of the 2006 Act and pursuant to the Regulations

2.4 The Pooled Fund Arrangements proposed by this Agreement fulfill the objectives set out in the NHS HCCG Integrated Commissioning Strategy.

2.5 The provisions of this Agreement shall take effect on the 1st April 2013.

3 GOVERNANCE

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

3.2 The Parties have established a Complex Care Board for the purpose of discharging their duties in relation to the commissioning and provision of Complex Care as outlined in Schedule 1. 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. From April 2015 this Board will be known as the "Better Care Board" (BCB).

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

3.4 The Parties have established the Executive Commissioning Board (ECB) as a joint committee within the meaning of Regulation 10 (2) of the Regulations. From April 2015 the ECB will be known as the Better Care ECB (BCECB). The BCECB will report to the BCB.

3.5 Decisions of the BCECB and/or the Pool Manager which are beyond their respective delegated authority limits (as set out in Schedule 5) or are inconsistent with the terms of this agreement would require the approval and ratification of the governing bodies of the Parties organisations.

4 THE BETTER CARE BOARD

4.1 The aims of the Better Care Board are to :

4.1.1 Determine the strategic direction and policy for the provision of services to people with complex needs to improve quality, productivity and prevention, via monitoring performance, reviewing and evaluating services and taking assertive action where performance is not satisfactory.

4.1.2 Promote inter-agency cooperation, via appropriate joint working agreements/ arrangements, to encourage and help develop effective working relationships between different services and agencies, based on mutual understanding and trust

4.1.3 Exercise financial control over budgets associated with the running of the Services supporting those with Complex Care needs, ensuring financial probity.

4.2 Membership

The membership of the Better Care Board is outlined in Schedule 2.

5 THE POOLED FUND

5.1 There will be a budget time table set for the pooled fund outlined in Schedule 4. There will be one Pooled Fund. The amounts to be contributed by the Parties for the Financial Year beginning 1st April 2015 are set out in Schedule.

5.2 The Pooled Fund will cover the expenditure on both staffing and service contracts by the Parties during the term of this Agreement

5.3 The Parties may contribute additional amounts to the Pooled Fund during the term of this agreement. The proportionate contribution of the Parties to the Pooled Fund will be adjusted accordingly for the purposes of dividing the Pooled Fund at the termination of the agreement as outlined in 11.3.1.

5.4 The Better Care Executive Commissioning Board will produce an annual work plan in January of each year for the following financial year. This will be reviewed and agreed by the Better Care Board and the Parties by 1st March.

5.5 The management of and administration of the Pooled Fund shall be carried out in accordance with the terms and conditions set out in Schedule 4 and within the delegation limits set out in Schedule 5.

6 MANAGEMENT OF THE POOLED FUND

6.1 The host party for the purposes of Regulation 7(4) of the Regulations shall be HBC or such other Party as the Parties may from time to time unanimously agree.

6.2 The Parties will appoint an officer to be the Pool Manager for the purposes of Regulation 7(4) of the Regulations who may delegate some or all of their functions as hereinafter set out. The Pool Manager will be an Operational Director, HBC.

6.3 The Pool Manager shall ensure that the standard budgetary controls, standing orders, financial contract regulations and monitoring arrangements of the host organisation will apply.

6.4 The Pool Manager shall manage the Pooled Fund and the Finance Manager shall submit bi monthly financial reports to the BC ECB, quarterly reports to the Better Care Board and Parties and ensure an end of year memorandum of accounts and balance sheet extract are prepared relating to the income and expenditure from the Pooled Fund and other information which the Parties may reasonably require so that the Parties may monitor the effectiveness of the Pooled Fund arrangements. Financial reporting will comply with the audit requirements of both HBC and NHS HCCG.

6.5 The approved Revenue Budget for the Pool shall be deemed to give authority to the Strategic Directors to expend or incur liabilities, during the period covered by that budget, to the extent of the detailed provisions contained therein. In accordance with the Council's scheme of delegation, these deemed authorities shall be exercisable by the Operational Directors. Revisions to the budget must be in accordance with 5.2.2 of the Council's Constitution and reflected in the bi monthly financial reports presented to BC ECB.

6.6 The Pool Manager will provide to the BC ECB and the Better Care Board all relevant information concerning specific grants and other funding initiatives so that development bids can be coordinated against the relevant funding.

6.7 HBC will arrange for the accounts of the Pooled Fund to be audited and shall request Grant Thornton to make arrangements to certify an annual return of those accounts under Section 28(1) (d) of the Audit Commission Act 1998.

7 CHARGES

7.1 Charges to clients for services funded by HBC within Fair Access to Care Services eligibility will be applied, in line with national and local guidance. This applies to HBC funded elements of joint funded services between NHS HCCG and HBC.

7.2 Charges do not apply to clients eligible for Intermediate Care and Equipment Services in line with current national and local guidance.

7.3 Charges do not apply to clients eligible for Continuing Health Care funded services in line with current national and local guidance.

8 POOLED FUND AUDIT AND MONITORING ARRANGEMENTS

8.1 Grant Thornton will act as external auditors to the BC ECB and will assume responsibility for auditing the Pooled Budget.

8.2 The Finance Manager (HBC) will ensure the Pool Manager receives a retrospective bimonthly Pooled Budget statement not more than one month after the end of the previous month. This will form the basis of the bi monthly finance report referred to in 6.4.

8.3 The Pool Manager will scrutinise the Pooled Budget statement and investigate discrepancies.

8.4 Procurement of, and payment for, all services and goods from the Pooled Budget with be undertaken using HBC Agresso financial system

8.5 The Pool Manager will ensure that detailed financial reports are presented to Better Care Board and they reflect the latest financial position as previously reported at BC ECB.

8.6 HBC will prepare an end of year financial memorandum of accounts and extract balance sheet. Once the memorandum has been certified by Grant Thornton it will be presented to the BC ECB, Better Care Board and the Parties by the Pool Manager.

9 STAFF AND ACCOMMODATION RELATING TO THE POOLED FUND

9.1 The Pool Manager shall be an employee of HBC.

9.2 The Chair of the BC ECB shall lead within the BC ECB on implementing the commissioning priorities to achieve the required outcomes of the Joint Working Agreement and the Pooled Fund arrangements.

9.3 The Pool Manager will (in addition to the obligations referred to in clause 7.3) monitor progress and will submit regular reports to the BC ECB and the Better Care Board as at clauses 8.3, 8.5 and 8.6.

9.4 The Chair of the ECB will make recommendations to the Better Care Board and the Parties upon the type and level of staff and support required to ensure the operation of the Pooled Fund in consultation with the Pool Manager

9.5 HBC and NHS HCCG will provide the necessary staff accommodation and support services required in connection with the Pooled Fund Arrangements.

10 COMMISSIONING ARRANGEMENTS

10.1 The BC ECB shall be responsible for proposing all Complex Care Services to be commissioned and prepare reports for the Better Care Board on the same. In developing such proposals the BC ECB will need to demonstrate the involvement of the commissioning teams of the Parties. The Better Care Board shall review commissioning proposals, determine the appropriateness or otherwise of the proposals and report to the Parties. Such services commissioned through contracts and / or service level agreements shall be authorised on behalf of the Parties by the chair of the BC ECB. The role, function and constitution of the BC ECB is outlined in Schedule 3.

11 DURATION AND TERMINATION OF THE JOINT WORKING AGREEMENT

11.1 This agreement will commence on 1st April 2013 and terminate on 31st March 2016. The Parties can negotiate a further agreement for the next financial period. Annual reviews of the viability of the agreement will be conducted by the ECB and a decision reached by 1st March.

11.2 Any of the Parties may terminate this agreement by the giving at least six months prior written notice to the other.

11.3 Upon the termination:-

11.3.1 Each of the Parties shall in respect of any unspent Revenue Payments held by the Pooled Fund on behalf of the Parties be entitled to be repaid from the Pooled Fund the contributions they shall have made to it in the same proportion as the budget contribution made at the beginning of the Financial Year with additional contributions made during the year taken into the proportioning.

11.3.2 None of the Parties will be obliged to make any further Revenue Payments to the Pooled Fund other than to discharge the reasonable costs, liabilities and expenses incurred by the Pooled Fund prior to the date of termination. HBC shall use its best endeavors to mitigate such costs, liabilities and expenses.

11.3.3 Upon the date of termination such of the Capital Assets purchased with monies provided from the Pooled Fund will be disposed of with the proceeds reverting to the Pooled Fund after taking into account the reasonable cost of disposal and the proceeds shall be discharged in accordance with the proportions set out in paragraph 11.3.1 above. With the agreement of the Parties ownership of a Capital Asset may transfer to one of the Parties on receipt of funds to the Pooled Fund equivalent to the value of the said asset on the date of termination.

12 REVIEW

12.1 The Better Care Board will review the agreement during the period and report on progress to the Parties in March of each year of the agreement.

13 COMPLAINTS

13.1 Complaints and compliments relating to services jointly-provided by HBC and NHS HCCG serving the client group will be dealt with in accordance with the 'Concordat on Cross Boundary Complaints'.

14 DISPUTES

14.1 The Parties will act together in good faith to resolve any dispute that may arise under this agreement. If the parties are unable to resolve a dispute an arbitrator shall be nominated by either the National Commissioning Board or the Regional Government Office who will either adjudicate on the point at issue or will direct the parties as to the method of dispute resolution.

15 CONTRACT (RIGHTS OF THIRD PARTIES) ACT 1999

15.1 Unless the right of enforcement is expressly provided, it is not intended that a third party should have the right to enforce a provision of this agreement pursuant to the Contract (Rights of Third Parties) Act 1999.

15.2 The parties may, by agreement, rescind or vary this agreement without the consent of a third party to which the right of enforcement of any of its terms has been expressly provided.

16 RISK MANAGEMENT

16.1 Each of the Parties shall assume responsibility for their own liability for all claims within their own sphere of influence and arising from this agreement including clinical negligence, Professional indemnity, Employers and Public Liability, income tax, national Insurance, VAT or other taxation liabilities however arising. This assumption of liability also applies to existing contracts operated by the Parties and any liability arising there from. The Parties hereby each individually indemnify each other from any liability arising from this agreement. All new contracts awarded by HBC or N H S HCCG on behalf of the Parties will require that the contractor (private or voluntary organisation) will provide their own indemnity insurance. Neither Party will accept any claims from the other Party which relates to the period prior to the commencement of this agreement.

17 DATA PROTECTION

17.1 The Parties acknowledge their respective obligations under the Data Protection Act 1998, Freedom of Information Act 2000 and the Environment Information Regulations 2004.

The Parties agree that each will facilitate the performance by the other of their obligations under the Act, the Regulations and under any other legislation that requires disclosure of information.

The Parties will abide by the agreed Information Sharing Protocol for the sharing of the Client group information.

SIGNATURES SHEET

SIGNED on behalf of

HALTON CLINICAL COMMISSIONING GROUP

…… (signature)

…… (print name)

…… (position)

…… (date)

(duly authorised in that behalf)

SIGNED on behalf of

HALTON BOROUGH COUNCIL

…… (signature)

…… (print name)

…… (position)

…… (date)

(duly authorised in that behalf)

SCHEDULE 1

ASSESSMENT, ELIGIBILITY AND LOCAL DISPUTE PATHWAY

Introduction

S1.1 The Better Care Fund between NHS HCCG and HBC will provide the main financial resource to be used for adults who are eligible for care and support services. This pathway supports Practitioners and Managers within Health and Social Care Teams to ensure assessment of need and considerations of eligibility are undertaken in a transparent way, involving the person and their significant others in the associated processes. The pathway complies with and promotes the use of the national and local guidance, policies and procedures in relation to Fair Access to Care Services (FACS), Continuing Health Care (CHC),Funded Nursing Care (FNC) and Jointly Commissioned Care.

Assessment Process

Short Term Intervention/Intermediate Care Services

S1.2 There are a range of commissioned services designed to provide assessment and intervention work to enable individuals to regain, maintain and improve their physical, social and mental health functioning and abilities. Some of these services are for people with specific conditions, whilst others are generic working with all adults.

S1.3 This range of services should be considered in the first instance where an individual presents with new or changing needs. Whilst there is some variation between services in the process, access to these services is gained through assessment leading to treatment, care and support planning and intervention work. Most of these services will then plan for and initiate longer term services as required towards the end of the intervention work. This group of services can also work alongside existing long term services where appropriate.

Long Term Provision (including provision of equipment)

S1.4 Across the Health and Social Care economy in Halton there are a variety of Practitioners and Teams involved in the assessment of individuals to determine long term needs. Irrespective of the specialty, the process is broadly the same and is illustrated in the pathway diagram. At Practitioner and Team level the detail and scope of the assessment process undertaken is determined by an initial assessment of the presenting needs with a focus on utilising short term intervention services to maintain, restore or improve functional ability and manage short term changes in a person's life before considering long term care and support provision.

S1.5 Where short term interventions have been undertaken, or were not indicated, then the next stage of the assessment process is to determine the nature of risks for an individual, their long term care and support needs and the range and type of interventions / services required to manage these. As part of this process, Practitioners and Teams need to consider issues of eligibility. Utilising existing FACS, CHC, FNC, Joint Funding and Equipment guidance and associated tools, Practitioners and Teams, with the individual and their significant others, will determine the appropriate type of funding the individual is eligible for. This determination is subject to quality assurance and authorisation processes.

End of Life Fast Track Eligibility

S1.6 Where an individual is approaching the end of their life and requires palliative treatment, care and support, then medical or nursing practitioners and teams will ensure that the appropriate guidance and tools are utilised to inform their decision making about an individual's eligibility for funding through the 'fast track' process.

Quality Assurance

S1.7 Existing supervisory and management structures within the respective organisations undertake a quality assurance process in relation to the assessment of risk and need, and the decision in relation to eligibility. Specifically Team Managers and Supervisors will be responsible for:

• ensuring short term preventative services have been utilised to full effect;
• reviewing the consistency, quality and veracity of all the assessments leading to a request for funding, and undertake more in-depth sample auditing of cases as per organisation policies;
• verifying and validating recommendations on eligibility by the Practitioner or Team in line with national and local guidance;
• agreeing required actions where issues or concerns arise in relation to the assessment and eligibility determination;
• referring issues of unmet need or service deficit (including issues of out of borough placements) which could potentially impact on wider/overall commissioning intentions through to the appropriate Commissioning Manager; and
• ensuring out of borough placements are only agreed after all local options have been explored.

S1.8 Quarterly reports will be presented by a relevant Divisional Manager (HBC) and the Complex Care Clinical Lead (NHSHCCG) to the Executive Commissioning Board outlining key issues and actions in relation to the quality assurance process.

Resource Allocation Authorisation

S1.9 Authorisation for the level and type of resource allocation to support an individual will be undertaken by appropriate Managers and Leads within HBC and NHS HCCG (and delegated to CMCSU) in line with the respective organisations financial standing orders and delegation limits.

S1.11 HBC and NHS HCCG will operate a Joint Authorisation Process.

S1.11 Low level Social Care services will require authorisation from an appropriate Divisional Manager (or delegate) within Halton Borough Council.

S1.12 Authorisation for Social Care services to meet complex care needs and / or where significant risk is identified will be approved through risk enablement processes with financial authorization commensurate with financial Standing Orders.

S1.13 Authorisation of services to meet complex care needs and / or where significant risk is identified requiring Social Care and Health care funding elements ('joint funded') will be approved by the Joint Authorisation Process.

S1.14 Authorisation for wholly health funded services to meet complex care needs and / or where significant risk is identified requiring health care funding will be approved by the Joint Authorisation Process.

S1.15 Authorisation for end of life fast track will be approved by the Locality Lead, Complex Care Clinical Lead (or delegate)

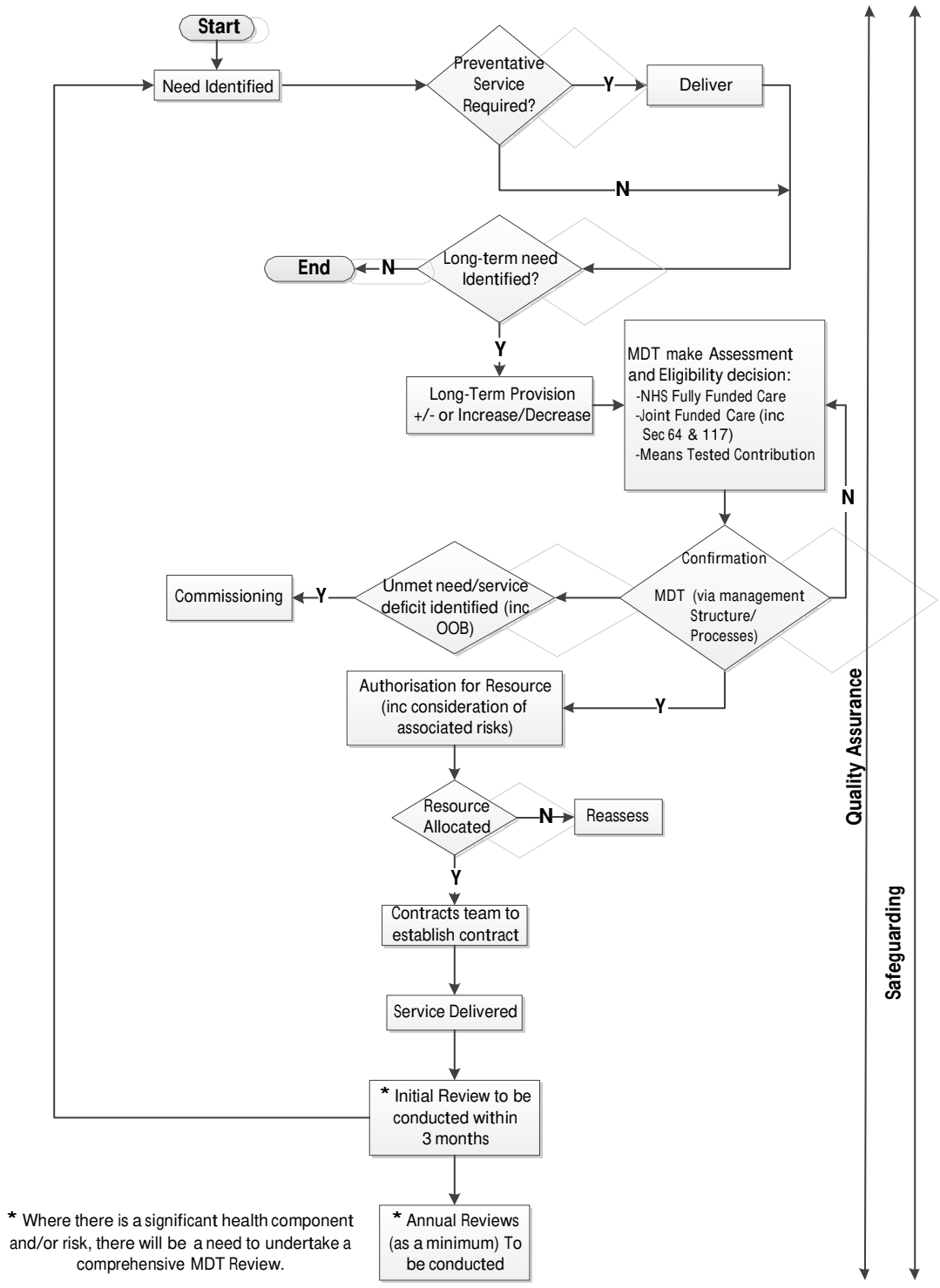
S1.16 Where an individuals' needs require a significant level of funding from the Pooled Budget then this should be agreed through a Risk Enablement Panel, jointly chaired by the Pool Manager (HBC) and a lead from NHS HCCG (or delegate). The individual case should be presented by the Case Manager and an appropriate Divisional Manager. This panel will meet on an ad hoc basis.

Local Dispute Management

S1.17 The Joint Authorisation Panel is the operational body through which disputes between Health and Social Care Practitioners on eligibility should be resolved, with clear reference to the national and local guidance.

S1.18 Cases should be referred to the Risk Enablement Panel where a resolution cannot be achieved through Joint Authorisation Process.

Complex Care – Proposed Pathway



* Where there is a significant health component and/or risk, there will be a need to undertake a comprehensive MDT Review.

SCHEDULE 2

ROLE, FUNCTION AND CONSTITUTION OF THE BETTER CARE BOARD

S2.1 In this Schedule, "member" or "members" shall be defined by reference to the bodies (as amended from time to time as hereinafter set out) as listed in 4.2 of the Joint Working Agreement

S2.2 There will be regular reviews of the composition of the Better Care Board in order to reflect any changes in the Parties and members or in national guidance or legislation

S2.3 Any of the members and Parties may from time to time replace or fill a vacancy of one or more of its appointees to serve on the Better Care Board

S2.4 Each of the members and Parties shall appoint named persons as substitute members who shall attend meetings of the Better Care Board in the absence of the member for whom they are a substitute member.

S2.5 The Better Care Board may co-opt persons to sit on the Better Care Board for a fixed period or to assist with specific matters but such co-opted members shall not be entitled to vote at any meetings of the Better Care Board

S2.6 Any representative/appointee of the member of the Better Care Board wishing to resign shall give written notice to the Chair of the Better Care Board who shall report the matter to the member body who has appointed the representative/appointee

S2.7 The Chair of the Better Care Board will be HBC's Executive Portfolio Holder (Health and Adults).

S2.8 The Chair shall preside over the Better Care Board meetings. If the Chair is not present then the Vice-Chairperson shall preside. If neither the Chair nor the Vice-Chairperson is present the members of the Complex Care Board present (with voting rights) shall select a Chair for the meeting from the members who are present at the meeting.

S2.9 The Better Care Board shall meet on a bi-monthly basis. The timing of the meeting may change in exceptional circumstances to the satisfaction of the Parties and agreed by the Chair. Reports and agendas shall be circulated, wherever possible, to the members at least five working days in advance of the said meeting. The agenda papers shall be sent to the members of the Better Care Board and to such other persons and agencies who would normally receive the papers had the Parties been reporting to their own respective boards in respect of the Pooled Fund Arrangements. Any items or matters, which are deemed to be exempt from discussion in public or before the press must be properly and clearly marked and endorsed with the reason thereof. For Exempt Information see definition 1.10 on Page 4. For full information see Appendix Two.

S2.10 The minutes of all meetings of the Better Care Board shall be sent to the members and the Parties. The Better Care Board shall prepare and send the members and Parties an annual report on both finance and activity.

S2.11 Extraordinary meetings of the Better Care Board may be called at any time upon a request by at least one third of the members entitled to vote and giving at least 5 working days prior written notice

S2.12 All members of the Better Care Board shall be entitled to one vote, except where they have disclosed an interest. Votes should be cast in person. Nominated substitutes will assume the voting rights of the nominator

S2.13 Members of the Better Care Board must disclose an interest when a Board meeting considers an item in which they have a personal interest and are likely to benefit. Members who disclose an interest should withdraw from the meeting until the item has been discussed. This should be noted within the minutes

S2.14 The role of the Better Care Board is to ensure that an integrated system is developed and appropriately managed to ensure that the resources available to both Health and Social Care are effectively used in the delivery of personalised, responsive and holistic care to those who are most in need within our community. This will be achieved through :-

- Determining the strategic direction and policy for the provision of services to people with complex needs to improve quality, productivity and prevention, via monitoring performance, reviewing and evaluating services and taking assertive action where performance is not satisfactory.

- Promoting inter-agency cooperation, via appropriate joint working agreements/ arrangements, to encourage and help develop effective working relationships between different services and agencies, based on mutual understanding and trust.

- Exercising financial control over budgets associated with the running of the Services supporting those with Complex Care needs, ensuring financial probity.

S2.15 The Better Care Board will encourage the full use of the Health Act flexibilities as defined within the NHS Act 2006.

S2.16 The Better Care Board will take responsibility for the management monitoring and use of the Pooled Fund Arrangements for Complex Care services and receive reports and information on the operation of the same. Votes on financial issues can only be based on recommendations from the Executive Commissioning Board

S2.17 Meetings of the Better Care Board shall be quorate when at least two members from the NHS HCCG (with voting rights) and two members from HBC (with voting rights) are in attendance.

S2.19 **Membership**

The Better Care Board is chaired by HBC's Executive Board Portfolio Holder (Health and Adults) and membership of the Board will consist of the following representatives:-

- ***Halton Borough Council***
  - HBC Executive Board Portfolio Holder (Resources)
  - Strategic Director, Communities
  - Operational Director (Prevention & Assessment)
  - Operational Director (Commissioning & Complex Care)
  - Finance Manager

- ***Halton Clinical Commissioning Group***
  - Chief Officer Designate
  - Chair
  - Operational Director (Integration)
  - GP Clinical Lead
  - Chief Nurse
  - Director of Finance

S2.20 The Better Care Board will elect a Vice Chair from within its membership.

S2.21 The Board has the right to co-opt non-voting members and invite non-voting individuals to attend for specific issues.

S2.22 Any of the Parties may from time to time replace one or more of its representatives to serve on the Board.

S2.23 Any member of the Board wishing to resign shall give written notice to the Chair who shall report the matter to the Better Care Board. Members from HBC and HCCG shall cease to be members of the Board where their employment with or elected membership of HBC and HCCG ceases.

S2.24 Each member of the Better Care Board will have one vote unless otherwise stated above at S2.17.

S2.25 The minutes of all meetings shall be sent to the Members and the Better Care Board shall prepare and send to the Parties an annual report.

S2.26 The Better Care Board shall adhere to the role, function and constitution as laid out in Schedule 2.

SCHEDULE 3

ROLE, FUNCTION AND CONSTITUTION OF THE BETTER CARE EXECUTIVE COMMISSIONING BOARD

S3.1 To develop and make recommendations to the Better Care Board on the strategic, commissioning and operational direction of Complex Care in Halton.

S3.2 To be responsible for oversight of the management, monitoring and use of the Pooled Fund by the Pool Manager through monthly reports, and report to the Better Care Board and Parties in all matters relating to the Pooled Fund.

S3.3 To be responsible for the monitoring contractual relationships with service providers financed by the Pooled Fund through the implementation of a performance management framework and report to the Better Care Board in all matters relating to such monitoring.

S3.4 To be responsible for overseeing the implementation of the decisions of the Better Care Board.

S3.5 To implement the commissioning of Complex Care services for the Borough of Halton.

S3.6 To do detailed planning work on behalf of the Better Care Board.

S3.7 To prepare detailed planning proposals for Complex Care services and present to the Better Care Board for discussion and approval.

S3.8 To consider bids for projects from the Better Care Board, and to report such initiatives to the Better Care Board for information.

S3.9 To analyse government policies, local and national research and audit and national information relating to Complex Care and to present such information to the Better Care Board for the purposes of the development and commissioning of Complex Care services in Halton. This will include sources of any available funding.

S3.10 Meetings of the BC ECB shall be held monthly and will be quorate when at least two members from the NHS HCCG and two members from HBC (with voting rights) shall be in attendance.

S3.11 **Membership**

The BC ECB is chaired by HBC's Operational Director (Prevention & Assessment)
and membership of the Board will consist of the following representatives:-

- ***Halton Borough Council***
  - Operational Director (Commissioning & Complex Needs)
  - Divisional Manager (Urgent Care)
  - Divisional Manager (Commissioning)
  - Finance Manager

- ***Halton Clinical Commissioning Group***
  - Operational Director (Transformation)
  - Commissioning Manager
  - Finance Manager
  - Complex Care Clinical Lead

- **Halton Borough Council/Halton Clinical Commissioning Group (Non-Voting)**
  - Lead Policy Officer (People & Communities)

- ***Other Organisations (Non-Voting)***
  - Bridgewater Community Healthcare NHSF Foundation Trust
  - 5 Borough's Partnership NHS Foundation Trust
  - Cheshire and Merseyside Commissioning Support Unit
  - Warrington and Halton Hospitals NHS Foundation Trust
  - St Helens and Knowsley Teaching Hospitals NHS Trust

S3.12 Each member of HBC and NHS HCCG will have one vote and any decisions taken by the BC ECB will require a majority vote unless otherwise agreed by the Parties.

S3.13 The ECB may co-opt non-voting members for the purposes of providing expertise to the BC ECB in relevant matters.

SCHEDULE 4
FINANCE

S4.1. **CONTRIBUTIONS FINANCIAL YEAR 2015-16**

S4.1.1 For the purposes of Paragraph 5 the contributions to be made to the Pooled Fund by the HBC and the NHS HCCG for the period 1st April 2015 to 31st March 2016 are set out below (subject to variation as agreed between the Parties):-

HBC:- to be confirmed

NHS HCCG:- to be confirmed

Grants:- to be confirm

Full breakdown of the above budgets are outlined in Appendix 2.

S4.2 **CONTRIBUTIONS YEARS 2013/14, 2014/15 AND 2015/16**

S4.2.1 The contributions for the financial years 2013/14, 2014/15 and 2015/16 will be determined by the respective Parties and agreed by 1st March of the preceding financial year.

S4.3 **ADDITIONAL FUNDS**

S4.3.1 If any additional funding related specifically to the Clients becomes available to any of the Parties during the current Financial Year the Pool Manager should be advised of such circumstances and the funds shall be transferred to the HBC for inclusion in the Pooled Fund.

S4.4 **VARIATIONS OF CONTRIBUTIONS**

S4.4.1 If in exceptional circumstances any of the Parties should wish to reduce their contributions to the Pooled Fund during the term of the agreement by a sum which would exceed 5% of their annual contribution, then such party shall serve six months previous notice in writing upon the other.

S4.5. **OVERSPENDS**

S4.5.1 The Pooled Fund shall be managed by the Pool Manager with the intention of producing a balanced budget at the end of the financial Year

S4.5.2 In the event that the Pool Manager identifies (at any period during the financial year) that there will be insufficient budgetary provision to meet the likely expenditure for the current Financial Year then this shall be reported to the ECB.

S4.5.3 In the event referred to in paragraph S4.5.2 the following procedure will take effect:-

S4.5.3.1 The BCECB will be convened within 2 weeks to produce a financial plan to address the budget insufficiencies within the existing Pool Fund allocation.

S4.5.3.2 The financial plan will be presented to the Parties for discussion and agreement within 4 weeks of the deficit being identified.

S4.5.3.3 Where the Pool Fund is unlikely to be able to meet the agreed contractual duties of the Joint Working Agreement then HBC may specify particular reasonable requirements of the ECB including a reduction in service activity, and seek further action of the Parties as special conditions for the temporary support of the budget.

S4.5.3.4 Prior to the implementation of the financial plan referred to above at S4.5.3.2 any conditions which the HBC shall seek to impose including amendments to this Agreement shall first be agreed with HCCG, whose agreement cannot reasonably be withheld.

S4.6. **TERMINATION OF JOINT WORKING AGREEMENT**

S4.6.1 At the expiration of the Term or at any other date of termination as hereinbefore referred to, then such surplus of monies shall be repaid to the Parties in such proportion, as is equal to their respective contributions made during the term of this agreement and is subject to Audit approval.

S4.6.2 Any surplus of monies left in the Pooled Fund at the end of the relevant Financial Year, other than at termination, representing an underspend for that year shall be rolled over into the next successive Financial Year unless otherwise agreed by Better Care Executive Board.

At the expiration of the Term or at any other date of termination as hereinbefore referred to, then such surplus of monies shall be repaid to the Partners in such proportion, as is equal to their respective contributions to the Pooled Fund at the beginning of the relevant Financial Year, subject to Audit approval.

S4.6.3 At the expiration of the Term or at any other date of termination as hereinbefore referred to, then such surplus of monies shall be repaid to the Parties in such proportion, as is equal to their respective contributions to the Pooled Fund at the beginning of the relevant Financial Year, subject to Audit approval.

S4.7. **DEBT**

S4.7.1 Where charges to clients for services funded by HBC within Fair Access to Care Services eligibility are made and debts are incurred, then HBC will use the Authority's Debt Recovery policy to recovery those debts. This will also apply to HBC funded elements of joint funded services between NHS HCCG and HBC.

S4.8. **S.151 OFFICER**

S4.8.1 The Pool Manager will be accountable for managing the Pooled Fund and reporting to the ECB and HBC's Strategic Director Policy and Resources Directorate, who is the officer appointed by HBC for the purposes of S.151 of the Local Government Act 1972 and S.114 of the Local Government Finance Act 1988.

S4.9. **HBC'S FINANCIAL STANDING ORDERS AND FINANCE REGULATIONS**

S4.9.1 HBC's Financial Standing Orders will apply to the operation of the Pooled Fund where the Revenue Payments made by HCCG have been paid to HBC to be held in the Pooled Fund managed by HBC. Any expenditure incurred by the Parties on behalf of the Pooled Fund shall comply with the appropriate regulations and orders of each of the Parties

S4.9.2 All Service Contracts and conditions of either of the Parties existing at the commencement of this agreement will be honoured until the date of their expiry. Any new Service Contracts entered into by either Party will be made in accordance with paragraph 4.9.1.

S4.10. **MONITORING AND REPORTING ARRANGEMENTS**

S4.10.1 HBC will provide the Pool Manager with bimonthly budget reports on the Pooled Fund and any expenditure incurred from the same. Where expenditure is incurred on behalf of the Pooled Fund by the Parties or those it commissions to carry out such work then those agencies will be required to record the detailed transactions within their accounting systems and provide bimonthly reports (in a format to be agreed by the Parties) to HBC for inclusion within the bimonthly Pooled Fund reports to the BCECB.

S4.11. **VAT**

S4.11.1 VAT will be applied in accordance with advice issued by H M Revenue and Customs. As HBC will be the host party it is envisaged that the VAT regime adopted will be that currently applicable to the Local Authority Sector.

S4.12. **EXPENSES**

S4.12.1 Any expenses as agreed by the Better Care Board incurred by service users and carers in attending meetings of the Better Care Board may be paid from the Pooled Fund in accordance with the HBC subsistence and travel rules and the expenses of any other members of the Better Care Board shall be met by their employers or respective body.

S4.13. **PAYMENT ARRANGEMENTS**

S4.13.1 In the event of NHS HCCG making its Revenue Payment to the Pooled Fund such payment shall be by quarterly installments within 5 working days of the start of each month commencing on April 2013 on production of an invoice from HBC.

S4.13.2 HBC will where appropriate pay NHS HCCG in 12 equal monthly installments on receipt of an appropriate invoice and where necessary, supporting documentation has been received on 15th of each month commencing from 15th April 2013 provided that such payment to the HCCG will be dependent upon receipt of the Revenue Payments mentioned in clause S4.13.1

S4.14. **EFFICIENCY SAVINGS**

S4.14.1 The Pooled Fund will have to demonstrate that it is achieving the required efficiency targets set by the Parties.

S4.15. **CAPITAL EXPENDITURE**

S4.15.1 Capital expenditure for the purchase of Capital Assets cannot be incurred without the prior written approval of the BC ECB and Section. 151 officer

S4.15.2 In the event of approval being given the HBC shall purchase and own the Capital Assets on behalf of the Parties and thereafter be responsible for the maintenance, repair, renewal and insurance costs of the Capital Assets on behalf of the Parties.

S4.15.3 The Pool Manager shall be responsible for producing and thereafter maintaining a register of Capital Assets purchased from the Pooled Fund.

S4.15.4 On the disposal or sale of any of the Capital Assets, either during the Term of this agreement or upon termination of the same (for whatever reason) the net proceeds from such disposal or sale shall be returned by HBC to the Pooled Fund.

S4.15.5 If the proposed cost of any of the Capital Assets shall exceed £30,000 then such cost shall not be funded from the Pooled Fund but shall require the submission and preparation by a manager of an initial Business Case to be made to the BC ECB which shall, if it accepts the validity of the Business Case, then refer such request for making a formal bid or request whether by submission of a formal Business Case for approval or otherwise to the appropriate statutory funder for such monies and if approved such Party shall retain legal ownership of the Capital Assets.

S4.15.6 In the event of receiving Capital Expenditure grant from the Government a protocol will be agreed by the BC ECB, taking advice from the S.151 officer of the HBC.

S4.16. **SPECIFIC GRANTS**

S4.16.1 It is recognised by the Parties that the contribution to the Pooled Fund made by HBC and the NHS HCCG will not include specific grant monies from the Department of Health. In the event that specific grant monies become available the process described at S4.3.1 is to be followed.

S4.16.2 In the event that such grants monies are withdrawn none of the Parties shall be required to fund such shortfall from its own resources and the Parties shall inform the Better Care Board and the Pool Manager of such event arising as soon as reasonably practicable

S4.16.3 The Parties shall apply such information detail and audit evidence relating to the expenditure incurred by the Pooled Fund as may be required by the Parties and their auditors to satisfy any of the conditions which may have been imposed upon the Parties by the relevant funding body on receipt of such grant monies including evidence of the activities upon which such expenditure was incurred

S4.17 BUDGET TIMETABLE

S4.17.1 The annual HBC Budget for the whole Council will be set in accordance with the HBC's Corporate Budget Setting Process, identified below.

S4.17.2 The Finance Manager will contact the Budget Managers within Adult and Older People Services, including the Pooled Budget Manager, to request any information required and arrange meetings with Budget / Pooled Budget Managers during September and October each year, in preparation of setting the budget for the forthcoming year. It is essential that the information be provided promptly so that the overall deadlines for budget preparation are to be achieved.

S4.17.3 The indicative budget timetable is as follows:

- The current year budget will be revised continuously, as soon as virements are approved in accordance with standing orders.
- The current year budget will be reviewed each year in September & October, in conjunction with Budget Managers.
- The forthcoming year's base budget (i.e. before growth and savings) will be prepared by Mid-December.
- The Provisional Local Government Finance settlement from Central Government is expected by mid-December.
- Management Team and Executive Board will then consider the forthcoming base budget in the light of the provisional settlement.
- Management Team and Executive Board will consider growth and savings options during January and once approved these will be built into the forthcoming budget
- The budget will be approved and published in the Communities electronic Budget book. This will be available to all budget managers by the end of March.
- Executive Board or Executive Board Sub Committee will consider the levels of fees and charges proposed for the forthcoming year during March.

S4.17.4 The NHS HCCG Finance Manager will confirm the NHS HCCG's contribution to the Better Care Fund, to the HBC Finance Manager, by the end of February each year.

S4.17.5 The budget setting process is summaried below :-

Deadline Date	**Item**
September/October	Meetings with Budget Managers for mid-year review.
Mid December	Forthcoming year's Base Budget (before growth & savings) to be prepared
Mid December	Provisional Revenue Support Grant (RSG) settlement analysed
Late December	Base Budget comparison to RSG reported to Management Team
End of January	Incorporate approved growth & savings into budgets
End of February	Confirmation of NHS HCCG contribution to HBC Finance Manager
February/March	Forthcoming year's Fees & Charges recommended for approval by Members
End of March	Distribute Communities Directorate electronic Budget Book to Budget Managers

SCHEDULE 5

DELEGATION LIMITS

S6.1. Delegated Authority: As stated in Governance 4.2, the Better Care Board is not an autonomous body and does not therefore have legal status. Any decisions of the ECB and/or the Pool Manager which are beyond their respective delegated authority/limits (as set out in Schedule (6.1.2) or are inconsistent with the terms of this agreement would require the approval and ratification of the governing bodies of the Parties organisations in accordance with both Parties Standing Orders and Schemes of Delegation.

S6.1.1 As stated Schedule 4, paragraph 9.1 the Pooled Fund will be operated under the Council's Constitution, Standing Orders and Finance Regulations. Within paragraph 3.4 of the Standing Orders relating to Finance there is provision for Delegated Authority to be granted to Officers of the Council for the certification of financial and personnel documents with the approval of the Strategic Director Communities and Head of Internal Audit.

S6.1.2 Delegated Authority has been granted to Officers who have responsibility for managing the Pooled Fund. These Officers and their certification limits are set out below and may change from time to time. The ECB shall agree spend relative to the Pool

List of Officers who have delegated authority relative to this pool to certify Financial Documents within the following limits.

	Orders/ Invoices
Operational Director	£1m
Divisional Manager	£100k

S6.1.3 Authorised Certifying Officers shall be responsible for all financial arrangements delegated as per the list and shall maintain a sufficient record of all transactions to account for the Pooled Funds.

S6.1.4 The Pool Manager should ensure that certifying officers are familiar with the procedures and requirements set out in the Standing Orders Relating to Finance and Procurement and be satisfied that officers are aware of and comply with the correct procedures.

S6.1.5 Authorised Certifying Officers have a responsibility to assist the Internal Auditors acting on behalf of the Council when reviewing any internal or financial control system for which they are responsible.

S6.1.6 Delegated powers are restricted to individual areas of management control as stated within the Joint Working Agreement. In particular the certification of financial documents requires responsibility for ensuring adequate budgetary provision is available and documents are processed strictly in accordance within the specific authorisation limits as detailed in the list.

S6.1.7 Any changes to the officers included in the list can only be authorised jointly by the Strategic Director, Communities and the Chief Internal Auditor.

S6.1.8 Specimen signatures have been obtained for all the certifying officers and copies provided to the relevant sections within Communities Directorate, and the Policy and Resources Directorate.

Appendix 1

Exempt Information

1 The Better Care Board may choose to discuss in private this information which is not intended to be an exhaustive list, but merely examples of the same any item of business which includes or is likely to involve discussion of Exempt Information for the purposes of Schedule 12A Local Government Act 1972. The categories of Exempt Information applicable as at 29 September 2004 are listed for illustrative purposes only in Appendix 1 to this agreement and references in Schedule 12A to 'the authority' shall in the context of this Agreement be taken to refer to the Board.

2 The Better Care Board shall discuss in private any item of business which includes or is likely to involve discussion of Confidential information.

3 In the context of this Clause the expression 'Confidential Information' shall typically, though not exhaustively, mean:-

a) information furnished to the Better Care Board of any member of the Board or to the Council or to the NHS HCCG by a government department upon terms (however expressed) which forbid the disclosure of the information to the public; or

b) information the disclosure of which to the public is prohibited by or under any enactment or by order of a court.

Appendix 2

Finance

NHS Halton Clinical Commissioning Group

to

Total	**12,627,546**

Notes

Halton Borough Council

Total	

Notes

Grants: