Public Document Pack

Health Policy and Performance Board

Tuesday, 10 March 2015 at 6.30 p.m.
Council Chamber, Runcorn Town Hall

Chief Executive

BOARD MEMBERSHIP

Councillor Ellen Cargill (Chairman)	Labour
Councillor Joan Lowe (Vice-Chairman)	Labour
Councillor Sandra Baker	Labour
Councillor Marjorie Bradshaw	Conservative
Councillor Mark Dennett	Labour
Councillor Margaret Horabin	Labour
Councillor Martha Lloyd Jones	Labour
Councillor Chris Loftus	Labour
Councillor Carol Plumpton Walsh	Labour
Councillor Pauline Sinnott	Labour
Councillor Pamela Wallace	Labour
Mr T Baker	Healthwatch Co-optee

Please contact Lynn Derbyshire on 0151 511 7975 or e-mail lynn.derbyshire@halton.gov.uk for further information.

The next meeting of the Board is to be confirmed

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

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Members are reminded of their responsibility to declare any Disclosable Pecuniary Interest or Other Disclosable Interest which they have in any item of business on the agenda, no later than when that item is reached or as soon as the interest becomes apparent and, with Disclosable Pecuniary interests, to leave the meeting during any discussion or voting on the item.	
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In accordance with the Health and Safety at Work Act the Council is required to notify those attending meetings of the fire evacuation procedures. A copy has previously been circulated to Members and instructions are located in all rooms within the Civic block.

REPORT TO: Health Policy & Performance Board

DATE: 10 March 2015

REPORTING OFFICER: Strategic Director, Policy & Resources

SUBJECT: Public Question Time

WARD(s): Borough-wide

1.0 PURPOSE OF REPORT

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

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

2.0 RECOMMENDED: That any questions received be dealt with.

3.0 SUPPORTING INFORMATION

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

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

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

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

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

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

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

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

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

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

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

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

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

4.0 POLICY IMPLICATIONS

None.

5.0 OTHER IMPLICATIONS

None.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

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

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

6.3 **A Healthy Halton** – none.

6.4 **A Safer Halton** – none.

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

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

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

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

Agenda Item 4

REPORT TO:	Health Policy and Performance Board
DATE:	10 March 2015
REPORTING OFFICER:	Chief Executive
SUBJECT:	Health and Wellbeing minutes
WARD(s):	Boroughwide

1.0 PURPOSE OF REPORT

1.1 The Minutes relating to the Health and Wellbeing Portfolio which have been considered by the Health & Wellbeing Shadow Board Minutes are attached at Appendix 1 for information.

2.0 RECOMMENDATION: That the Minutes be noted.

3.0 POLICY IMPLICATIONS

3.1 None.

4.0 OTHER IMPLICATIONS

4.1 None.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 **Children and Young People in Halton**

None

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

None

5.3 **A Healthy Halton**

None

5.4 **A Safer Halton**

None

5.5 **Halton's Urban Renewal**

None

6.0 RISK ANALYSIS

6.1 None.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

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

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

HEALTH AND WELLBEING BOARD

At a meeting of the Health and Wellbeing Board on Wednesday, 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.

Agenda Item 5a

REPORT TO: Health Policy & Performance Board

DATE: 10 March 2015

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health & Wellbeing

SUBJECT: Priority Based Report 2014-15 (Quarter 3)

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

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

2.0 RECOMMENDATION: That the Policy and Performance Board:

i) Receive the Quarter 3 Priority Based report

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

iii) Highlight any areas of interest or concern for reporting at future meetings of the Board

3.0 SUPPORTING INFORMATION

3.1 The Policy and Performance Board has a key role in monitoring and scrutinising the performance of the Council in delivering outcomes against its key health priorities. Therefore, in line with the Council's performance framework, the Board has been provided with a thematic report which identifies the key issues in performance arising in Quarter 3, 2014-15.

4.0 POLICY IMPLICATIONS

4.1 There are no policy implications associated with this Report.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 There are no other implications associated with this Report.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**

There are no implications for Children and Young People arising from this Report.

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

There are no implications for Employment, Learning and Skills arising from this Report.

6.3 **A Healthy Halton**

The indicators presented in the thematic report relate specifically to the delivery of health outcomes in Halton.

6.4 **A Safer Halton**

There are no implications for a Safer Halton arising from this Report.

6.5 **Halton's Urban Renewal**

There are no implications for Urban Renewal arising from this Report.

7.0 **RISK ANALYSIS**

7.1 Not applicable.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 There are no Equality and Diversity issues relating to this Report.

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

None under the meaning of the Act.

Health Policy & Performance Board Priority Based Report

Reporting Period: Quarter 3: 1st October 2014 – 31st December 2014

1.0 Introduction

This report provides an overview of issues and progress against key service area objectives and milestones and performance targets, during the third quarter of 2014/15; for service areas within the remit of the Health Policy and Performance Board. These areas include:

- Prevention & Assessment
- Commissioning & Complex Care (including housing operational areas)
- Public Health

2.0 Key Developments

There have been a number of developments within the third quarter which include:

COMMISSIONING & COMPLEX CARE SERVICES

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.

Housing

Subject to contract, the Salvation Army submitted the winning tender for the provision of the housing support service at the new homeless accommodation scheme in Albert Road, Widnes.

Plus Dane submitted the winning tender to retain the contract for the floating housing support service. Both contracts are due to commence in April 2015.

Other developments within the Commissioning and Complex Care Division

Emergency Duty Team: detailed work is now being undertaken to review the role, function and effectiveness of the current arrangements for delivering emergency social service support out of hours. This service is currently delivered in partnership with St Helens Borough Council, and covers both children's and adults services; changes in legislation and increased demands on the service mean that it is timely that this service is comprehensively reviewed. In addition, Warrington Borough Council have indicated that they would like to join the partnership, and they are contributing their own information to the review as a part of this potential development.

PREVENTION & ASSESSMENT

Making It Real

We have developed a steering group to take forward the 'Making it real: Marking progress towards personalised, community based support' in relation to the 'Personalisation' agenda. This helps check our progress and decide what we need to do to keep moving forward to deliver real change and positive outcomes for people. We met with members of the TLAP programme (Think Local Act Personal) and they helped us facilitate a 'Making It Real Live" event that took place on the 4th of June. The event was well attended and involved people using services, a wide cross sector of partners and other agencies, including the independent sector and voluntary agencies. From the event, we developed an action plan and identified leads to take forward task finish groups which the steering group will oversee. A follow up event was successfully held on the 12th of December 2014 to update those attending of the work progressed since the original event. Our action plan has been uploaded onto the TLAP website.

Winterbourne View

Winterbourne View Review Concordat: Programme of Action was published by the Department of Health in December 2013. Halton CCG and Council are in the process of developing a localised action plan – this will be monitored through the Winterbourne View Strategic Group then reported to the Learning Disability Partnership Board and CCG Quality and Integrated Governance Committee.

- Department of Health have issued Winterbourne View – Time for Change (November 2014), report detailing 11 recommendations to act as a driver for change to make a reality of the Winterbourne pledge. The Council and CCG continue to work on implementing the recommendations.
- Halton has a strategic task group set up to ensure those placed out of area are managed and monitored appropriately with professionals tasked with reassessing those individuals to enable them to return to Halton. This work has been on-going with successful placements now achieved locally with the co-work of the care management teams, health colleagues and the Positive Behaviour team.
- Joint Health and Social Care Learning Disability SAF is scheduled for submission in January 2015.
- Autism Self Assessment Framework is scheduled for submission in March 2015
- Bryon Unit 5 Borough Partnership Inpatient bed usage currently being monitored. Usage in 2014/15 has returned to previous levels; prior to 2013/14, the bed usage at Bryron Unit was low, approx. 4/5 admissions per year; in 2013/14 this increased to over 10 admissions. The number of admissions for 2014/15 is less than 5 at present. At the end of Q4 a brief overview of bed admissions will be provided.
- Winterbourne View Inpatient review programme – Halton Borough Council and Halton CCG commissioners attended reviews at Calderstones Secure Inpatient Facility in December 2014. All inpatients will be reviewed by January 2015.

Learning Disability Nursing Team

The team continue to work proactively with individuals, their family, carers and professionals such as GPs and allied Health professionals. Progress to date:

- The team continue to seek the view of customers on their experiences with team members. These are in easy read format and show consistently positive results
- A nursing team member has recently supported a lady with Learning Disabilities to return to live within the Halton Borough.

- A nursing team member has delivered Learning Disability awareness training to the dignity and safeguarding champions at Warrington Hospital to support people with learning disabilities accessing the acute trust. The feedback from this was very positive.
- Two team members have just completed another successful men's group. Educating people with learning disabilities around relationships, personal hygiene, consent and the law, and awareness of physical health.
- The team have been completing peer observations and management observations to ensure the service provided is of a high quality.
- A team member has been training carers alongside the Health Improvement Team to support people with a learning disability to make healthy lifestyle choices
- Team members have been working with GPs to look at their learning disability register and cleanse the data.
- To support the transition of an individual from an inpatient setting, visits have taken place with potential placements and providers to ensure the placement is of high quality with good outcomes and timely support for the individual.
- Individual one to one work has been successfully completed with a client. This work was in understanding Diabetes, the work was completed in easy read and visual format.

PUBLIC HEALTH

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.

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

3.1 A number of emerging issues have been identified during the second quarter that will impact upon the work of the Directorate including:-

COMMISSIONING & COMPLEX CARE

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.

Halton Supported Housing

Halton Supported Housing Network continues to work to bring back people to the borough, closer to family and friends. The shop in Widnes should be open in the next 5 weeks and we are in the process of selecting goats for our cheese and milk production.

Carers Respite

A new specification is being developed to cover a range of areas related to Carers respite. This new specification is aimed at improving outcomes as well as value for money. It is envisaged that the specification will be completed by February 2015.

Information Model

Work has begun on co-producing an information model that will help local people to navigate through the challenges of accessing information. This work is being carried out as a response to the implementation of the Care Act that comes into operation in April 2015.

PREVENTION & ASSESSMENT

The Personal Budgets Outcomes and Evaluation Tool (POET)

The Personal Outcomes Evaluation Tool (POET) is a survey that has been developed over the last 10 years by In Control and Lancaster University as a way of measuring what is and isn't working with personal budgets. The Government recommends that all councils use the tool. Two surveys have been carried out in Halton – one with Personal Budget (PB) recipients (73 respondents) and the other with carers of PB holders (62 respondents). Surveys were conducted by the Direct Payments Team, mostly over the telephone but also face-to-face and via post. Responses were inputted directly onto the In Control website system to allow them to complete analysis and reporting. The report from the survey feedback from In Control is being analysed and will be taken through the respective reporting mechanisms.

Independent Living Fund (ILF)

The Independent Living Fund (ILF) delivers financial support to disabled people so they can choose to live in their communities rather than in residential care. On 8th December 2014 the High Court upheld the Government's decision to close the ILF. This will affect approximately 18,000 disabled people across Britain and more specifically 54 people in Halton. On 30th June 2015, funding for ILF users will be transferred to the Local Authority to administer. A task and finish group will be set up to ensure that all ILF recipients in Halton are assessed prior to the transfer and to develop a transition plan. ILF are working with Halton to ensure a timely transfer.

PUBLIC HEALTH

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, support for the New Shoots Food Co-op, Credit Crunch Cooking, work with Housing Trusts around welfare reforms, Healthy Homes/ Warm Homes initiatives, work with the CAB and Supporting Residents at Risk of Home Repossession project.

4.0 Risk Control Measures

Risk control forms an integral part of the Council's Business Planning and performance monitoring arrangements. As such Directorate Risk Registers were updated in tandem with the development of the suite of 2014 – 15 Directorate Business Plans.

Progress concerning the implementation of all Directorate high-risk mitigation measures was reported in Quarter 2 and Risk Registers are currently being reviewed for 2015 – 16 in tandem with the development of next year's Directorate Business Plans.

5.0 Progress against high priority equality actions

There have been no high priority equality actions identified in the quarter.

6.0 Performance Overview

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

Commissioning and Complex Care Services

Key Objectives / milestones

Ref	Milestones	Q3 Progress
CCC1	Continue to monitor effectiveness of changes arising from review of services and support to children and adults with Autistic Spectrum Disorder. **Mar 2015.** (AOF 4)	✓
CCC1	Continue to implement the Local Dementia Strategy, to ensure effective services are in place. **Mar 2015.** (AOF 4)	✓
CCC1	Continue to implement 5Boroughs NHS Foundation Trust proposals to redesign pathways for people with Acute Mental Health problems and services for older people with Mental Health problems. **Mar 2015** (AOF 4)	✓
CCC1	The Homelessness Strategy be kept under annual review to determine if any changes or updates are required. **Mar 2015. (AOF 4, AOF 18)**	✓
CCC2	Ensure Healthwatch is established and consider working in partnership with other Councils to deliver this. **Mar 2015 (AOF 21)**	✓
CCC3	Undertake on-going review and development of all commissioning strategies, aligning with Public Health and	✓

	Clinical Commissioning Groups, to enhance service delivery and continue cost effectiveness, and ensure appropriate governance controls are in place. **Mar 2015. (AOF 21 & 25)**	

Key Performance Indicators

Supporting Commentary

CCC 1 Services / Support to children and adults with Autism
The Autism Strategy group continues to monitor the progress of the Autism Strategy 2012 – 2016 action plan.
Key milestones have been:

- Autism Capital Funding completed to develop and amend local services to meet the needs of individuals with Autism.
- Autism Self-Assessment will be submitted in March 2015.
- Supported Accommodation being developed through 2014/15 to meet the needs of individuals with autism.

CCC 1 Dementia Strategy
During Q3 the Dementia Partnership Board identified funding and endorsed the decision to commission an Admiral Nurse service in Halton to further strengthen community dementia provision. This action will be progressed during Q4.

During Q3 achievement of the 67% diagnosis rate target was a priority, supported by the roll out of the NHSE Data Quality Tool Kit. The Dementia Partnership Board continues to work with local GP Practices to achieve this target by end of March 2015.

It was agreed in December 2014 that 'ward rounds' will be undertaken by a consultant psychiatrist in two residential care homes, commencing in February 2015.

CCC 1 Mental Health
The Council continues to work closely with both the 5Boroughs and the CCG to monitor the delivery of the Acute Care Pathway (ACP) and the Later Life and Memory Service. A detailed review of the effectiveness of the ACP is being put in place, developed by the CCG but fully supported by the Council. In addition a review is taking place of the roles and tasks of the social work and outreach services (see above), which will feed directly in to the ACP review.

CCC 1 Homelessness Strategy
The 2013/18 Homelessness Strategy has been implemented and a number of actions within the action plan have been achieved. The designated sub groups will continue to meet on a bi monthly basis to discuss and implement the strategic action plan. The focus is presently around improving the monitoring & performance of the service, with further emphasis to develop prevention initiatives around Health. The strategy will be reviewed on an annual basis to ensure it is a working document that captures future change, trends and demands

CCC 2 HealthWatch
Healthwatch continues to develop and events for local residents are scheduled. Discussion with partner Councils related to advocacy services are underway to ensure the best possible service is delivered. A report is going to the Council's Executive Board in the near future with options to the provision of advocacy.

CCC 3 Review and development of commissioning strategies to align with Public Health and Clinical Commissioning Groups
Work in this area is progressing as scheduled. The Integration agenda continues to move towards greater alignment around governance and the integrated approach to performance management. For example, new Governance arrangements for Mental Health and other work streams have been put in place.

Key Performance Indicators

Ref	Measure	13 / 14 Actual	14 / 15 Target	Q3 Actual	Q3 Progress	Direction of travel
CCC 4	Adults with mental health problems helped to live at home per 1,000 population	2.64	3.5	**2.57**	✓	⇩
CCC 5	The proportion of households who were accepted as statutorily homeless, who were accepted by the same LA within the last 2 years (Previously CCC 6).	0	1.2	**0**	✓	⇧
CCC 6	Number of households living in Temporary Accommodation (Previously NI 156, CCC 7).	11	12	**4**	✓	⇧

<u>Supporting Commentary</u>

CCC 4 Adults with mental health problems helped to live at home per 1,000 population
This month's figures are part of a continuing trend, arising from the reduced numbers of people who are managed through the 5Boroughs Partnership, following the introduction of the Acute Care Pathway last year. The redesign of the social care services (described earlier) is anticipated to increase this figure.

CCC 5 The proportion of households who were accepted as statutorily

homeless, who were accepted by the same LA within the last 2 years
Merseyside Sub Regional, No Second Night Out scheme which provides an outreach service for hard to reach clients and rough sleepers. The service has proven invaluable and the organisation has successfully worked in partnership with Halton to identify and assist this vulnerable client group.
The contract is due to end March 2015 and each Authority is looking to develop an exit strategy to ensure that adequate services are made available to sustain a zero tolerance towards repeat homelessness within the district and facilitate reconnection with neighbouring authorities.

CCC 6 Number of households living in Temporary Accommodation
The changes in the TA process and amended contracts for accommodation providers has had a positive impact upon allocation placements and resulted in the reduction of TA accommodation.

Prevention and Assessment Services

Key Objectives / milestones

Ref	Milestones	Q3 Progress
PA 1	Fully implement and monitor the effectiveness of the complex care pooled budget **March 2015.** (**AOF 2,3,4,10,21)**	✓
PA 1	Continue the integrated provision of frontline services including multidisciplinary teams, care homes, safeguarding services and urgent care **March 2015** (**AOF 2,3,4,10,21)**	✓
PA 1	Develop a Care Management Strategy to reflect the provision of integrated frontline services for adults **March 2015** (**AOF 2,3,4,10,21)**	✓
PA 1	Work within adult social care to focus on preventative service to meet the needs of the population **March 2015** (**AOF 2,3,4,10,21)**	✓
PA 1	Develop an integrated approach to the delivery of Health and Wellbeing across Halton **March 2015** (**AOF 2,3,4,10,21)**	✓
PA 2	Continue to establish effective arrangements across the whole of adult social care to deliver personalised quality services through self-directed support and personal budgets **March 2015 (AOF 2, 3,4,10,21)**	✓
PA 2	Continue to review the quality of commissioned services and continue to develop the role of the integrated safeguarding unit **March 2015 (AOF 2, 3,4,10,21)**	✓

Supporting Commentary

PA 1 Complex care pooled budget
Fully implemented.

PA 1 Integrated provision of frontline services
These teams are now fully operational.

PA 1 Develop a Care Management Strategy
The Care Management Strategy has been presented to Senior Management Team; it will now follow a period of consultation and be presented to respective boards and partners.

PA 1 Work within Adult Social Care focussing on Preventative Services
The Initial Assessment team (IAT) continues to work closely with Sure Start/Bridge Building Teams and Telecare. IAT is starting to look at better signposting and capturing information that ensures positive outcomes for people using services. There has been improved delivery of stair-lifts for people with end of life care needs.

PA 1 Develop an integrated approach to the delivery of Health and Wellbeing across Halton
The Health Improvement Team (HIT) has now transferred to the local authority and is working well.

PA 2 Personalisation/Self-directed Support
To ensure effective arrangements for 'Personalisation' across adult social care, we have developed a steering group to take forward the 'Making it Real' agenda. TLAP (Think Local Act Personal) supported us to facilitate a 'Making It Real Live" event that took place on 4th June. From the event we developed an action plan and have now identified leads to take forward task finish groups which the steering group will oversee. The Action Plan has now been loaded on the TLAP website. A follow up event was now held in December 2014 to update those attending the original event. This work is ongoing with work-streams adopting a co-production approach working with people who use services.

PA 2 Integrated Safeguarding
Continuing to develop and embed a care and safeguarding dashboard which will enable professionals to receive up to date information across the Halton landscape.

Key Performance Indicators

Ref	Measure	13 / 14 Actual	14/15 Target	Q3 Actual	Q3 Progress	Direction of travel
PA 2	Numbers of people receiving Intermediate Care per 1,000 population (65+)	81.31	82	**58.3**	✓	⇔
PA 3	Percentage of VAA Assessments completed within 28 days	87.69%	85%	**87.2%**	✓	⇩

Ref	Measure	13 / 14 Actual	14/15 Target	Q3 Actual	Q3 Progress	Direction of travel
PA 7	Percentage of items of equipment and adaptations delivered within 7 working days	96.3%	97%	**96.3%**	✓	⇧

Supporting Commentary

PA 2 Numbers of people receiving Intermediate Care per 1,000 population (65+)
On track to meet end of year target. Please note though current figures are approximate as awaiting further data from Whiston hospital team.

PA 3 Percentage of VAA Assessments completed within 28 days
We are on track to meet this target.

PA 7 Percentage of items of equipment and adaptations delivered within 7 working days
Performance continues to improve. It is expected that target will be met.

Public Health

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 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 rates locally. 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 (previously PH LI 04 [2013/14],NI 122)	145.1 July 13 to June 14	140	126 (Oct 13 – Sept 14)	✓	⇧
PH LI 02	A good level of child development	37%	40%	46% (2013/14)	✓	⇧
PH LI 03 New SCS Measure Health 2013-16)	Falls and injuries in the over 65s (Public Health Outcomes Framework) (previously PH LI 06 [2013/14])	2,850.4 (Jan 13 – Dec 13)	2,847	2,796.3 (Jul 13 – Jun 14)	✓	⇧
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 (previously PH LI 08, 2013/14)	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 1 – Financial Statements

COMMISSIONING & COMPLEX CARE DEPARTMENT

Revenue Budget as at 31st December 2014

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (overspend) £'000
Expenditure				
Employees	7,434	5,356	5,278	78
Premises	304	206	202	4
Supplies & Services	1,922	1,494	1,499	(5)
Carers Breaks	423	353	353	0
Transport	200	153	153	0
Contracts & SLAs	160	100	91	9
Payments To Providers	3,816	2,216	2,216	0
Emergency Duty Team	103	26	18	8
Other Agency Costs	795	484	488	(4)
Total Expenditure	**15,157**	**10,388**	**10,298**	**90**
Income				
Sales & Rents Income	-284	-242	-277	35
Fees & Charges	-173	-148	-112	(36)
CCG Contribution To Service	-840	-553	-526	(27)
Reimbursements & Grant Income	-662	-497	-487	(10)
Transfer From Reserves	-948	-948	-948	0
Total Income	**-2,907**	**-2,388**	**-2,350**	**(38)**
Net Operational Expenditure	**12,250**	**8,000**	**7,948**	**52**
Recharges				
Premises Support	192	151	151	0
Transport	436	274	274	0
Central Support Services	1,685	1,245	1,245	0
Asset Charges	76	0	0	0
Internal Recharge Income	-1,685	-1,597	-1,597	0
Net Total Recharges	**704**	**73**	**73**	**0**
Net Departmental Total	**12,954**	**8,073**	**8,021**	**52**

Comments on the above figures:

Net operational expenditure is £52,000 below budget profile at the end of the third quarter of the financial year.

Employee costs are currently £78,000 below budget profile. This results from savings made on vacant posts, specifically in relation to Mental Health and Day Services. The majority of these posts have now either been filled, or are in the process of being recruited to. It is therefore not anticipated that the current spend below budget profile will continue at this level for the remainder of the financial year, and will not impact significantly on the 2015/16 budget year.

Income is below target to date. There is an anticipated shortfall on Fees & Charges income due to the temporary closure and refurbishment of a homeless facility. Additionally, income received from the Clinical Commissioning Group is projected to be below target. This income relates to Continuing Health Care funded packages within Day Services and the Supported Housing Network. The income received is dependent on the nature of service user's care packages, and is out of the direct control of the service. This shortfall is partly offset by an over-achievement of trading income from Day Services ventures, which is reflected in income above target to date of £35,000 for Sales and Rents. This trend is anticipated to continue for the remainder
of the financial year.

At this stage in the financial year, it is anticipated that a balanced budget overall will be achieved for the year. Whilst income is projected below target, this will be offset by in-year savings in other areas, principally savings on staff turnover above the set target.

Capital Projects as at 31st December 2014

	2014-15 Capital Allocation £'000	Allocation To Date £'000	Actual Spend To Date £'000	Total Allocation Remaining £'000
ALD Bungalows	100	0	0	100
Lifeline Telecare Upgrade	100	0	0	100
Halton Carer's Centre Refurbishment	50	16	16	34
Section 256 Grant	55	0	0	55
Community Capacity Grant	166	0	0	166
Total	**471**	**16**	**16**	**455**

PREVENTION & ASSESSMENT DEPARTMENT

Revenue Budget as at 31st December 2014

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (underspend) £'000
Expenditure				
Employees	6,510	4,735	4,644	91
Other Premises	63	31	27	4
Supplies & Services	935	245	247	(2)
Aids & Adaptations	113	90	109	(19)
Transport	8	6	9	(3)
Food Provision	28	20	22	(2)
Other Agency	23	16	15	1
Transfer to Reserves	962	77	77	0
Contribution to Complex Care Pool	17,971	9,330	9,326	4
Total Expenditure	**26,613**	**14,550**	**14,476**	**74**
Income				
Other Fees & Charges	-232	-155	-174	19
Reimbursements & Grant Income	-898	-112	-122	10
Transfer from Reserves	-2,485	-2,485	-2,485	0
Capital Salaries	-39	0	0	0
Government Grant Income	-155	-137	-137	0
CCG Contribution to Service	-597	-504	-507	3
Total Income	**-4,406**	**-3,393**	**-3,425**	**32**
Net Operational Expenditure	**22,207**	**11,157**	**11,051**	**106**
Recharges				
Premises Support	221	166	166	0
Asset Charges	210	0	0	0
Central Support Services	1,980	1,412	1,412	0
Internal Recharge Income	-419	-307	-307	0
Transport Recharges	50	34	38	(4)
Net Total Recharges	**2,042**	**1,305**	**1,309**	**(4)**
Net Departmental Total	**24,249**	**12,462**	**12,360**	**102**

Comments on the above figures:

In overall terms, the Net Operational Expenditure for the third quarter of the financial year is £98,000 under budget profile excluding the Complex Care Pool.

Employee costs are currently showing £91,000 under budget profile. This is due to savings being made on vacancies within the department, in particular Care Management. Some of these vacancies have been advertised and have been or are expected to be filled in the coming months. However if not appointed to, the current underspend will continue to increase beyond this level.

Expenditure on Aids and Adaptations is £19,000 over budget profile in the third quarter. Aids and Adaptations continue to be a pressure area as more people are supported within their own homes.

Overall income has for the third quarter, over achieved by £32,000. Lifeline income is £17,000 higher than anticipated at budget setting time; however this is offset by an increase in transport recharges of £4,000 for diesel, vehicle repairs, tyres and casual hire. This trend is expected to continue for rest of the financial year.

A detailed analysis of the Complex Care Pool is shown below:

COMPLEX CARE POOL

Revenue Budget as at 31st December 2014

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (overspend) £'000
Expenditure				
Intermediate Care Services	3,691	2,245	2,234	11
End of Life	192	171	171	0
CHC Assessment Team	255	255	255	0
Sub Acute	1,788	1,311	1,302	9
Joint Equipment Store	532	312	320	(8)
Intermediate Care Beds	596	403	400	3
Adult Care:				
Residential & Nursing Care	20,198	13,022	12,972	50
Domiciliary & Supported Living	9,910	7,726	7,686	40
Direct Payments	3,293	2,745	2,950	(205)
Day Care	457	309	297	12
Total Expenditure	**40,912**	**28,499**	**28,587**	**(88)**
Income				
Residential & Nursing Income	-4,920	-3,939	-4,017	78
Community Care Income	-1,552	-999	-1,021	22
Direct Payments Income	-189	-150	-142	(8)
Other Income	-485	-485	-485	0
CCG Contribution to Pool	-12,784	-12,841	-12,841	0
Reablement & Section 256 Income	-3,011	-755	-755	0
Total Income	**-22,941**	**-19,169**	**-19,261**	**92**
Net Divisional Expenditure	**17,971**	**9,330**	**9,326**	**4**

Comments on the above figures:

The overall net expenditure budget is £4,000 under budget profile at the end of the third quarter.

The number of clients in receipt of residential & nursing social care from April this year has increased by 1%. The number of clients in receipt of domiciliary social care (including supported living) from April this year has decreased by 1%, this is due in part, to 38 clients moving to Direct Payments. This was a one off transfer and all of the clients have now transferred.

The number of clients in receipt of a Direct Payment has substantially increased this year and this is due in part to the renegotiation of the Domiciliary Care contracts. Clients who were receiving a commissioned domiciliary care package have now opted to take a Direct Payment and new clients who have never received a package of care, but now have the choice are now also opting to take a Direct Payment than receive the traditional package of care commissioned by the council.

Due to expenditure by nature, being volatile and fluctuating throughout the year depending on the number and value of new packages being approved and existing packages ceasing, trends of expenditure and income will be scrutinised in detail throughout the next quarter of the year to ensure a balanced budget is achieved at year-end and in order to identify pressures that may affect the budget in the short to medium term.

The budgets across health and social care have been realigned to reflect the demand for services this financial year.

Capital Projects as at 31st December 2014

	2014-15 Capital Allocation £'000	Allocation To Date £'000	Actual Spend To Date £'000	Total Allocation Remaining £'000
Disabled Facilities Grant	500	375	247	253
Energy Promotion	12	6	6	6
Stair lifts (Adaptations Initiative)	250	188	180	70
RSL Adaptations (Joint Funding)	200	150	133	67
Total	**962**	**719**	**566**	**396**

PUBLIC HEALTH DEPARTMENT

Revenue Budget as at 31st December 2014

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (underspend) £'000
Expenditure				
Employees	2,331	1,559	1,494	65
Supplies & Services	223	107	98	9
Other Agency	20	20	17	3
Contracts & SLA's	5,003	3,239	3,237	2
Transport	5	1	0	1
Transfer to Reserves	707	0	0	0
Total Expenditure	**8,289**	**4,926**	**4,846**	**80**
Income				
Other Fees & Charges	-59	-45	-39	(6)
Sales Income	-26	-25	-18	(7)
Reimbursements & Grant Income	-3	0	0	0
Government Grant	-8,749	-4,374	-4,374	0
Transfer from Reserves	-200	0	0	0
Total Income	**-9,037**	**-4,444**	**-4,431**	**(13)**
Net Operational Expenditure	**-748**	**482**	**415**	**67**
Recharges				
Premises Support	50	37	38	(1)
Central Support Services	2,135	2,018	2,020	(2)
Transport Recharges	25	18	15	3
Net Total Recharges	**2,210**	**2,073**	**2,073**	**0**
Net Departmental Total	**1,462**	**2,555**	**2,488**	**67**

Comments on the above figures:

In overall terms, the Net Operational Expenditure for the third quarter of the financial year is £67,000 under budget profile.

Employee costs are currently £65,000 under budget profile. This is due to savings being made on vacancies within the department. Some of the vacant posts, specifically in relation to trading standards have now been filled. If vacancies remain unfilled, the current underspend will increase beyond this level by the end of the financial year.

In October 2014, The Health Improvement Team transferred from Bridgewater Community Healthcare to Halton Borough Council. This part of the Bridgwater Community Healthcare contract amounted to £1,568,000 per annum. Therefore the Contracts & SLA's budget has reduced and the Employee, Supplies & Services, Transport budgets have increased accordingly for the remainder of the financial year.

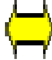
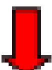
APPENDIX 2 – Explanation of Symbols

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.*

Agenda Item 5b

REPORT TO: **Health Policy & Performance Board**

DATE: **10th March 2015**

REPORTING OFFICER: **Strategic Director Policy & Resources**

SUBJECT: **Business Planning 2015 – 2018**

PORTFOLIO: **Resources**

WARDS: **Borough wide**

1.0 PURPOSE OF THE REPORT

1.1. To provide an update on Business Planning for the period 2015 - 18 and to consider the Directorate priorities, objectives and targets for service areas that fall within the remit of this Board.

2.0 RECOMMENDED: that the Board receive the advanced draft of the Business Plan prior to its consideration by Executive Board.

3.0 SUPPORTING INFORMATION

3.1 Each Directorate of the Council develops a medium-term business plan, in parallel with the budget that is subject to annual review and refresh. The input of the Policy and Performance Boards into the business planning process and the setting of priorities for the Directorate is an important part of this process.

3.2 Key priorities for development or improvement for the various functional areas reporting to this Policy & Performance Board were presented to and considered by the Board in autumn 2014.

3.3 In light of the meeting Draft Directorate Business Plans have now been developed.

3.4 Each of the Plans will contain appendices identifying specific Departmental activities and performance measures and targets that would provide a focus for the on-going monitoring of performance throughout the year. Directorate Business Plans will be subject to annual review and refresh in order that they remain fit for purpose taking account of any future change in circumstances, including any future funding announcements that may emerge.

3.5 Given the remit of this Board relevant extracts from the Communities Directorate and the Policy & Resources Directorate Business Plans are now available for consideration by the Board.

3.6 It should be noted that plans can only be finalised once budget decisions have been confirmed in March and that some target information may need to be reviewed as a result of final outturn data becoming available post March 2015.

4.0 POLICY IMPLICATIONS

4.1 Business Plans form a key part of the Council's policy framework. Plans also need to reflect known and anticipated legislative changes.

4.2 Elected member engagement would be consistent with Best Value guidance to consult with the representatives of a wide range of local persons.

5.0 OTHER IMPLICATIONS

5.1 Directorate Plans will identify resource implications.

5.2 Directorate Plans will form the basis of the Priority Based Performance Reports which will continue to be presented to the Board during 2015 - 16.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 The business planning process provides a means by which the Corporate Priorities of the Council are integrated into the delivery of services at an operational level.

7.0 RISK ANALYSIS

7.1 The development of a Directorate Plan will allow the authority to both align its activities to the delivery of organisational and partnership priorities and to provide information to stakeholders as to the work of the Directorate over the coming year.

7.2 Risk Assessment will continue to form an integral element of Directorate Plan development and the annual review and refresh of Directorate Risk Registers.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 Equality and diversity considerations, and the Councils responsibilities under equalities legislation, remain integral to the business planning process. An annual report will be made available to Members as an element of the Council's performance management arrangements.

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

9.1 There are no relevant background documents to this report.

Relevant Business Plan Extracts For Health PPB

April 2015 to March 2018

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Introduction

Key Messages

Priorities in Focus

Factors Affecting Priority Focus

Organisational Initiatives
- Equality, Diversity & Community Cohesion
- Environmental Sustainability
- Risk Management
- Arrangement for Managing Data Quality

Business Planning

Appendices

1. Departmental Service Objectives/Milestones and Performance Indicators

2. National Policy Guidance/Drivers

This document represents an amalgamation of excerpts from Business Plans across the three Directorates. It highlights those areas pertinent to the Health Policy and Performance Board.

1.0 INTRODUCTION

Business planning and performance management are key tools by which public sector organisations are expected to ensure their services, and those they commission, are meeting the needs of the population they serve efficiently and effectively. In our Directorate, they underpin the ideology of the Department of Health, Audit Commission and the Care Quality Commission in their inspections, reports and guidance to Local Authorities on the most appropriate way to manage business.

Business planning is the process of developing the blueprint for the ongoing performance management of the Directorate and, without good business planning, the preparation needed to manage performance is missing. Without ongoing performance management, strategies and plans developed through business planning will not be implemented and will have no impact upon actual activities of the Directorate, or on outcomes for service users and carers.

This document is a key business planning document and should be used alongside performance information when developing service and team plans. Its overall aims are to:-

- identify the key objectives for the Directorate over the next 12 months;
- improve the quality of the services provided; and
- deliver better outcomes for service users and carers.

The plan is underpinned by the principles and strategic objectives Halton Borough Council (HBC) has adopted in its Corporate Plan 2011 - 2016. It aims to be a key reference document for elected members, staff in the Directorate and our partner agencies. It provides the rationale and framework for the major areas of the Directorate's activity. It does this by taking account of the national, inter-agency and Council planning and budget priorities and interweaves these with what we know - or what our service users and carers tell us - about how services should be developed in order to meet needs and expectations more effectively.

The plan needs to be understood in the context of a wide range of other documents. The main strategic documents are:-

- Sustainable Community Strategy for Halton: 2011 – 2026;
- The Borough Council's Corporate Plan 2011 - 2016;

These plans/strategies commit the Borough Council and its partners to achieving explicit and realistic priorities over the coming year. This Business Plan highlights the Community Directorate's elements of those commitments within the context of the Government's overall agenda for local Government. The achievement of these elements continues to depend on partnerships with many other agencies, and members are committed to testing these achievements.

The plan does not attempt to describe all the day-to-day activities that make up most of the Directorate's work, but only to set out the overall framework within which that work takes place. It needs to be remembered, however, that it is the everyday assessment of needs and arrangement of services to meet those needs that is the fundamental task of the Directorate. Undertaking this effectively requires the continuing dedication and enthusiasm of staff, together with the Directorate's commitment to recruit, retain and train staff who are able to meet the challenges of the future. None of this is straightforward. However, this does not diminish the Directorate's determination to deliver improved outcomes for our service users and carers. It makes it even more of a challenge, but one which we will seek to tackle as effectively as possible through partnership with other agencies and corporate working across the Borough Council.

2.0 KEY MESSAGES

Overall Directorate Strategic Direction

The Council and its partners have reaffirmed the direction within the Council's Corporate Plan and the Sustainable Community Strategy for Halton, and the general strategic direction and priorities are clearly articulated. In this context, the Directorate's strategic direction becomes clearer and, at a macro level, includes the following:

- Community Leadership;
- Commissioning;
- Empowering and brokering of services;
- Providing direct services;
- Regulatory functions; and
- Promotion and prevention.

Strategic Priorities and Challenges

Based upon the national, regional and local picture, there are a number of key strategic priorities and challenges which the Council must consider.

The Directorate Plans reflect operational requirements while also taking into account the position and priorities of related Policy and Performance Boards. These two elements bond closely together to form the strategic outlook. For the Health Policy and Performance Board these priorities have been established as:

- Prevention
- Safeguarding
- Personalisation of Care and Support
- Quality Assurance
- Access to Care Services (including seven-day working)

Scrutiny Reviews

The Policy and Performance Boards continue to review and scrutinise areas of note. A number of scrutiny reviews have been undertaken during 2014 including (for the Health PPB) Care at Home. Areas for scrutiny for 2015-16 will be chosen early into the year.

Financial Pressures

The Council continues to operate within a challenging financial climate. Despite these constraints we are obligated to meet our statutory responsibilities across all areas of operation. This is achieved through effective financial management and the integration of national policy initiatives with efficient arrangements for service delivery.

Integration

In a move towards greater integration across the work of the Council and NHS, the position of Operational Director for Transformation, as a joint venture between the NHS Halton Clinical Commissioning Group and the Communities Directorate, forms a pivotal arrangement for ensuring cohesive and cost-effective approaches to services. In particular, requirements of the Care Act 2014 will necessitate effective collaboration between health and social care provision.

3.0 PRIORITIES IN FOCUS

The priorities for the Plans have been set against a backdrop of extensive legislative change and increased financial pressures. They reflect the service requirements for the Borough, the focal areas identified by the Council's Policy and Performance Boards, and consider areas for development in relation to forthcoming issues faced by the Authority.

The following section contains extracts of particular priorities which relate to Health.

3.1 Health, Wellbeing and Social Care

3.1.1 The Care Act 2014

The **Care Act 2014** sets out a single, modern law for adult care and support that replaces outdated and complex legislation. The Act provides an opportunity to develop and promote a change in culture that reflects good practice into statute.

The premise underpinning the Act is that, if adult care and support in England is to respond to future challenges it must help people to stay well and remain independent.

To achieve this the Communities Directorate must undertake activity to:

- Promote people's wellbeing
- Enable people to prevent and postpone the need for care and support
- Put people in control of their lives so they can follow opportunities to realise their individual potential

Fundamental to the provision under the Care Act is the requirement to work with both current and future service-users to identify and anticipate needs. **Prevention and early intervention** are key to this, and work undertaken by the Directorate is well-established and structured. Additional active engagement with the community will form new areas of work and the transfer of the Health Improvement Team (HIT) from the NHS to the Authority will underpin this approach. Approaches to **wellbeing** will be planned and delivered in cohesive and efficient ways, and will further ensure the integration of health and social care agendas.

The Directorate strives to put individuals at the heart of the provision and **Personalisation** has been embedded across adult social care services. The Care Act consolidates and legitimises the person-centred care and support approaches taken by the Authority and requires further development on process and practice already in place.

Among other duties aimed at enhancing person-centred approaches, the Act requires the Directorate to:

- Produce individual care and support plans for service-users and their carers (The Authority has a duty to assess whenever it appears there are care and support needs)
- Support and review a person's financial situation in relation to their personal budgets and direct payments
- Provide information and advice on eligibility for support

As with all additional duties coming under the Care Act, this will require workforce training and capacity development, and action plans will be rolled out over the coming period.

The Care Act provides a new statutory framework for adult protection. **Safeguarding** is everyone's business, and keeping people safe and ensuring that they are treated

with respect and dignity continues to be a high priority for Halton Borough Council. Halton has an established multi-agency Safeguarding Board arrangement which has been a positive move forward in dealing effectively with safeguarding issues in a more cohesive way. The multi-agency team has a good skill mix and knowledge base in leading on safeguarding across Health and Social Care and on cases that have a complex safeguarding element to them. Its remit now needs to be expanded to take account of the Care Act's enquiry, inter-agency information sharing and continuity of care duties.

The Care Act significantly changes the provision for **carers**, who now have the same right as the person they care for in terms of assessment, support plan, direct payments, and service access. Wide-ranging work including engagement with carers across Halton is to be planned and undertaken to address these changes.

3.1.2 **Mental Health**

As the local older population increases due to people living longer, we have seen a significant increase in the number of people diagnosed with **dementia**. As a result of this we have developed the local dementia strategy - 'Living Well with Dementia in Halton: 2013-2018' - that aims to address the needs of people with dementia and their carers. The strategy outlines the importance of early diagnosis, particularly in Primary Care, access to services in the community and improved quality in accommodation based service provision, for example, residential care. The strategy has an associated action plan and implementation of this plan is the responsibility of the local Dementia Partnership Board.

Further activity around the area of dementia will involve the formation of a new **Halton Dementia Action Alliance** which will be jointly supported by the Authority and the CCG.

Following a Supreme Court ruling the Council has seen, and is set to further see, an increase in **Deprivation of Liberty Safeguards (DoLs)** applications. The judgements in the cases 'P v Cheshire West and Chester Council and another' and 'P and Q v Surrey County Council' determined arrangements made for the care and/or treatment of an individual lacking capacity to consent to those arrangements and state decisions to continuous supervision and control without option. The Council's arrangements and policy will need to be reviewed in line with this change.

Acute and related Mental Health Services – the redesigned pathways around acute services, aimed at preventing admissions and aiding recovery, are now well established. The Council's Mental Health social workers have co-located with colleagues from the 5 Boroughs NHS Foundation Trust and there is a multi-agency Mental Health Strategic Commissioning Board (CCG, HBC, 5 Boroughs and others) which oversees strategic developments. Current pressures include those upon acute beds in line with the national position, and continuing pressure upon the community care budget. A new Mental Health and Wellbeing Commissioning Strategy has been produced which sets out priorities up until 2018. Key in this is the preventative work undertaken by the Council's Public Health function. The Council's Mental Health Outreach team is currently piloting work with GP surgeries in order to identify people who may benefit from this service and therefore prevent relapse, a further priority will be extending the range of day services and work related opportunities.

3.1.3 **Prevention**

There is growing recognition that **Loneliness** is a formidable problem with 10-13% of the population estimated to be acutely lonely. There is increasing evidence that people who are lonely are more likely to use health and social care services and a developing confirmation, through personal stories, of the emotional costs and misery that loneliness

can cause. A Loneliness Strategy is now in place and incorporates various strands to help combat the issue. The **Visbuzz pilot project** (which uses tablet technology to keep people in touch with their family and friends, a befriending service, various social groups, tele-friending, intergenerational services and care homes twinned with schools are just some of the ways in which the Directorate has been addressing this particular challenge.

Falls are one of the Health and Wellbeing Board's key priorities in Halton. Falls are a leading cause of mortality due to injury amongst people over 65. Falls can have a serious impact on the quality of life of older people and can undermine the independence of an individual. Falls may be caused by a person's poor health or frailty, or by environmental factors, such as trip hazards inside and outside their home. Halton's Falls Strategy was implemented during 2013 and will be monitored through its action plan.

3.1.4 Integration

Developments across the health, wellbeing and social care landscape reinforce the requirements for social services to work in closer partnership with NHS and Health Services.

Since April 2013 Halton Borough Council and Halton Clinical Commissioning Group (HCCG) have had a Section 75 Agreement in place for the commissioning and provision of services for people with complex care needs. Pooling financial resources from Adult Social Care, Continuing Health Care, Intermediate Care and a range of grant allocations, the two organisations are working on improving the effectiveness and efficiency of services to ensure Halton people with complex needs will continue to receive high quality care and support into the future. This will continue to be achieved through streamlining assessment, support planning, commissioning and contracting arrangements. This work is led through the Complex Care Partnership Board with Marie Wright (portfolio holder for Health and Wellbeing) and Mike Wharton (portfolio holder for Resources).

Halton Borough Council and NHS Halton Clinical Commissioning Group are continuing to actively work together in conjunction with our partners on Halton's Urgent Care Working Group. A review and redesign of provision is being undertaken with emphasis on quality of and access to service.

The Better Care Fund (BCF), launched through the Spending Round in June 2013 and highlighted as a key element of public service reform, has a primary aim to '…drive closer integration and improve outcomes for patients and service users and carers'. The fund in Halton builds on the pooled budget arrangements already in place between the Council and the NHS Halton CCG, with a total BCF fund of £42M. The BCF fund covers the two-year period from April 2015 to March 2017. A portion of the funding is related to performance in non-elective admissions, which has been set at a reduction of 3.5% over the two-year period. There are 19 schemes within the BCF and the monitoring of these schemes will be undertaken by the Better Care ECB and Better Care Board. Progress will be reported regularly to the Health and Wellbeing Board who have overall responsibility for the BCF.

For more information about the BCF, click on the link here.

Additionally, the Council and HCCG are working with frontline health and social care teams to review our overall approach. Frontline integrated services include the following:

The **Care Homes Project** is a partnership project between Bridgewater Community NHS Trust, Halton Borough Council, Halton Clinical Commissioning Group, Halton and St Helens NHS and Warrington and Halton Hospitals NHS Trust. National and local audit data from the Care Quality Commission identifies that there are a range of healthcare interventions and services that may not be easily accessible to people who live in

residential and nursing homes and as such their healthcare needs may not be appropriately met. These include the following areas: end of life care planning; medical cover; mental health support; dietetics and nutritional advice; access to therapy services; access to specialist services - tissue viability, falls, etc.; access to psychiatric services; access to Geriatricians; and multi-agency working.

A joint working initiative, in the form of a pilot entitled **‘Living Well’**, is currently taking place across the community. The pilot engages with a number of agencies who come into contact with those 75 years and over. It involves conducting memory screenings, loneliness and falls assessments, and results in referrals where appropriate. The pilot runs until December 2014 after which evaluation is to take place to look at the potential for further development of the services being offered.

3.1.5 **Managing Needs and Access to Service**

Factors affecting **Urgent Care** requirements – for example, an ageing population and increased frailty; pressures on acute services across the NHS; changes to access of services (GP appointment systems); the need for rapid assessment and measures to defer more complex care - have impacted on Halton’s need to take action. Halton is working closely with the CCG to look at the requirements for **Urgent Care Centres** within Runcorn and Widnes and will continue to collaborate on needs.

Intermediate Care multi-disciplinary team – the team help people stay living safely and independently in their homes for longer and with a better quality of life. They offer a wide range of Home Care, Intermediate Care and Reablement Services seven days a week that includes support from nurses, care assistants and occupational therapists. The team also support people recovering from a hospital stay and needing temporary help to maintain their independence and quality of life at home.

A shared out-of-hours **Emergency Duty Team** is already in place across Halton and St Helens, and is the subject of a formal partnership agreement. The current arrangement has drawn some interest from two local authorities who have engaged in preliminary discussions about joining the partnership. Halton Borough Council will be working in partnership with St Helen’s Council to scope out and consider in detail the potential for developing future collaborations with these authorities.

3.1.6 **Complex Care**

The 2014/15 **Joint Health and Social Care Self-Assessment Framework** (SAF) builds on the 2013/14 submission released in late September 2014 and formally submitted in January 2015. The SAF requires the local validation and sign-off by individuals who use services and the Learning Disability Partnership Board. Resultant data and information will be used to ensure a targeted approach is made towards ensuring that people with a learning disability are supported to stay healthy, be safe and live well.

The **Halton Autism Strategy** action plan is to be refreshed following the release of Government revisions to the implementation of the National Autism Strategy in ‘Think Autism – Fulfilling and Rewarding Live (an update). Halton’s alignment to the updated paper will ensure that local priorities parallel the national agenda and ensure that partners and stakeholders are engaged in the process and implementation of the action plan up to 2016. The annual self-assessment of progress made against the baseline position in 2012 will highlight evidence of good practice which can be shared and remaining challenges which need to be addressed.

The Department of Health’s “Transforming Care a National Response to Winterborne View Hospital” set out a timetabled action plan with 63 areas that would improve the lives of individuals with Learning Disabilities and/or Autism. The action plan is designed to be

implemented nationally with guidance and good practice cascaded to Local Authorities and CCGs for local implementation. In response, Halton has formed **'Halton Winterbourne Strategic Group'**, a multi-agency strategic group that monitors and holds to account professionals working with individuals who are either an inpatient or are placed out of borough within a care home setting. This group reports to the Health and Wellbeing Board, Better Care Fund Board and Learning Disabilities Partnership Board.

The Local Authority and CCG are taking a joint approach to the completion and implementation of all the above programmes with a clear focus on improving life opportunities for individuals with Learning Disabilities and/or Autism. The Autism Strategy continues to be implemented. In 2015 the **Learning Disability Strategy** and **Transition Strategy** will be launched building on existing good practice and national developments, with particular reference to the Care Act (2014) and the Children and Families Act (2014), focussing on Special Education Needs Disabilities (SEND).

The **Positive Behaviour Support Service (PBSS)**, introduced in 2010, is aimed at meeting the needs of individuals with Learning Disabilities and/or Autism. PBSS employs Board-certified Behaviour Analysts (BCBA) who work with children and adults who present behaviours that challenge services and the team is a pivotal member of multi-agency teams. Halton's PBSS is the first of its kind within the country and, being based on evidence of positive outcomes, ensures that individuals access services and are given real-life opportunities. The PBSS team's model has been nationally recognised, winning the prestigious BILD Award for Innovation and Leadership during 2014. Building on this accolade and disseminating best practice will be key to service development. A **Positive Behaviour Support Strategy** is due for completion and will be taken forward over the next period. The strategy is informed by the recent publication by the LGA and NHS England, 'Ensuring Quality Services' and formalises Halton's innovative approach.

3.1.7 Homelessness and Housing

In line with the need to make savings and reduce pressure on already tight budgets, the Council's programme of Efficiency Reviews continues. **Halton Support Housing Network** is being reviewed as part of this programme and, during 2015, this will include a need to evaluate requirements for active support of complex needs.

The Council's **Housing Solutions** service has implemented effective prevention services. This foundation will be built upon over the coming period and re-evaluation of service needs will follow. Early intervention has the potential to create significant savings on more complex service requirements.

In the coming year, the Housing Solutions Team will be working towards accreditation under the Government's **Gold Standard** framework for homeless services, which is funded by the Department of Communities and Local Government and based on the Government report 'Making Every Contact Count'. This accreditation process comprises a sector-led peer review designed to deliver a more efficient and cost effective homelessness prevention service. The review follows a 10 step continuous improvement approach that starts with a pledge for local authorities aspiring to 'strive for continuous improvement in front line housing services' and culminates in an application for the Gold Standard Challenge.

Following consultation with young people across the Borough a **Youth Homelessness Strategy** is to be developed during 2015.

With new housing in mind, the authority is engaged with the **Liverpool City Region Combined Authority's Housing and Spatial Planning Board** and its developing role to recommend priorities across the City Region. The Board will look at managing the scale,

mix and distribution of new housing development and the allocations of pooled public/private sector/LEP (local enterprise partnership) housing resources to meet key strategic priorities.

3.2 **Community and Residents' Quality of Life**

Introduction of the Government's '**Universal Infant Free School Meals**' in state-funded schools from September 2014, has been implemented across Halton resulting in a significant increase in service delivery. The Directorate has conducted a recruitment drive to achieve delivery of the service and needs to monitor resourcing of the initiative. The longer term impact of this initiative is sustained health benefits as well as influencing educational attainments. Within Halton, as a result of high deprivation, the scheme is likely to have a significant impact on the community.

The **Halton Sports Strategy**, 2012 to 2015 details the Directorate's priorities up to 2016 and seeks to enhance work in increasing participation and widening access to sport; the further development and strengthening of sports club; coach education and volunteer development; sporting excellence; finance and funding for sport; and the enhancement of sports facilities and provision.

The Council has an extensive programme of **physical activity** initiatives designed to improve health and develop healthy life styles. The current physical activity initiatives in Public Health will need to be integrated further with this programme.

Halton's network of **Community Centres** is to be promoted as Community Hubs. The range of services accessed through them is to be reviewed and increased, and will include activity aimed at community cohesion as well as initiatives to encourage the integration of health and social services.

3.3 Public Health and Public Protection

One of the major concerns for Public Health continues to be the issue of Health Inequalities across Halton. The main focus for this is the Health and Wellbeing Strategy. During 2014/15 the Health and Wellbeing Board has continued to implement the five priority action plans. This work is supported by the Public Health, Public Protection, Environmental Health and Health Improvement Teams. Details and progress on each of the five areas is outlined below.

3.3.1 **Prevention and early detection of cancer**

Cancer remains a particular challenge in Halton and is therefore a key priority for the local Health and Wellbeing Strategy. Contributory factors include poor diet, smoking and a screening rates.

Smoking rates in Halton have reduced dramatically over the past decade, however, the rise in the popularity and availability of E Cigarettes (not currently recognised as a quit aid by the NHS) has reduced smoking quit rates at both a national and local level. However, as Halton still has a higher than average proportion of smokers, we need to find new ways of encouraging people to stop.

Another key activity within this priority is around screening. Halton offers screening against breast, cervical and bowel cancers as part of national screening programmes. Uptake of

these programmes is variable across the borough. To reduce inequalities and reduce the burden of cancer, we need to increase the uptake, in particular for bowel cancer, to ensure that everyone has an equal opportunity to benefit from these preventive programmes.

During 2014 the **Halton Action on Cancer Board** developed a local Cancer Strategy and action plan with an emphasis on three key areas along the cancer pathway. These include; Prevention and early diagnosis, Better treatment and quality of life and patient experience. The strategy provides a framework and action plan for all those involved in delivering cancer care across Halton and across the cancer pathway.

3.3.2 **Improved child development**

Data from the national Millennium Cohort study shows that by 3 years children in families with incomes below the poverty line are 8 months behind in language and 9 months behind in school readiness compared to those with incomes above. The data also provides evidence that there are potential modifiable factors, daily reading, regular bedtimes and library visits, which parents can implement and health and social care professionals can recommend to parents in order to improve **cognitive development**.

Locally, the percentage of children achieving a good level of readiness for school development at the beginning of reception increased from 37% in 2013 to 46% in 2014, however, this is still significantly below the national average.

Commissioning responsibility of both the **Health visiting service and Family Nurse Partnership** moves to Halton Borough Council in October 2015. Both of these services are central to delivering the Healthy child programme, which works with families to maximise children's health and wellbeing, identify issues early and maximise child development. Work is therefore underway to ensure a smooth transition occurs and does not disrupt the service.

The Department of health has issued six high impact areas to improve children's health and development. Work is underway in Halton to implement recommendations where feasible. The priorities include:

- Transition to parenthood and the early weeks
- Maternal mental health
- Breastfeeding
- Healthy weight, Healthy nutrition (and physical activity)
- Managing minor illness and reducing hospital admissions
- Health, wellbeing and development of the child age 2 and integrated review.

Local work in these areas includes working towards **UNICEF Baby Friendly** award to support women to breastfeed, reducing the number of women who smoke and drink during pregnancy and reducing the number of children who are overweight when they go to school by working with families and early year's providers.

The impact of child poverty will continue to be a focus, through the local strategy and that directed by **Liverpool City region child poverty commission**. Examples of work in this area include work on reducing sugar intake, working with food banks and encouraging free school meal uptake.

Mental health is also an essential component to improving child development, and work is ongoing to ensure the early identification of mental health issues in pregnant and new mothers, and supporting families to ensure positive parenting and bonding practices.

3.3.3 **Reduction in the number of falls in adults**

Falls are a leading cause of mortality due to injury amongst people over 65. Falls can have a serious impact on the quality of life of older people and can undermine the independence of an individual.

In 2012 a review was undertaken to look at the falls service in Halton conducted by a multi-agency steering group. From an early stage the review highlighted that services linked to falls were fragmented and there was no overarching vision. In addition to this overall performance was significantly worse than the national average. For example the hip fracture rate in people over 65 in Halton was 499 per 100,000, compared to the National average of 452 per 100,000. At this point it was agreed that a falls strategy was required to cover the period of time between 2013– 2018. The strategy was important because for the first time it allowed agencies to focus on eight key deliverables that could and should improve performance.

The eight deliverables are:
- Develop current workforce training
- Develop a plan for awareness raising with both the public and professionals
- Improve partnership working
- Set and deliver specific targets to reduce falls
- Develop an integrated falls pathway
- Develop a prevention of falls pathway
- Identify gaps in funding of the pathway
- Improve Governance arrangements to support falls

Falls remain one of the 5 priorities of the **Health & Wellbeing Board** as work continues to address readmission rates to hospital and workforce development.

3.3.4 **Reduction in the harm from Alcohol**

Alcohol harm is a key public health issue and also has a significant impact on crime, community safety and the wider economy. Progress has been made in reducing levels of alcohol-related harm locally especially among local children and young people but there is still more work required.

In order to further reduce alcohol-related harm in Halton, an **alcohol strategy** has been developed in partnership with colleagues from health, social care, education, the voluntary sector, police and the community safety team. The strategy sets out our local 5 year plan aimed at rebalancing the relationship Halton has with alcohol. As a problem that cuts across our entire population and affects local residents of all ages, the strategy takes a life course approach to reduce harm at all stages of life from birth to old age.

In addition during 2014/15 Halton became one of only twenty areas in the country to have been awarded the status of being a **Local Alcohol Action Area (LAAA)**. This award provides support from the Home Office and Public Health England related to addressing the harm from alcohol across three areas – health, crime and anti-social behaviour, and diversifying the night time economy.

As part of the alcohol strategy development work a refreshed action plan for 2014-15 has been developed and signed up to by all partners.

Key activities include:
- Holding a **Halton Alcohol Inquiry**
- Developing a health education campaign promoting an alcohol free pregnancy
- Developing a coordinated alcohol awareness campaign

- Continuing school and community outreach alcohol awareness work to reduce underage drinking
- Training key staff in Halton in the early identification of people who misuse alcohol (alcohol IBA)
- Reviewing alcohol treatment pathways and ensuring the provision of effective local treatment services for young people and adults and promoting recovery
- Ensuring the local **licensing policy** supports alcohol harm reduction agenda
- Working with local premises to adopt more responsible approaches to the sale of alcohol
- Diversifying the night time economy offer within Halton

3.3.5 **Prevention and early detection of mental health conditions**

Mental Health is a key health and wellbeing priority and as such, is supported by the new **Mental Health Strategy and Action Plan**. This provides a robust framework which identifies need and co-ordinates activity across the life-course from maternal mental health, through to childhood and into old age. The strategy also covers the spectrum of need from prevention and early intervention to treatment services.

Key activities include:

- The commissioning of a new CAMHS Service.
- Training on maternal mental health
- Development of dementia programmes.
- A schools emotional health and wellbeing programme.
- A new Suicide Prevention Strategy and Action Plan.

3.4 Public Protection - Trading Standards and Environmental Health

3.4.1 **Food Supply Networks and Food Crime**

In July 2014 the final report of the **Elliot review** into the integrity and assurance of food supply networks was published. The purpose of the review was to consider issues which impact upon consumer confidence in the authenticity of food products. It included an examination of any systemic failures in networks and systems - including regulation - with implications for food safety and public health. The review followed the **2013 Horse Meat Crisis**.

The report recommends that a priority for food regulation must be the prevention and detection of food crime. Criminals are exploiting the high value of some food products to commit food fraud. In addition to meat products foods known to be subject to fraud include olive oil, honey, rice and alcohol including wine, spirits and champagne. In some cases the adulteration renders the food unfit for human consumption.

There will be a role for international, national and local regulators including Environmental Health and Trading Standards. A recommendation of the review is that the Food Standards Agency establishes a dedicated **Food Crime Unit** to direct local and national action. The Food Standards Agency has indicated that they will expect local authorities to have a greater focus on food authenticity and fraud.

The future challenge for the Environmental Health food team will be to balance the need to protect public health through the inspection of hygiene standards in food premises with the increased focus on food fraud and the labelling and composition of food stuffs.

3.4.2 **Trading Standards and Health Improvement**

To maximise the opportunities created by the return of trading standards and the transfer of health improvement team into the authority - the environmental health department will work directly with businesses and workplaces on initiatives that contribute to the borough's key public health objectives e.g. alcohol, tobacco, underage sunbed use and pre-school nutrition

4.0 FACTORS AFFECTING PRIORITY FOCUS

There are numerous factors that have been identified as having a potential impact on the delivery of services during the life of this Plan. Some of the main factors are outlined below: -

POLITICAL	SOCIAL FACTORS
The integrated working requirements across social care and health, including with Public Health and the Clinical Commissioning Group	Ageing Population resulting in pressures on acute health services
Implementation of the Care Act 2014 and the delivery of the Better Care Fund objectives	Dementia rising sharply amongst over 65s
Increased joint working with neighbouring Authorities	Rise in need for informal carers and how the Local Authority works with and supports them
Halton Clinical Commissioning Group	Greater access to information, choice and control, and further advances towards personalised care
Joint Strategic Needs Assessment (Joint Health & Wellbeing Boards)	Increased expectations of the social care workforce and the need to monitor standards and provide upskilling and progression opportunities
Health and Wellbeing Strategy	**GP Strategy**, Halton CCG has worked with local practices to redefine how primary care will work in the future, there will be new opportunities for practices to work differently, new models of engagement with health improvement, pharmacies; wellbeing and other community providers. The primary care strategy group has worked in concert with public health on developing a focus on cancer and cardiovascular disease.
ECONOMIC CLIMATE	TECHNOLOGICAL DEVELOPMENTS
Continued budgetary pressures	Telecare/Telehealth
Better Care Fund	Visbuzz pilot
Increased need to work with social enterprises and the voluntary sector to meet social care requirements due to budgetary constraints	Calls for greater data sharing across services to safeguarding welfare of service-users and provide more integrated ways of working – issues to overcome in relation of data protection
Personal Budget Holders and self-funders – potential impact on choices of services accessed	Carefirst Financials – implementation of real-time finance data for costings of services – to be captured within Carefirst
Anticipated rise in need for Housing Solutions services, such as Mortgage Rescue Service (MRS), as interest rates start to rise	**Transfer and access of some required data sets-** particularly relating to NHS data for which Public Health have accountability for reporting is problematic. This is a national issue and solutions are being sought both locally and nationally. Some data sets may not therefore be as current as possible and provisional data may not yet be verified as a result of this situation.

Economic Downturn- This has affected a number of services across Environmental and Public Health, for example, pest control where residents are choosing to deal with issues themselves rather than pay the Pest Control service to deal with it. Evidence shows that economic crisis can also have implications for public health for example in terms of diet and healthy eating, mental health and depression, suicide rates and smoking.	
LEGISLATIVE	ENVIRONMENTAL
Care Act 2014 Major reform to the law relating to the care and support of adults, including standards of care; the funding of care, and requirements to steer service users through the complexities of care funding and signpost to independent advice; new rights to appeal against decisions on service eligibility; support for carers; and provisions for safeguarding against abuse and neglect. Additional requirement for Local Authority intervention in wellbeing and preventative services.	
Supreme Court judgement on DoLs assessments	
Universal Infant Free School Meals	

NB – text in blue and underlined indicates a hyperlink to further information.

5.0 ORGANISATIONAL INITIATIVES

There are a number of initiatives that have been developed at an organisational level to ensure consistency and synergy between individual business units of the Council. As such these initiatives are relevant to the work of all Directorates of the Council and have implications for, and are supported by, the work of the individual departments that sit beneath them. Such initiatives include:

5.1 Equality, Diversity and Community Cohesion

Halton Council is committed to ensuring equality of opportunity within all aspects of its service design and delivery, policy development, and employment practices. This commitment is reflected in a range of policies, strategies, and other framework documents and practices that underpin the work of the Council through its day-to-day operational activities.

The Council reviewed and refreshed its Single Equality Scheme in 2009. As a result of the introduction of the Equalities Act (2010), the scheme has recently been further reviewed and refined slightly to ensure that it remains current and fit for purpose.

The scheme sets out the Council's approach to promoting and securing equality of opportunity, valuing diversity and encouraging fairness, and creating and promoting a social environment in which people can work, learn, and live free from discrimination and victimisation in all of its forms. The Council will combat discrimination throughout the organisation and will use its position of influence in the borough to help to identify and remove discriminatory barriers and practices where they are found to exist.

The Council has developed a systematic approach to examine and address the equality implications of its existing and future policies, procedures, and practices through the use of a Community Impact Review and Assessment process.

The Public Sector Equality Duty requires the authority to publish equality information annually and the progression of equality-related issues will be monitored through this process.

Work continues within the Directorate to improve the access and the signposting of members of the Black and Minority Ethnic communities to support services that:

- Advise on housing options
- Establish the skills to maintain appropriate permanent housing
- Enable service users to remain in their own homes, and avoid eviction and homelessness
- Provide access other services including health, social care, education, training and leisure services.
- Help to ensure the more vulnerable amongst the minority and hard-to-reach communities can live independently
- Help prevent minority communities from feeling socially excluded and/or isolated, and provide community development support to build engagement mechanisms
- Support Gypsies and Travellers to access services including health, social care and education.

Directorate Equalities Group strives to develop and maintain a systematic approach to ensure that equality and diversity are embedded within our Directorate and members of the group will take on board the responsibility of being Equality and Diversity Champions.

5.2 Environmental Sustainability

The Council is committed to taking a lead and setting an example in tackling climate change. The Council has developed a Carbon Management Plan that will support the organisation in managing

its carbon emissions and developing actions for realising carbon and financial savings and embedding carbon management into the authority's day-to-day business.

The Plan was reviewed and updated during 2011/12, with a revised energy emissions reduction target and it is now set at a reduction of between 5% and 10% over 2010/11 figures for a 5 year period. The main measure included in the revised plan is the Green House Gas emissions indicator, which differs from the previous carbon emissions indicator.

The GHG emissions figure for 2011/12 was 23,917 tonnes CO_2 which was a 7.3% reduction on the 2010/11 figure. This total figure breaks down as follows:-

Corporate buildings - 7505 tonnes CO_2 (estimated)
Schools - 8393 tonnes CO_2 (estimated)
Street lighting - 6211 tonnes CO_2 (estimated)
Vehicle fleet - 1359 tonnes CO_2 (estimated)
Business Miles - 449 tonnes CO_2 (estimated)

To improve the focus on achieving its targets the Directorate, through the Carbon Group, will develop specific plans and, where appropriate, specific reduction targets around buildings and vehicle fleet and business miles

Linked to the development of the Affordable Warmth Strategy, which aims to raise awareness of fuel poverty and build on referral mechanisms, it is also intended to improve properties in terms of energy efficiency through appropriate insulation and improved heating systems, which will contribute to the Council's commitment to tackling Climate Change issues.

Eco-friendly solar panels at the Stadium are due to generate income of £12,000 a year for the Council as well as saving up to £3,000 a year in energy bills. The Council will benefit from income from the feed in tariff from the solar panels – 32.9 p for every kWh it generates income which will increase year-on-year in line with inflation. The total energy saving will be in the region of £75,000 over 25 years.

The Stadium also continues to drive forward its commitment to enhancing energy efficiency particularly around its electrical consumption. Through raising staff awareness of how they can reduce energy consumption and the resulting impact it could have on the environment along with a number of investments in energy initiatives such as the fitting of low energy devices, Voltage Optimization System and appliances to reduce water waste, since 2006/7 the Stadium has seen a reduction in over 27% of its electrical consumption, not just having an impact on the environment but also having the effect of generating cost savings.

Open Space Services continues to develop areas of woodland for the purposes of carbon capture and in order to take areas out of intensive management that requires the burning of carbon based fuels. Through the management of twelve local nature reserves and through environmental good practice, underpinned by a partnership with the Cheshire Wildlife Trust and with Mersey Forest the Division works to ensure biodiversity throughout the Borough.

The Council is committed to improving a good quality of life for the people of Halton and one of the ways this can be achieved is through allotment gardening. Being part of the allotment gardening community brings an opportunity to meet and share experiences with people from all walks of life. There are also health and social benefits which can give plot-holders a sense of well-being. Our aim is to continue to build on the good practices and positive improvements, but the biggest obstacle is the shortage of growing space. .

Halton is working with local authorities and Registered Providers in Merseyside and third sector organisation Fusion 21 to develop a fully worked up bid for European Regional Development Fund (ERDF) resources to provide energy efficiency measures to vulnerable households in the sub region, following a successful expression of interest. If successful, the bid should enable new

technologies such as combined heat and power systems to be installed in selected social rented blocks and provide solid wall insulation for hard to treat properties.

5.3 Risk Management

Risk Management, which forms a key element of the strategic and performance management processes of the Council, is a business discipline that is used to effectively manage potential opportunities and threats to the organisation in achieving its objectives.

Risk assessments are the process by which departments identify those issues that are, or may be, likely to impede the delivery of service objectives. Such risks are categorised and rated in terms of both their probability, i.e. the extent to which they are likely to happen, and their severity i.e. the potential extent of their impact should they occur.

Following such assessments a series of risk treatment measures are identified that will mitigate against such risks having an adverse impact upon the delivery of departmental / organisational activities.

Each Directorate will maintain a Risk Register which will be reviewed and refreshed in conjunction with the annual budget setting and business planning process. Additionally the implementation of risk treatment measures will be monitored by the appropriate Strategic Director and reported through quarter 2 mid-year performance reports.

5.4 Arrangements for managing Data Quality

Good quality data provides the foundation for managing and improving services, determining and acting upon shared priorities, and accounting for performance to inspecting bodies and the local community.

In recognising this, the Council has developed a Corporate Data Quality Strategy that will provide a mechanism by which the authority can be assured that the quality of its data remains robust and fit for purpose. This strategy, which will remain subject to periodic review, identifies five key corporate objectives and establishes the key dimensions of good quality data i.e. that data is

Accurate: For its intended purpose;

Valid By being consistently recorded and used in compliance with predetermined definitions and rules;

Reliable By reflecting stable and consistent data collection processes;

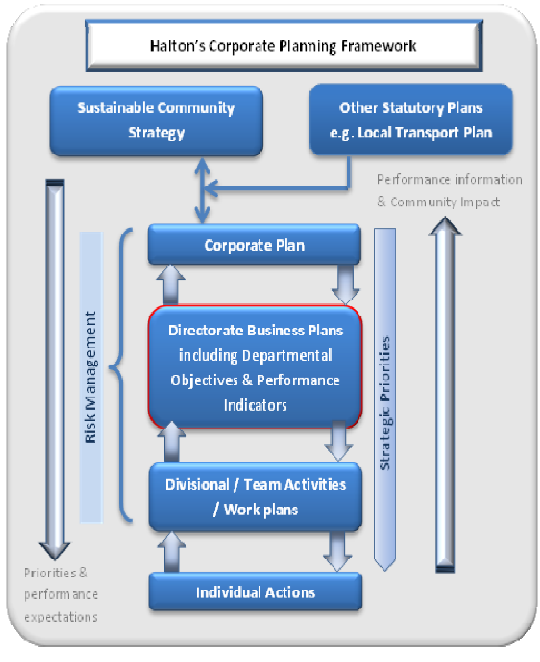
Timely By being made available as soon as possible after the activity or event and in line with organisational requirements;

Relevant For the purpose intended;

Complete In that the monitoring of incomplete, missing or invalid data is avoided as far as is possible.

6.0 BUSINESS PLANNING

Directorate Plans form an integral part of the authority's corporate planning framework, as illustrated within the diagram opposite.



This framework ensures that the Council's operational activities are complementary to the delivery of its community aspirations and legal and statutory responsibilities.

Such plans, and the Quarterly Monitoring Reports that flow from them, are an essential tool in enabling the public, Elected Members, Senior Management, and staff how well Council departments are performing and what progress is being made in relation to improving the quality of life within the borough and service provision for local people, businesses and service users.

Performance Monitoring and Reporting

It is imperative that the Council and interested members of the public can keep track of how the Council and its Departments are progressing and that mechanisms are in place to enable councillors and managers to see whether the service is performing as planned.

As a result Departmental progress will be monitored through:

- **The day to day monitoring by Strategic Directors through their regular interaction with Operational Directors;**
- **Provision of Quarterly progress reports to Corporate and Directorate Management Teams;**
- **The inclusion of Quarterly progress reports as a standard item on the agenda of all the Council's Policy and Performance Boards.**
- **Publication of Quarterly monitoring reports on the Councils intranet site.**

In demonstrating its commitment to exploiting the potential of Information and Communications Technology to improve the accessibility of its services and related information an extensive range of documentation, including this plan and its associated quarterly monitoring reports, are available via the Council's website at
http://www3.halton.gov.uk/content/councilanddemocracy/council/plansandstrategies

Additionally information and assistance can be accessed through any of the Council's Halton Direct Link facilities (HDL) or the Council's libraries.

7.0 APPENDICES

Appendix 1: Service Objectives / Milestones and Performance Indicators

Appendix 2: National Policy Guidance / Drivers

Appendix 1

Commissioning & Complex Care Services

Service Objectives/Milestones/Performance Indicators:

2015 – 2018

Departmental Service Objectives

Corporate Priority:	**A Healthy Halton**
Key Area Of Focus:	**AOF 4** Providing services and facilities to maintain the independence and well-being of vulnerable people and those with complex care needs within our community.

Service Objective:	**CCC 1 –** Working in partnership with statutory and non-statutory organisations, evaluate, plan, commission and redesign services to ensure that they meet the needs and improve outcomes for people with Complex Care needs	**Responsible Officer**
Key Milestone(s) (15/16)	▪ Continue to monitor effectiveness of changes arising from review of services and support to children and adults with Autistic Spectrum Disorder. **Mar 2016.** (AOF 4) **(KEY)**	*Operational Director (Commissioning & Complex Care)*
	▪ Continue to implement the Local Dementia Strategy, to ensure effective services are in place. **Mar 2016.** (AOF 4) **(KEY)**	Operational Director (Commissioning & Complex Care)
	▪ Continue to work with the 5Boroughs NHS Foundation Trust proposals to redesign pathways for people with Acute Mental Health problems and services for older people with Mental Health problems. **Mar 2016.** (AOF 4) **(KEY)**	Operational Director (Commissioning & Complex Care)
	▪ The Homelessness strategy be kept under annual review to determine if any changes or updates are required. **Mar 2016.** (AOF 4, AOF 18) **(KEY)**	*Operational Director (Commissioning & Complex Care)*
Key Milestone(s) (16/17)	▪ Monitor and review all CCC 1 milestones in line with three year planning cycle. **Mar 2017.**	*Operational Director (Commissioning & Complex Care)*

Key Milestone(s) (17/18)	▪ Monitor and review all CCC 1 milestones in line with three year planning cycle. **Mar 2018.**	Operational Director (Commissioning & Complex Care)
Linked Indicators	CCC4, CCC5, CCC6	

Corporate Priority:	A Healthy Halton
Key Area Of Focus:	**AOF 3** Working with service users to provide services focussed around intervention and prevention and where this is not possible, helping people to manage the effects of long term conditions.

Service Objective:	**CCC 2 -** Effectively consult and engage with people who have Complex Care needs to evaluate service delivery, highlight any areas for improvement and contribute towards the effective re-design of services where required	Responsible Officer
Key Milestone(s) (15/16)	▪ Ensure Healthwatch is established and consider working in partnership with other Councils to deliver this. **Mar 2016.** (AOF 21)	Operational Director (Commissioning & Complex Care)
Key Milestone(s) (16/17)	▪ Monitor and review all CCC 2 milestones in line with three year planning cycle. **Mar 2017.**	Operational Director (Commissioning & Complex Care)
Key Milestone(s) (17/18)	▪ Monitor and review all CCC 2 milestones in line with three year planning cycle. **Mar 2018.**	Operational Director (Commissioning & Complex Care)
Linked Indicators	None under Health priorities	

Departmental Performance Indicators

Ref[1]	Description	Halton 13/14 Actual	Halton 14/15 Target	Halton Targets		
				15/16	16/17	17/18

Service Delivery

CCC 4	The proportion of households accepted as statutorily homeless who were accepted as statutorily homeless by the same LA within the last 2 years (Previously CCC5 [13/14])	**0**	1.2	1.2	1.2	1.2
CCC 5	Number of households living in Temporary Accommodation (Previously CCC6 [13/14], NI 156)	**12**	12	11	10	10
CCC 6	Households who considered themselves as homeless, who approached the LA housing advice service, and for whom housing advice casework intervention resolved their situation (the number divided by the number of thousand households in the Borough) (Previously CCC7 [13/14], PCS 11)	**2.0**	5	5.5	6	6.5

Prevention & Assessment Services

Service Objectives/Milestones/Performance Indicators:

2015 – 2018

Departmental Service Objectives

Corporate Priority:	**A Healthy Halton**
Key Area Of Focus:	**AOF 2** Providing services and facilities to maintain and promote good public health and well-being. **AOF 3** Working with service users to provide services focussed around intervention and prevention and where this is not possible, helping people to manage the effects of long term conditions. **AOF 4** Providing services and facilities to maintain the independence and well-being of vulnerable people and those with complex care needs within our community.

Service Objective: PA 1	Working in partnership with statutory and non-statutory organisations, evaluate, plan, commission and redesign services to ensure that they meet the needs and improve outcomes for vulnerable people	**Responsible Officer**
Key Milestone(s) (15/16)	▪ Monitor the effectiveness of the Better Care Fund pooled budget ensuring that budget comes out on target (**AOF 21 & 25**) **March 2016** **(KEY)**	Operational Director (Prevention & Assessment)
	▪ *Integrate frontline services with community nursing (AOF 2, 4, & 21)* ***March 2016***	Divisional Manager (Urgent Care)
	▪ *Develop and implement the Care Management Strategy to reflect the provision of integrated frontline services for adults* ***(AOF 2,3 & 4) March 2016***	Operational Director (Prevention & Assessment)
	▪ Implement the Care Act (AOF 2,4, 10, 21) ***NEW*** **(KEY)**	Operational Director (Prevention & Assessment)
	▪ *Develop an integrated approach to the delivery of Health and Wellbeing across Halton (AOF 2, 4, 21)* ***March 2016***	Operational Director (Prevention & Assessment)

Key Milestone(s) (16/17)	▪ Monitor and review all PA 1 milestones in line with three year planning cycle. **Mar 2017.**	Operational Director (Prevention & Assessment)
Key Milestone(s) (17/18)	▪ Monitor and review all PA 1 milestones in line with three year planning cycle. **Mar 2018.**	Operational Director (Prevention & Assessment)
Linked Indicators	PA 1, PA 4, PA 10, PA 11, PA 12, PA 13, PA 14, PA15, PA 16	

Corporate Priority:	A Healthy Halton
Key Area Of Focus:	**AOF 2** Providing services and facilities to maintain and promote good public health and well-being. **AOF 3** Working with service users to provide services focussed around intervention and prevention and where this is not possible, helping people to manage the effects of long term conditions. **AOF 4** Providing services and facilities to maintain the independence and well-being of vulnerable people and those with complex care needs within our community.

Service Objective: PA 2	Continue to effectively monitor the quality of services that are commissioned and provided in the borough for adult social care service users and their carers.	**Responsible Officer**
Key Milestone(s) (15/16)	▪ *Continue to establish effective arrangements across the whole of adult social care to deliver personalised quality services through self-directed support and personal budgets.* ***Mar 2016.*** *(AOF 2, AOF 3 & AOF 4)*	Divisional Manager (Care Management)
Key Milestone(s) (16/17)	▪ Monitor and review all PA 2 milestones in line with three year planning cycle. **Mar 2017.**	Operational Director (Prevention & Assessment)
Key Milestone(s) (17/18)	▪ Monitor and review all PA 2 milestones in line with three year planning cycle. **Mar 2018.**	Operational Director (Prevention & Assessment)
Linked Indicators	PA 1, PA 4, PA 10, PA 11, PA 12, PA 13, PA 14, PA15, PA 16	

Departmental Performance Indicators

Ref[2]	Description	Halton 13/14 Actual	Halton 14/15 Target	Halton Targets		
				15/16	16/17	17/18
Service Delivery						
PA 1	Numbers of people receiving Intermediate Care per 1,000 population (65+) (Previously PA 2 [13/14])	81.31	82	85	90	90
PA 4	Proportion of adults with learning disabilities who live in their own home or with their family (ASCOF 1G, Previously PA 5 [13/14])	83%	79%	80%	80%	82%
PA 7	Clients receiving a review as a percentage of adult clients receiving a service (Previously PA 8 [13/14])	82%	80%	80%	80%	80%
PA 10	Permanent Admissions to residential and nursing care homes per 100,000 population 18-64 (ASCOF 2Ai, Previously PA 11, [13/14]	8.96	12	12	12	tbc
PA 11	Permanent Admissions to residential and nursing care homes per 100,000 population 65+ (ASCOF 2Aii, Previously PA 12 [13/14]) *Better Care Fund performance metric*	637.7	636.6	635.1	tbc	tbc
PA 12	Delayed transfers of care (delayed days) from hospital per 100,000 population *Better Care Fund performance metric*	2293	2293	2235	tbc	tbc

Ref[3]	Description	Halton 13/14 Actual	Halton 14/15 Target	Halton Targets		
				15/16	16/17	17/18

Service Delivery

PA 13 (SCS HH10)	Proportion of Older People Supported to live at Home through provision of a social care package as a percentage of Older People population for Halton (Previously PA 12 [13/14])	13%	15%	14%	13%	13%
PA 14	Total non-elective admissions in to hospital (general & acute), all age, per 100,000 population *Better Care Fund performance metric*	13437.2 Admissions: 16,944 Population: 126,098	13257.1 Admissions: 16,717 Pop: 126,098	12645.2 Admissions: 15,981 Pop: 126,380	tbc	tbc
PA 15	Hospital re-admissions (within 28 days) where original admission was due to a fall (aged 65+) (directly standardised rate per 100,000 population aged 65+) *Better Care Fund performance metric*	906.4	923.1	884.2	tbc	Tbc

Quality

PA 16	Proportion of Older People (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (ASCOF 2B) *Better Care Fund performance metric*	63.6%	68.2%	70%	70%	70%

Public Health Services

Service Objectives/Milestones/Performance Indicators:

2015 – 2018

Corporate Priority:	A Healthy Halton
Key Area Of Focus:	**AOF 2** Providing services and facilities to maintain and promote good public health and well-being. **AOF 3** Working with service users to provide services focussed around intervention and prevention and where this is not possible, helping people to manage the effects of long term conditions. **AOF 4** Providing services and facilities to maintain the independence and well-being of vulnerable people and those with complex care needs within our community.

Service Objective:	**PH 1 –** Prevention and early detection of cancer: Working with partner organisations to improve early detection of the signs and symptoms of cancer	**Responsible Officer**
Key Milestone(s) (15/16)	▪ Work with Public Health England to ensure targets for HPV vaccination are maintained in light of national immunisation Schedule Changes and Service reorganisations.	Director, Public Health
	▪ Work with partners to identify opportunities to increase uptake across the Cancer Screening Programmes by 10%. **Mar 2016**	Director, Public Health
	▪ Ensure referral to treatment targets are achieved and minimise all avoidable breaches. **Mar 2016**	Director, Public Health
Key Milestone(s) (16/17)	▪ Increase the number of overweight and obese residents attending weight management services across the Borough by 10%. **Mar 2017**	Director, Public Health
	▪ Increase the number of smokers attending stop smoking services across the Borough by 10%. **Mar 2017**	Director, Public Health
Key Milestone(s) (17/18)	▪ Continue to follow the overall trend line in declining cancer Mortality, achieving a Directly Standardised under 75 mortality rate of 174 Cancer deaths per 100,000 population. **Mar 2017**	Director, Public Health
Linked Indicator	PH LI 01	

Corporate Priority:	A Healthy Halton
Key Area Of Focus:	**AOF 1** Improve the future health prospects of Halton residents, particularly children through, through encouraging and providing opportunities to lead healthier and physically active lifestyles. **AOF 2** Providing services and facilities to maintain and promote good public health and well-being.

Service Objective:	**PH 2 –** Improved Child Development Working with partner organisations to improve the development, health, and wellbeing of children in Halton and to tackle the health equalities affecting that population	Responsible Officer
Key Milestone(s) (15/16)	▪ 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. **Mar 2016 KEY**	Director, Public Health
	▪ Fully establish the Family Nurse Partnership programme. **Mar 2016**	Director, Public Health
	▪ Facilitate the Halton Breastfeeding programme so that all mothers have access to breastfeeding-friendly premises and breastfeeding support from midwives and care support workers. Achieve UNICEF baby friendly stage 3 award. **Mar 2016 KEY**	Director, Public Health
Key Milestone(s) (16/17)	▪ Monitor and review all PH 2 milestones in line with three year planning cycle. **Mar 2017**	Director, Public Health
Key Milestone(s) (17/18)	▪ Monitor and review all PH 2 milestones in line with three year planning cycle. **Mar 2018**	Director, Public Health
Linked Indicator	PH LI 02	

Corporate Priority:	A Healthy Halton
Key Area Of Focus:	**AOF 2** Providing services and facilities to maintain and promote good public health and well-being. **AOF 3** Working with service users to provide services focussed around intervention and prevention and where this is not possible, helping people to manage the effects of long term conditions. **AOF 4** Providing services and facilities to maintain the independence and well-being of vulnerable people and those with complex care needs within our community.

Service Objective:	**PH 3 –** Reducing the number of falls in adults	**Responsible Officer**
Key Milestone(s) (15/16)	▪ Develop a new triage service between Rapid Access Rehabilitation Team and Falls Specialist Service. **Mar 2016**	Commissioning Manager
	▪ Develop a new Voluntary Sector pathway to support low-level intervention within Falls Service in the borough. **Mar 2016**	Commissioning Manager
Key Milestone(s) (16/17)	▪ Expand the Postural Stability Exercise Programme. **Mar 2017**	Commissioning Manager
	▪ Review and evaluate the performance of the integrated falls pathway. **Mar 2017**	Commissioning Manager
Key Milestone(s) (17/18)	▪ Link Falls service to an effective frailty pathway for both Hospitals and community services. **Mar 2018**	Commissioning Manager
Linked Indicator	PH LI 03	

Corporate Priority:	A Healthy Halton
Key Area Of Focus:	**AOF 2** Providing services and facilities to maintain and promote good public health and well-being. **AOF 3** Working with service users to provide services focussed around intervention and prevention and where this is not possible, helping people to manage the effects of long term conditions. **AOF 4** Providing services and facilities to maintain the independence and well-being of vulnerable people and those with complex care needs within our community.

Service Objective:	**PH 4 –** Reduction in the Harm from Alcohol Working with key partners, frontline professionals, and local community to address the health and social impact of alcohol misuse	**Responsible Officer**
Key Milestone(s) (15/16)	▪ Implement the Halton alcohol strategy action plan working with a range of partners in order to minimise the harm from alcohol and deliver on three interlinked outcomes: reducing alcohol-related health harms; reducing alcohol-related crime, antisocial behaviour and domestic abuse and establishing a diverse, vibrant and safe night-time economy.	Director, Public Health
	▪ Deliver a local education campaign to increase the awareness of the harm of drinking alcohol when pregnant or trying to conceive.	Director, Public Health
	▪ Hold a community conversation around alcohol – using an Inquiry approach based on the citizen's jury model of community engagement and ensure recommendations for action are acted upon by all local partners.	Director, Public Health
Key Milestone(s) (16/17)	Monitor and review all PH 4 milestones in line with three year planning cycle. **Mar 2017**	Director, Public Health
Key Milestone(s) (17/18)	Monitor and review all PH 4 milestones in line with three year planning cycle. **Mar 2018**	Director, Public Health
Risk Assessment	PH LI 04, PH LI 05	

Corporate Priority:	A Healthy Halton
Key Area Of Focus:	**AOF 1** Improve the future health prospects of Halton residents, particularly children through, through encouraging and providing opportunities to lead healthier and physically active lifestyles. **AOF 2** Providing services and facilities to maintain and promote good public health and well-being. **AOF 3** Working with service users to provide services focussed around intervention and prevention and where this is not possible, helping people to manage the effects of long term conditions. **AOF 4** Providing services and facilities to maintain the independence and well-being of vulnerable people and those with complex care needs within our community.

Service Objective: PH 5	**PH 5 –** Prevention and early detection of mental health conditions Working with schools, GP practices, and Children's Centres to improve the mental health and wellbeing of Halton residents	**Responsible Officer**
Key Milestone(s) (15/16)	▪ Implement a new tier 2 Children and Young Peoples Emotional Health and Wellbeing Service. **Mar 2016**	Director, Public Health
	▪ Monitor and review the Mental Health Action plan under new Mental Health Governance structures. **Mar 2016**	Director, Public Health
	▪ Implement the Suicide Action Plan. **Mar 2016**	Director, Public Health
Key Milestone(s) (16/17)	▪ Monitor and Review all PH5 milestones in line with the three year planning cycle. **Mar 2017**	Director, Public Health
Key Milestone(s) (17/18)	▪ Monitor and Review all PH5 milestones in line with the three year planning cycle. **Mar 2018**	Director, Public Health
Linked Indicator	PH LI 06	

Departmental Performance Indicators

Ref	Description	Halton 13/14 Actual	Halton 14/15 Target	Halton 14/15 Actual	Halton Targets		
					15/16	16/17	17/18
PH LI 01 (SCS HH 7)	Mortality from all cancers at ages under 75[4] (Previously NI 122) 2011 Directly Standardised Rate, per 100,000 population *Published data based on calendar year; note year for targets*	199.3 2013/14 (Apr-Mar)	182.7 (2015)	177.7 Oct 13 – Sep 14	180.6 (2016)	178.7 (2017)	176.9 (2018)
PH LI 02	Children achieving a good level of development at the end of reception	37% (2012/13)	N/A	46% (2013/14)	TBC (Awaiting confirmation of new target definition)	TBC (Awaiting confirmation of new target definition)	TBC (Awaiting confirmation of new target definition)
PH LI 03 New SCS Measure Health 2013-16)	Hospital admissions for injuries due to falls (65+) Directly Standardised Rate, per 100,000 population	3515.6 2013/14 (Provisional)	3375.8	3414.5 (Oct '13-Sep '14)	3335.7	3301.8	3272.4
PH LI 04 (SCS HH 1)	Alcohol related admission episodes - narrow definition	811.8 (2013/14)	811.8	807.0 (Q1 2014/15)	808.4	785.9	753.6
PH LI 05	Under 18 alcohol-specific admissions	73.5 (10/11 to 12/13)	64.3	No data available yet	59.0	50.3	42.7
PH LI 06	Mental health: Self-reported wellbeing.	N / A	69%	N/A	TBC	TBC	TBC

[4] Please note, PH LI 01 and PH LI 03 are based on directly standardised rates. During 2014 the standard population used for such calculations was updated, which has affected rates nationally. As such the rates displayed here may differ substantially from those previously produced. In these terms, the rates stated here, and from now on, are not comparable to those previously stated.

APPENDIX 2

NATIONAL POLICY GUIDANCE/DRIVERS

Local Government		
Comprehensive Spending Review		With the continued Coalition Government's Comprehensive Spending Review, the Council has on-going budgetary pressures and each Directorate will need to ensure that they effectively contribute to the Authority's response to dealing with the current economic climate.
Health & Social Care Act 2012		It is the most extensive reorganisation of the structure of the National Health Service in England to date. It proposes to abolish NHS primary care trusts (PCTs) and Strategic Health Authorities (SHAs). Thereafter, £60 to £80 billion of "commissioning", or health care funds, would be transferred from the abolished PCTs to several hundred clinical commissioning groups, partly run by the general practitioners (GPs) in England. A new public body, **Public Health England**, is planned to be established on 1 April 2013.
Care Act 2014		The Care Act 2014 is the first major reform to care legislation in over 60 years. Bringing together over 30 previous Acts, the new legislation aims to create a consistent, fair and streamlined framework. It puts those requiring care, and their carers, at the heart of the entire process from assessment to provision. | The Act covers: • General responsibilities of local authorities (wellbeing, prevention, integration, information and advice, provision of a diverse and quality provider market) • Putting carers on the same footing as adults with support needs • Care and financial systems (assessment, eligibility, charging, support and care planning, cap on care costs) • Safeguarding adults at risk of abuse or neglect • Provider failure and market oversight • Transition for children to adult services
Localism Act 2011		The Localism Act takes power from central government and hands it back to local authorities and communities - giving them the freedom and flexibility to achieve their own ambitions. The Localism Act includes five key measures that underpin the Government's approach to decentralisation: Community rights; Neighbourhood planning; Housing; General power of competence; and Empowering cities and other local areas.
Care Quality Commission (CQC)		The Care Quality Commission will regulate and improve the quality of health and social care and look after the interests of people detained under the Mental Health Act.
National Autism Strategy		Autism is a lifelong developmental disability and although some people can live relatively independently, others will have high dependency needs requiring a lifetime of specialist care. The strategy sets a clear framework for all mainstream services across the public sector to work together for adults with autism.
National Healthy Eating Agenda		The national healthy eating agenda and guidelines outline the need to have a school meal service that meets all national requirements around provision and healthy eating.

Universal Infant Free School Meals		Following the recommendations of the School Food Plan the Government obligated provision of free school meals, in state-funded schools in England, for pupils in infant education (Reception, Year 1 and Year 2). This was introduced from the start of the school year in September 2014.
Valuing People Now		The Government is committed to improving the life chances of people with learning disabilities and the support provided to their families. Government policy is that people with learning disabilities should lead their lives like any other person, with the same opportunities and responsibilities, and be treated with the same dignity and respect. This means inclusion, particularly for those who are most often excluded, empowering those who receive services to make decisions and shape their own lives.
Healthy Lives, Healthy People – update and way forward		This policy statement reaffirms the Government's bold vision for a new public health system. It sets out the progress that has been made in developing the vision for public health, and a timeline for completing the operational design of this work through a series of Public Health System Reform updates (July 2011).
Transforming Social Care		Is the first formal guidance outlining actions that local authorities are required to undertake in order to implement the 'personalisation agenda'. The guidance states that 'in the future, all individuals eligible for publicly funded adult social care will have a personal budget, a clear, upfront allocation of funding to enable them to make informed choices about how best to meet their needs, including their broader health and wellbeing'.
Putting People First		A shared vision and commitment to the transformation of adult social care outlines the aims and values which will guide the development of a new, high quality care system which is fair, accessible and responsive to people's individual needs.
Adult Social Care and Health Outcomes Framework		Transparency in Outcomes: a framework for quality in adult social care and health is a set of outcome measures, which have been agreed to be of value both nationally and locally for demonstrating the achievements of adult social care and health.
Welfare Reform Act 2012		The Act legislates for the biggest change to the welfare system for over 60 years. It introduces a wide range of reforms that will deliver the commitment made in the Coalition Agreement and the Queen's Speech to make the benefits and tax credits systems fairer and simpler by: creating the right incentives to get more people into work; protecting the most vulnerable in our society; delivering fairness to those claiming benefit and to the taxpayer.
Fair Access to Care Services 2010		Prioritising need in the context of Putting People First: A Whole System approach to eligibility of social care. The aim of this guidance is to assist councils with adult social services responsibilities (CASSRs) to determine eligibility for adult social care, in a way that is fair, transparent and consistent, accounting for the needs of their local community as a whole as well as individuals' need for support.
DfT Blue Badge Scheme LA Guidance 2012		This guidance provides local authorities with good practice advice on administering and enforcing the Blue Badge scheme. It replaces the previous guidance issued in 2008. This guidance was informed by an extensive independent programme of work undertaken on behalf of the DfT by Integrated Transport Planning Ltd (ITP) and the TAS Partnership Ltd (TAS). The final report of this work, referred to in the guidance as the 'independent review' has now been published.

Sport England Strategy 2012		The 2012-17 Youth and Community Strategy for Sport England was launched in January 2012. It describes how they will invest over £1billion of National Lottery and Exchequer funding over five years into four main areas of work: National Governing Body Funding; Facilities; Local Investment; and The School Games.

REPORT TO:	Health Policy and Performance Board
DATE:	10 March 2015
REPORTING OFFICER:	Chief Officer, NHS Halton CCG
PORTFOLIO:	Health & Wellbeing
SUBJECT:	Strategy for General Practice Services in Halton
WARDS:	Borough Wide

1.0 PURPOSE OF THE REPORT

1.1 This report follows that of 9th September 2014, where the Health Policy and Performance 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.

RECOMMENDATION: That the Health Policy and Performance Board note the report and accompanying documentation.

3.0 SUPPORTING INFORMATION

3.1 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.

3.2 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.

3.3 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

4.1 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

5.1 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

7.1 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

8.1 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.

NHS
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

Halton Clinical Commissioning Group

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 the timing of these national programmes complements and accelerates our local work and we have considered and aligned the approach accordingly.

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[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 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.

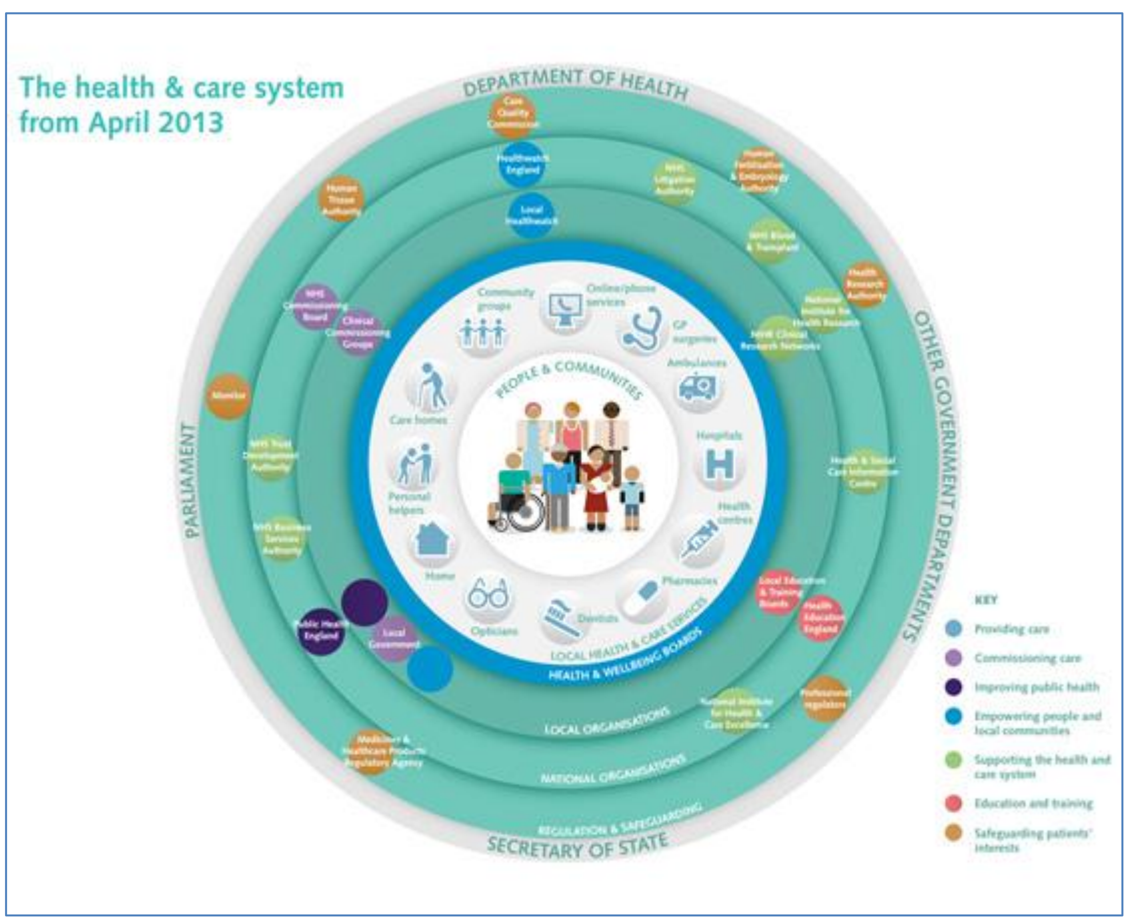

Figure One: The health and care system from April 2013[4]

[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.

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

[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/

- 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

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.

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

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. 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.

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

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 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

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

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** *Av.*	**52**	**2,711** *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

Practice	Clinical Sys.	Version	HIS/CCG Programme														
			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

Agenda Item 6a

REPORT TO:	Health Policy & Performance Board
DATE:	10 March 2015
REPORTING OFFICER:	Strategic Director, Communities
PORTFOLIO:	Health & Wellbeing
SUBJECT:	Care Act implementation – Current Position
WARD(S)	Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To present Health Policy and Performance Board with current progress towards the implementation of the Care Act in Halton. This updates the previous report to Health Policy and Performance Board presented on January 13th 2014.

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

3.0 **SUPPORTING INFORMATION**

3.1 In May 2014, the Care Bill received Royal Assent and became the Care Act 2014. Some elements come into effect from April 2015; others come into effect from April 2016.

The changes coming into effect in April 2015 which impact directly on the Council include:

- A duty to provide prevention, information and advice services
- A national minimum threshold for eligibility for both service users and carers.
- The entitlement for carers to assessment, support services and review equal to that of the service user
- The right for people who pay for their own care to receive advice and support planning.
- A universal system for deferred payments for residential care.

The changes coming into effect from April 2016 which impact directly on the Council include:

- A cap on the costs that people have to pay to meet their eligible needs.
- A ‘care account’ giving people with eligible social care needs an annual statement of their progress towards reaching the cap, whether their care is organised by the local authority or not.
- Extending the financial support provided by the local authority by

raising the means test threshold for people with eligible needs.

Appendix 1 summarises for each of the five major areas (Prevention, Assessment…etc.) current progress that has been made against the requirements of the Act. Their state of completeness expressed as complete (green), in progress (amber) or behind schedule (red). Currently none are behind schedule. In addition, such cross-boundary items as training, communication, IT and documentation (procedures and policies) are dealt with under appropriate headings.

A number of new posts will need to be recruited to deliver the expected increase in the number of assessments (see also *Appendix 1*, page 2, **Workforce Capacity**). This has been calculated using a specific toolkit, (the Lincolnshire model) to estimate the numbers of extra hours worked and hence extra staff that will be required to carry out Extra Carer and Self-Funder Assessments.

3.2 *Training*

Halton has been able to access a number of principal sources of training and at present is putting together a programme that is relevant to staff needs. In addition, staff are being directed to make use of sources freely available from the Internet and elearning. The Social Care Instituted for Excellence (SCIE) and Skills for Care (SFC) continue to produce effective training at all levels.

Specialist training materials from regional experts have been used by Halton's Assessment & Eligibility leads. Associated online lectures have also been offered to Halton staff as part of this training. These provide excellent case history examples and cover a number of relevant areas such as assessment and eligibility and provide an excellent analysis of the legal fabric of the Act that has proved useful to our legal advisors.

Halton has a representative on the North West regional Learning & Development Manager's Group, an important forum for the exchange of learning and joint training around the Care Act. As a result we are in the process of coordinating all training involving the Act, with an initial emphasis being placed on front-line staff throughout January and February 2015.

3.3 *Communication*

There are three strands to Halton's Communication Strategy for the Care Act to its staff, the local community and relevant stakeholders. These are:

- Haltonising freely available Public Health information that has

been produced by the DoH as part of its national campaign to communicate the Act. This is being carried out jointly between Halton Borough Council policy and marketing and Public Health making use of PH England's templates (published late December and Early January) and experience in marketing health messages in Halton to target, communicate and distribute information appropriately. This will tie in with adaptable media messages and advertising materials suitable for digital displays (doctor's waiting rooms) and local press releases scheduled for February and March 2015.

- A pro-active approach has been adopted to improve local people's access to information. This involves co-production. The work is not lead by any organisation, but instead a small number of professionals, along with key members of the public share information to identify problems and map themes (e.g. employment and welfare services). Each theme is then populated with organisations that can provide detailed information and direction. We are currently in the process of mapping themes and preparing for the next stage which is enabling people to navigate through the system, before presenting it to the wider public in early March.
- The third approach to communication is more long-term and will be developed throughout 2015/16. This will be along the lines of the DoH Framework for Information and Advice (and Advocacy) Strategy. This looks at the different ways of managing and organising the wealth of information that LAs already have about their services (often widely dispersed), delivery mechanisms and different ways of increasing awareness locally of the sources of information and advice. The Act stresses that good information and advice must cover the needs of everyone in Halton, not just those currently receiving council-funded care or support, but individuals who may need care and support for themselves or others in the future.

3.4 Information Communication Technology

There are four important aspects of Information Communication Technology that are important to Halton's effective implementation of the Act:

1. Changes to CareFirst 6 that are necessary to capture the additional information that will be required for the assessment and eligibility process, including personal budgets;
2. Secondly because an individual's care package can move with them to or from another authority outside Halton, it is important that steps are taken to ensure compatibility;
3. Thirdly, when the £72,000 Cap comes into play in 2016, it will be necessary for individuals to be able to track their financial progress toward the cap.

4.0 **POLICY IMPLICATIONS**

4.1 A list of policy, procedure practice documents that require editing to reference aspects of the Act has been drawn up. In addition, there are a few areas that will require new policies or major revisions of current policies. These include: Care Management (in particular assessment and eligibility as the Act totally replaces the approach taken by Fair access to Care (FACS) and charging. These revisions are being carried out piecemeal with emphasis on all policies that need to be in place for April 1st.

5.0 OTHER/FINANCIAL IMPLICATIONS

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

There are no implications for this priority.

6.2 Employment, Learning & Skills in Halton

The Act has a central role for carers and puts them on a par with any other adult in providing them with an assessment, whether or not they are funding their own care. Their wellbeing is viewed as crucial in enabling them to carry out their caring role. This concept of wellbeing is defined to enable them to:

- Connect with others
- Remain active
- Take notice of available opportunities
- Learn
- Give (the caring role)

Hence, the expected increase in Carers will also result in a significant increase in access to learning, employment and skills in Halton.

6.3 A Healthy Halton

The Care Act will have a significant impact on Healthy Halton due to its emphasis on Prevention and Wellbeing as a means of reducing the early slide into long-term care in either a care home or hospital. Instead, people are cared for in their own home as long as possible.

6.4 A Safer Halton

There are no implications for this priority.

6.5 Halton's Urban Renewal

There are no implications for this priority.

7.0 RISK ANALYSIS

7.1 The principal risk is how accurate are the increases predicted by the Lincolnshire model. The model has been explained earlier and has been sanctioned by ADASS and the LGA as the model of best practice. The Council's current budget model (Lincolnshire model) for the Care Act implementation predicts that there will be a significant increase in:

- The number of carers who will require an assessment – the model implies a doubling;
- The number of individuals who are funding their own care is expected to increase almost five-fold;
- New individuals coming forward for assessment as a result of media information about the Act over February – March 2015;
- If increases in staff levels are not approved Halton is unlikely to be able to meet its statutory obligations under the Care Act for the year 2015/16.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 There are no Equality and Diversity implications arising as a result of the proposed action.

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

There are no background papers under the Local Government Act 1972.

Appendix 1

The Care Act – Progress Towards Implementation

Sub-group	Statutory Requirements of the Act	Current Progress	Complete
(1) Prevention:	**Wellbeing Principle**. Wellbeing is defined holistically as: • Personal dignity • Physical, mental and emotional • Protection from abuse and neglect • Individual's control over their daily life • Participation in work, education, training or recreation • Social and economic stability • Domestic, family and personal relationships • Suitability of living accommodation • The individual's contribution to society • Improving health and wellbeing targets are central; to prevention..	The early intervention and prevention strategy. Has been updated, to ensure the Care Act requirements are incorporated. A task and finish group has been set up to look at: carer's documentation, process, self-assessment and allocation of resources. To complete early February 2015.	Green Amber
	Preventing need…	A review of best practice and technology options as ways to prevent or delay the need for care and support have been completed. A prevention pathway has also been produced and is under discussion for implementation. Expected agreement early February 2015.	Amber
	Market Shaping/ commissioning. One of our responsibilities as a local authority is to shape the Local Adult Social Care market so that there is appropriate provision and diversity of services to meet the needs of the local population.	A market positioning statement was produced by (April 2014) and recently reviewed (November 2014). This provides a summary overview of the current levels of demand, predicted future demand and how Halton can tackle future demands facing the Adult Social Care market in the future.	Green
	Provider failure & other service interruptions. Local Authorities are under a temporary duty to meet people's needs when a provider is unable to carry out their contracted activity due to business failure. If	A new Halton policy on provider failure and service interruptions (January 2015), has been completed in draft form	Green

	the provider's business has failed, but the		
	Workforce Capacity. If the expected significant increase in assessments occurs, then there will be knock-on effects on staffing levels in such areas as: the Contact Centre, IAT, Finance, contracts and legal. In addition, changes in staff roles (particularly SW in Care Management) are likely. To look at this Care Management have been using the Wigan SW tool recommended by Skills For Care to analyse the SW role and how this should change under the Act. The new approach is that SWs (there are 19) will deal with complex cases, Safeguarding, DoLS and the Mental Health Act.	A request for additional staff has been submitted to Chief Officers Management Team, in line with current estimates of impact.	Amber
(2) Assessment & Eligibility:	**Assessment of Need**. The council will undertake an assessment for any adult who appears to have any level of needs for care and support, regardless of whether or not the council thinks the adult has eligible needs. The assessment will determine how far the adults needs impact on their desired outcomes and on their wellbeing. Policy, procedure and practice components of the Care manual will need to be updated to accommodate the new approaches.	The assessment process is more extensive than previously under FACS and Care Management have been looking at ways to work differently as a means of preparing for the extended approach to the adult and/ or carer's needs. Senior staff have recognised the importance of training and for all staff who assess, training will be available throughout January – March 2015. Policy changes are planned for late January and February.	Amber Amber
	Eligibility. The new eligibility criteria are quite different from the previous three-stage FACS approach. As a consequence, considerable training and familiarisation is required for all staff required to carry out social care assessments. New procedures and practice will have to be written. There is also work being done around the Carer's Eligibility. Policies to update.	Care management team are working with ICT to update documentation and capture new information. Policy procedure and practice to be updated (January – February).	Amber Amber
	Independent Advocacy.	A new hub and spoke model of advocacy for Halton has been developed (January 2015).	Amber
	Care & Support Planning.	New processes are being developed under Care First 6 and also policy and procedure to capture the	Amber

		active involvement of the individual who own the plan and any future changes required as a result of a change of circumstances that have led to a review (Feb. '15).	
	Personal Budgets	In Place	Green
	Direct Payments	In Place	Green
	Transition to Adult Care & Support	In Place	Green
(3) Charging, Financial Assessment:	**Charging for care & Support.** Under the Act there is a facility to charge individuals who fund their own care (full cost clients) an administration fee for arranging care on their behalf. There is also a facility to charge Carers for services.	A decision on full cost client fees and charging carers for services has yet to be made. (February '15).	Amber
	12 week property disregard. Current rules are to be extended to allow a 12 week disregard where an existing disregard is lost due to a sudden change in circumstances.	Procedures and standard literature need to be changed. (March '15).	Amber
	Other disregard. There is discretion to allow a 12 week disregard for those who suffer financial shocks.	A decision regarding discretionary option to allow a 12 week disregard for financial shocks (February. '15).	Amber
	Choice of accommodation & Additional payments. Third-party top-ups should be administered through the LA. LA to offer at least one affordable option within a personal budget. Alternative options, where a 3rd party or in certain circumstances, the resident is willing and able to pay the additional cost.	Have identified 3rd party top-ups and the impact of administering these payments. Currently estimating the additional administration involved and the financial impact on LA administration (January '15).	Green Amber
	Pension Reform. From April 2015 a person with a defined contribution pension will be able to take it how they wish. This provides greater flexibility for people to access, invest or spend their money.	Waiting on more information on how these changes are likely to impact on financial assessments.	Amber
	Deferred Payment Agreements. There are a number of changes to		

	the current DPA scheme that Halton will have to implement: **1.** New requirement for property evaluations and regular reviews; **2.** A new upper limit to the amount of allowable DPA; **3.** There is now a requirement for the likely length of DPA to be discussed with the client; **4.** All administrative fees to be charged interest; **5.** The discretion to include top-up amounts in the DPA; **6.** Requirement for LAs to provide an extended range of information and advice.	1. A detailed action plan is required that is based on DoH guidance. 2. This will require changes to the current IT system (Jan. '15) 3. Changes to procedures and standard literature necessary (Feb. '15). 4. Decision required regarding the admin. Fee plus interest (Feb. '15) . 5. Decision regarding top-up amounts being included in the DPA (Feb. '15). 6. Liaise with Legal to develop new processes and their implications. 7. Identify and produce the additional information and advice. 8. Estimate the additional number of applications for DPA that may be received and the financial implications. 9). Revise DPA policy to incorporate all changes (Feb '15).	Green Amber Amber Amber Amber Green Green Green Amber
	Financial Assessments. These involve the following: **1.** Changes to capital limits for residential clients with property; **2.** Changes to personal allowance for residential clients with property;	Complete full checklist against DoH guidance on Financial Assessments. Requires changes to IT system (Feb. '15). Changes to procedures and standard literature (Feb. '15).. Estimate the impact on the individual's contributions/ income. Liaise with legal regarding	Green Amber Green

	      3. A new facility for LAs to consider – ‘light touch’ assessments for individuals on low incomes or high incomes; **4.** The LA can now choose to conduct a non-residential financial assessment for temporary respite stays in residential settings; **5.** Additional requirements regarding information and advice.	house valuations. Assess additional workload given new criteria and additional requirements. Decision around ‘light touch’ assessments (Feb. ’15). Decision around financial assessments for respite cases and the financial implications (Jan. ’15) Review current information and advice in the light of new requirements. Review both Fairer Charging and Residential Charging policies in the light on the changes and agreed discretionary areas (Jan. ’15).	 Green Amber Amber Amber Amber
	Debt Recovery. The following apply: **1.** It is no longer possible to place a charge against a person’s property; **2.** Debtors can be charged for the administrative costs of servicing the debts; **3.** Interest can be charged for debts. 4. Debts more than 3 years old after 2015 cannot be recovered.	No action is required for this as there are only 6 currently in place. Standard amounts to be published. Need to estimate the additional income that could result. Need to decide whether charges can be levied on individual debtors (Feb. ’15). Need to change procedures and standard letters (Feb. ’15) Investigate IT implications Investigate current debts that are more than 3 years old.	Green Green Green Amber Amber Green Green

(4) Carers:	**Funding**. **Assessments and Eligibility**. The focus is on preparing for the expected increase that has been predicted from the current version of the Lincolnshire Model. **Risk**. The major risk for carers is the accuracy of the estimates and the number of assessments emerging from the Lincolnshire model.	All funding involving carers is aligned and in a single pot. Negotiations have taken place with the Carer's Centre on how best to redesign services and procedures to support the implementation of the Act, the Better Care Fund and GP Enhanced Services. This redesign focuses on: • Older Carers in poor health • Male Carers over 65 • Individuals who provide over 50 hours of care each week • Individuals caring for people who have mental health issues/ dementia • Those caring for individuals with a substance misuse and/ or alcohol issue Those caring for individuals with learning disabilities and/ or Autism. Service Redesign (Feb. '15).	Green Amber
(5) Adult Safeguarding:	Formation of Safeguarding Adults Board (SAB)	Established for 7 years	Green
	Revise terms of reference of SAB to ensure adults are protected in Halton by coordinating and ensuring the effectiveness of what each of its members does.	Currently these are under revision in the light of the SAB's statutory status under the Care Act Feb '15).	Amber
	The SAB must arrange a **Safeguarding Adult Review** (SAR) if: **1.** There is reasonable cause for concern about how the SAB, specific members of it or other relevant persons worked together to safeguard the adult; **2.** The adult has died; **3.** The SAB knows or suspects the death resulted from abuse or neglect (whether or not the SAB knew or suspected abuse before the death); **4.** The adult is alive and the SAB knows or suspect serious abuse or	Current procedures are being revised to reflect the new SAR arrangements. The model reflects a 'light touch' approach that allows practitioners to discuss difficulties openly and to learn from incidents rather than to feel blamed (Feb- March 2015) Procedures for this are already in place	Amber Green

	neglect has occurred. The SAB can arrange for any other adult case, where the person has needs for care and support, in its area to be reviewed.		
	Information Sharing. Each member of the SAB must cooperate in and contribute to the review with a view to identifying any lessons to be learnt from the case and applying such learning to future cases. If an SAB requests information from an individual then the person must comply with the request if: **1.** the request is made to enable or assist the SAB to exercise its function; **2.** the request is made to a person the SAB considers likely to have information that would help them carry out their function.	Raising awareness of this has already taken place and it is unlikely an agency would not cooperate. The Act provides clear direction to challenge if need be. Halton has a joint Integrated Adults Safeguarding Unit with the NHS Halton Clinical Commissioning Group (CCG). This unit undertakes the most complex cases which include multi-agency police investigations and multiple abuse allegations within nursing and residential homes.	Green Green
	Membership of the SAB. Membership consists of: 1. HBC; 2. NHS Halton Clinical Commissioning Group (CCG); 3. Chief officer of police for the Halton area; 4. Other specific individuals specified in regulations and which after consultation are deemed appropriate. Appointment of an individual with the necessary skills and experience to act as Chair for 3 years. Each statutory member must appoint a representative on the SAB who is considered to have the necessary skills and experience.	The Board has revised its membership frequently and now has good representation. Invites need to be extended to Public Health and Job Centre Plus (as per draft guidance). Procedures for this are already in place. Named leads for each statutory member have been appointed.	Green Green Green
	Funding and Resources. A member of the SAB can claim expenses incurred by or for purposes connected with the SAB	Although not a statutory requirement Halton operates a pooled budget (currently £42m). An agreement between the SAB and the CCG has been reached	Green
	Strategic Planning. Each financial year the SAB must publish a Strategic plan which sets out its strategy for achieving its objective and what each member has to do to implement the strategy.	The strategic plan for 2014 is out for consultation and will be published post April 2015 once feedback has been received.	Amber

	Preparation of the plan must involve consultation with local Health-watch and the community.	Health-watch is on the SAB and so is an active partner in developing the plan (Jan-March 2015).	Amber
	Annual Report. As soon as feasible at the end of each financial year an SAB must publish an annual report outlining achievements towards objectives, implemented strategy and review findings.	The Annual Report has been produced for many years and the report for 2014 will be published in summer of 2015.	Green

Agenda Item 6b

REPORT TO:	Health Policy and Performance Board
DATE:	10 March 2015
REPORTING OFFICER:	Strategic Director, Communities
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Better Care Fund update
WARD(S)	Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To update the Board on the Better Care Fund (BCF) plan attached at the Appendix.

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

3.0 **SUPPORTING INFORMATION**

3.1 The BCF was announced in June 2013 as part of the 2013 Spending Round. It provides an opportunity to transform local services so that people are provided with better integrated care and support. The BCF is a joint submission between Halton Borough Council (HBC) and the NHS Halton Clinical Commissioning Group (HCCG).

3.2 During 2015/16 the Fund will be allocated to local areas, where it will be put into pooled budgets under Section 75 joint governance arrangements between HBC and the NHS Halton Clinical Commissioning Group (NHS CCG). With this in mind, the BCF has been developed jointly with the NHS HCCG and in conjunction with the NHS HCCG's 2 year and 5 year plan, a concise key/reference ties the documents together and the detailed schemes are aligned with the consulted 2014/15 commissioning intentions.

3.3 **Consultation**

Consultation has taken place throughout the drafting of the BCF submission, as follows:

- provider stakeholders including 5 Borough Partnership Mental Health Trust, Halton GPs and the Urgent Care Group
- There was a specific meeting organised with the Chief Executive and Warrington and Halton NHS Foundation Trust, the Director of Service Modernisation at St Helens and Knowsley Teaching Hospitals NHS Trust, the Director of

Community Services and Operational Director for Integrated Commissioning at Halton to discuss and plan the schemes;
- Discussions have taken place with operational adult social care teams within the borough council; and
- Patients, service users and the public have been fully involved in the development of this plan through the Halton People's Health Forum (HPHF).

3.4 Each statutory Health and Wellbeing Board (HWBB) has responsibility for signing off the plan and monitoring its implementation on behalf of its constituent council and CCG. As such, Halton's plan was approved at the HWBB in August 2014.

3.5 Halton submitted their BCF Plan to NHS England and the Local Government Association (LGA) on 12th December 2014. The outcome of the submission was received on 23rd January 2015 in a letter to the NHS Halton CCG and Halton Borough Council stating that the Plan was "Approved" and ready for implementation, with no outstanding conditions.

3.6 **Schemes within the BCF**
Within the BCF there are 17 schemes relating to health and social care. As from 2015/16 the total amount of funding to be released for the BCF is £10,594,000.

4.0 POLICY IMPLICATIONS

4.1 Nationally, the Public Health White Paper and the Care Act both emphasise more preventative services that are focussed on delivering the best outcomes for local people. Locally, the Integrated Commissioning Framework sets out formally the joint arrangements for Commissioning. The joint Health and Wellbeing Strategy includes shared priorities based on the Joint Strategic Needs Assessment and local consultation.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 The BCF will steer the funding of Health and Social Care over the next two years. In the second year (2015/16), a proportion of the funding allocation will be dependent on successful performance on the non-elective admissions that we identify as part of the plan.

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 BCF places more emphasis on preventative services in adult social care and health to ensure the people of Halton are supported to live at home for longer, a reduction in long-term care and a reduction in hospital admissions.

6.4 **A Safer Halton**
None identified.

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

7.0 RISK ANALYSIS

7.1 A proportion of the BCF funding is reliant on performance relating to non-elective admissions. Performance in this area is expected to reduce once the Urgent Care Centres are fully operational, relieving some pressure on non-elective admissions. This will be monitored through the Better Care ECB.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None identified.

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

Document	Place of Inspection	Contact Officer
Better Care Fund Plan	Electronic	Emma Sutton-Thompson

Updated July 2014

Better Care Fund planning template – Part 1

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

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

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

1) PLAN DETAILS

a) Summary of Plan

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

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	
By	Simon Banks
Position	Chief Officer
Date	17/09/14

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

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

c) Related documentation

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

Ref No	Page No	Document or information title	Synopsis and links
BCF 1	**4**	**Joint Strategic Needs Assessment (JSNA)**	Joint local authority and NHS HCCG assessments of the health needs of the local population in order to improve the physical and mental health and wellbeing of the people of Halton.
BCF 2	**8**	**Future impact of demographic changes on unplanned hospital care in Halton**	This document identifies areas with a potential for increased demand over the next five years in relation to demographic changes in the borough. These potential areas for increased demand are reflected within our aims and objectives.
BCF 3	**4**	**Halton Health and Wellbeing Strategy**	The Health and Wellbeing Strategy sets out the priorities and actions which the Health and Wellbeing Board are currently implementing.
BCF 4	**33**	**CCG 5 year strategic plan**	Detailed plans by the CCG delivery of services and associated performance measures and efficiency targets.
BCF 5	**33**	**CCG 2 year operational plan**	Detailed plans by the CCG delivery of services and associated performance measures and efficiency targets.

BCF 6	**6**	**Urgent Care Strategy**	The Urgent Care Strategy outlines the strategic direction for the delivery of urgent care in Halton over the next five years. The Strategy facilitates a common approach to provision and creates a framework within which care providers and commissioners can work to ensure seamless, high quality and appropriate care. It will help ensure that unplanned care becomes better planned and understood by the people of Halton, those responsible for managing urgent care services and the work force required to deliver them.
BCF 7	**11**	**Falls Prevention Strategy**	This strategy proposes the development of an integrated falls care pathway with sufficient capacity to deliver an agreed model of care to older people in Halton who are at risk of falling. The model would build on an agreed model of care that is highlighted in the local prevention and early intervention strategy.
BCF 8	**22**	**Complex Care Business Plan**	
BCF 9	**8**	**Joint Prevention and Early Intervention Strategy**	Strategy developed to establish a clear framework and rationale to support an increased shift to improving preventive and early intervention services in the borough.
BCF 10	**9**	**Telecare Strategy**	Two years into its five-year plan, Halton's Telecare strategy has been an undoubted success. Feedback from individual users' annual reviews (or those of their carers) has been very positive. The service has been able to expand to its present (2012) level of 250 individuals, with funding already in place (£170,000 per annum), for a further expansion and consolidation to 350 over the next two years (a total of £340,000 to cover staff and equipment). Data shows significant reductions in admissions to: hospital, long-term care and in re-admissions to hospital. There has also been an overall improvement in crisis intervention and an increase in the number of people supported at home.
BCF 11	**34**	**Market Position Statement (MPS)**	This statement provides a powerful signal to the market, summarising important intelligence and explaining how the local authority intends to strategically commission, and encourage the development of high quality provision to suit local populations.

2) VISION FOR HEALTH AND CARE SERVICES

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

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

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

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

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

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

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

The Marmot report ***Fair Society Healthy Lives*** brought forward the best available global evidence on health inequalities. This report demonstrated that health is socially derived, from the conditions of which we are born, live, work and age. Taking this evidence Halton is making a concerted effort to work collaboratively to develop social responses to the health challenges we face as a borough. Pro-active prevention, health promotion and identifying people early when physical and/or mental health issues become evident will continue to be at the core of all our developments with the patient and service user outcome of a measurable improvement in our population's general health and wellbeing.

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

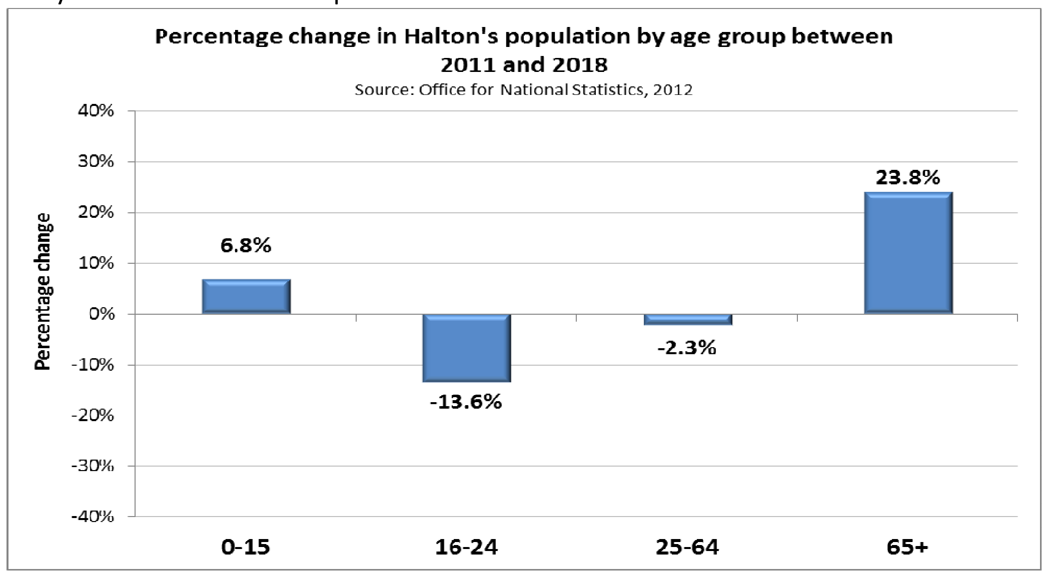
Understanding Current Need

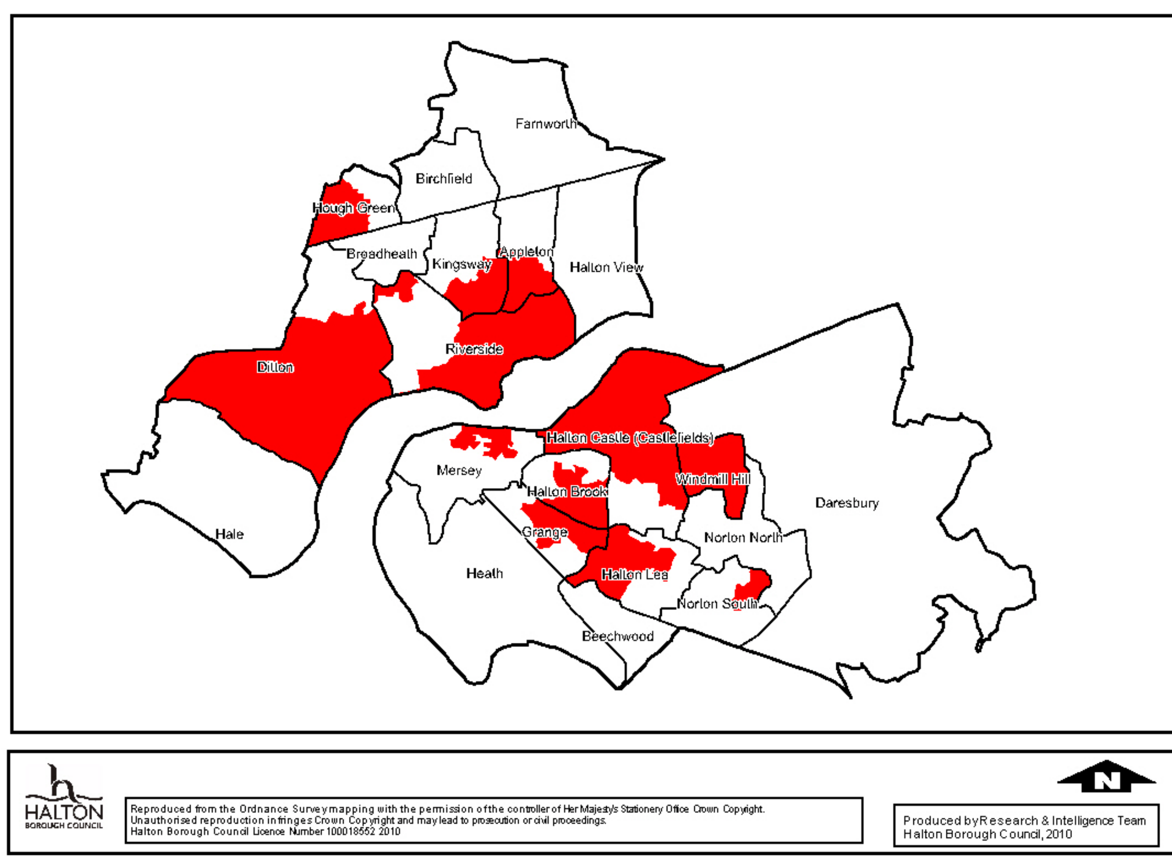
Our population of approximately 125,000 is centred on two towns with strong, supportive and active local communities. We have 17 GP practices with NHS Halton Clinical Commissioning Group (HCCG) co-

terminus with Halton Borough Council (HBC). The two acute hospitals used by the population are out of borough with a single community health care provider and a separate mental health provider. We have a thriving domiciliary and residential care market and active third, faith and voluntary sectors. Whilst we have high levels of deprivation and challenging health outcomes we are seeing improvements in a number of key areas.

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

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





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

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

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

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

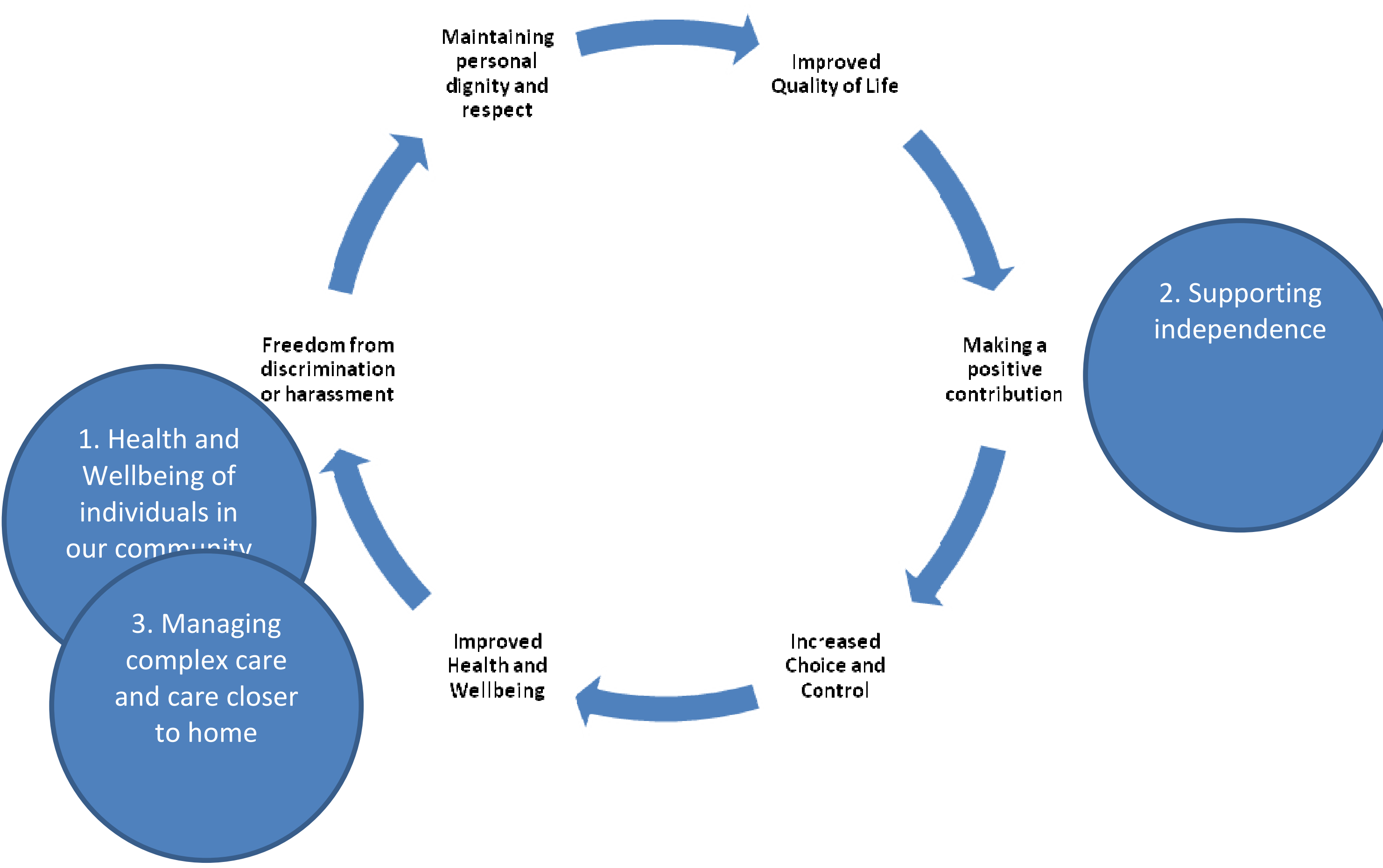
Programme below.

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

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

2. **Supporting independence**

3. **Managing Complex Care and Care Closer to Home**



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

The integration of commissioning, system realignment and multi-disciplinary teams provide Halton with the means to work effectively towards the overarching priority of improved health and emotional wellbeing.

This is led by Halton's JSNA and an in-depth health needs assessment entitled ***The Future Impact of Demographic Changes on Unplanned Hospital Care in Halton 2013 to 2018 (Ref BCF 2)*** which identifies areas and levels of increased hospital demand in the next 5 years in line with our ageing population.

Halton have developed a clear framework and rationale to support an increased shift to improving our approach to Health and Wellbeing.

The focus is on:

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

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

- Use of enabling technologies such as telecare and telehealth.

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

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

There has been a significant and growing emphasis, in recent national strategy reports, on the need to change the way services are delivered in response to the demographic challenge of an ageing population, and on the need for a whole system response built around personalised services with increased emphasis on well-being. Community engagement with an assets based approach, prevention of illness and early detection will lead to more people having healthy disability free lives, being able to live independently and a reduction in emergency admissions.

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

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

2. Supporting independence

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

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

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

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

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

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

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

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

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

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

3. Managing complex care and Care Closer to Home

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

We will ensure that we:

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

Case Study

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

My name is Anne, I'm 78, from Ditton and I used to feel lonely.

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

Sitting at home on my own with no one to talk to, it was as if the world was passing by without me. I started to become really

down and my daughter mentioned how tired and fed up I looked.

It took a while but one day I started to tell her how I felt and it all came out. We sat and hugged and she said I needed to get out more and start to build a new life with different things in it. I knew I had to do something, this couldn't go on. She found loads of dancing groups, Bingo and a flower arranging group. I was nervous at first but with my daughters help I went. I met quite a few new people, two had lost their husbands and also took it badly. But because I could see how they was coping, it gave me hope that feeling lost every day would eventually go. That was eighteen months ago and now I am busy and have new friends to have a laugh with; which I never thought I would say. I no longer feel lonely and on my own."

Performance Measures

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

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

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

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

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

Delayed Transfers of Care	Baseline 13/14	Planned 14/15	Planned 15/16
Numerator	2293	2293	2235

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

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

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

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

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

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

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

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

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

3) CASE FOR CHANGE

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

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

The analysis provided by Capita suggested:

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

One of the main conclusions from the Capita End-to End assessment highlighted the necessity to work towards greater integration.

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

NHS Halton CCG commissions acute services primarily from two providers, specific analysis has been undertaken on three patient groups identified as having the most to benefit from greater integrated care, this analysis concluded:
"Patients with dementia - Comparing lengths of stay for patients with a secondary diagnoses of dementia against patients with the same primary medical condition but no mental health co-morbidities shows a potential reduction of approximately 5,000 bed days (16 beds) at each of Warrington and Whiston.
Elderly patients (over 75's) - Modelling shows a potential reduction of up to 24,000 bed days (circa 73 beds) at both Warrington and Whiston hospitals. This is on the assumption that non-elective length of stays for elderly patients could be reduced to the same as younger patients with the same primary medical condition and similar levels of complication and co-morbidity.
Patients receiving end of life care - Comparing the length of stay of patients with and without palliative care for the same primary medical condition and similar complexity shows a potential shift of approximately 500 bed days (1.6 beds) at each of Warrington and Whiston.
All of the above are mutually exclusive, and in total represent potential reductions of around 20% in non-elective bed days for St Helens and Knowsley and Warrington and Halton Trusts.

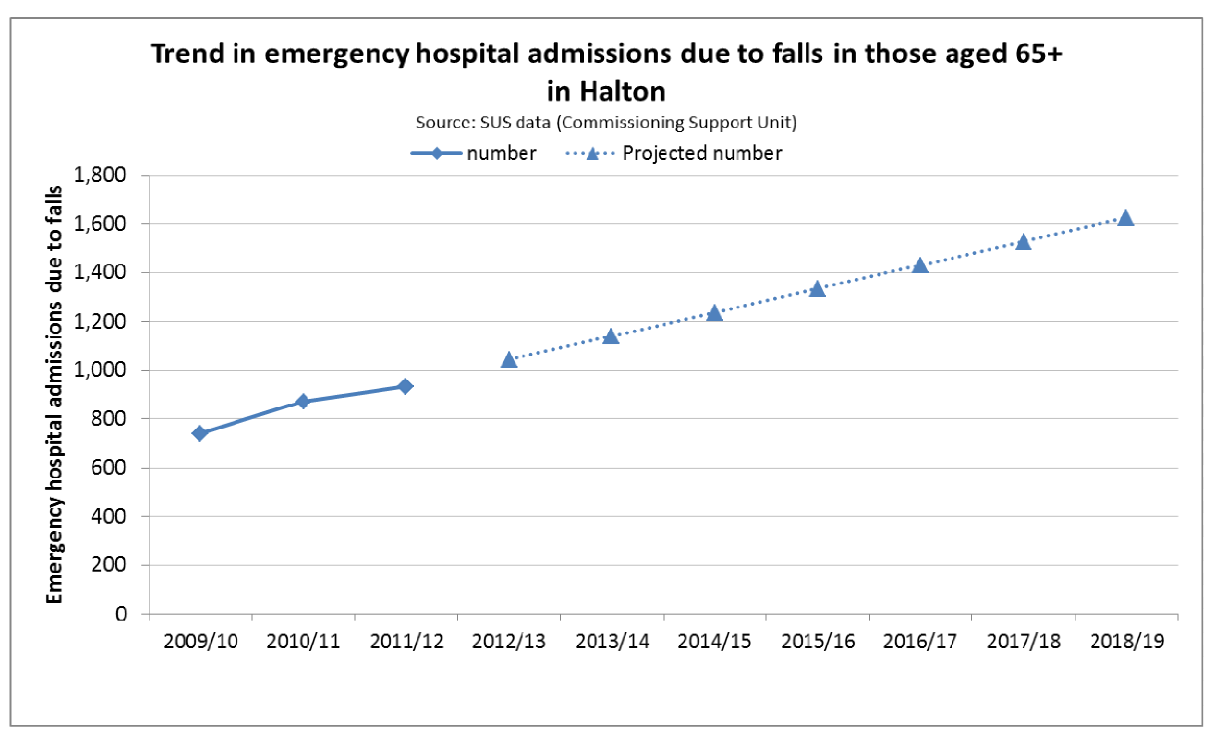
The i5 report focussed on how schemes across the whole health economy in Halton (including both the CCG and the Local Authority) would impact on specific patient cohorts with specific conditions with regard to hospital admissions and lengths of stay.

Overall both the i5 and Capita assessments give assurance that the Halton Health Economy's plans (2 and 5 year and draft BCF) were focussed in the right areas (deflect form acute care, focus on older people) and that the level of savings identified in the financial and operational plans are broadly achievable, although at the top end of what is possible. This is reflected in how a large proportion of the BCF is focused on these areas.

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

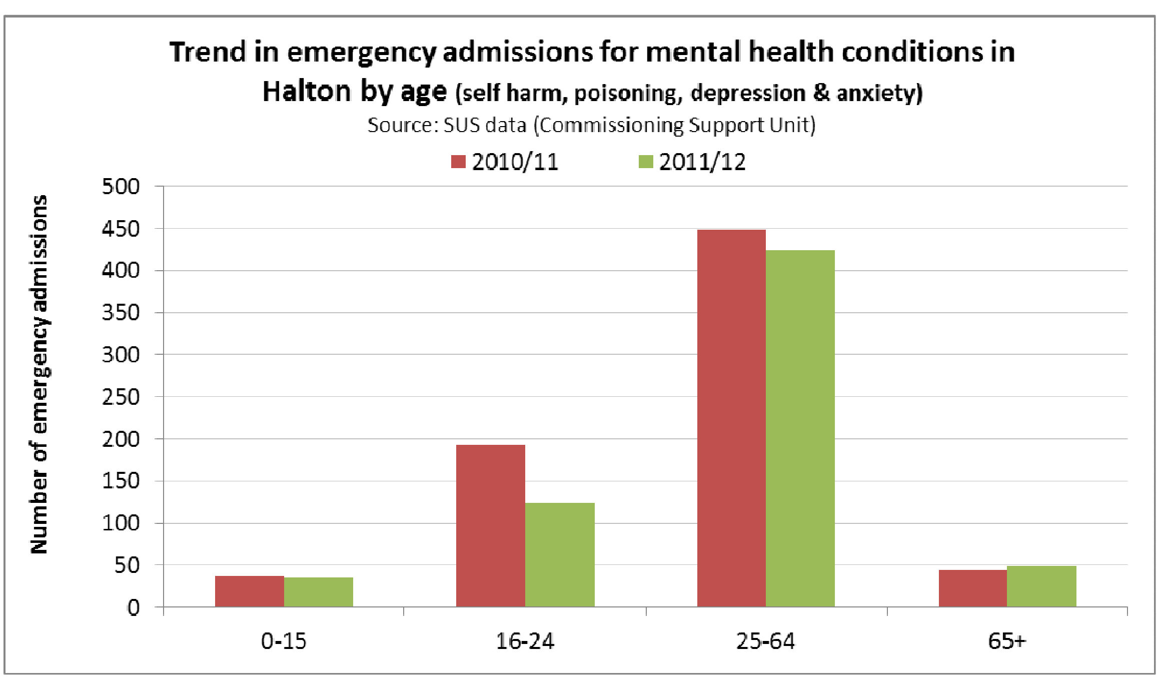
Falls and injuries

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

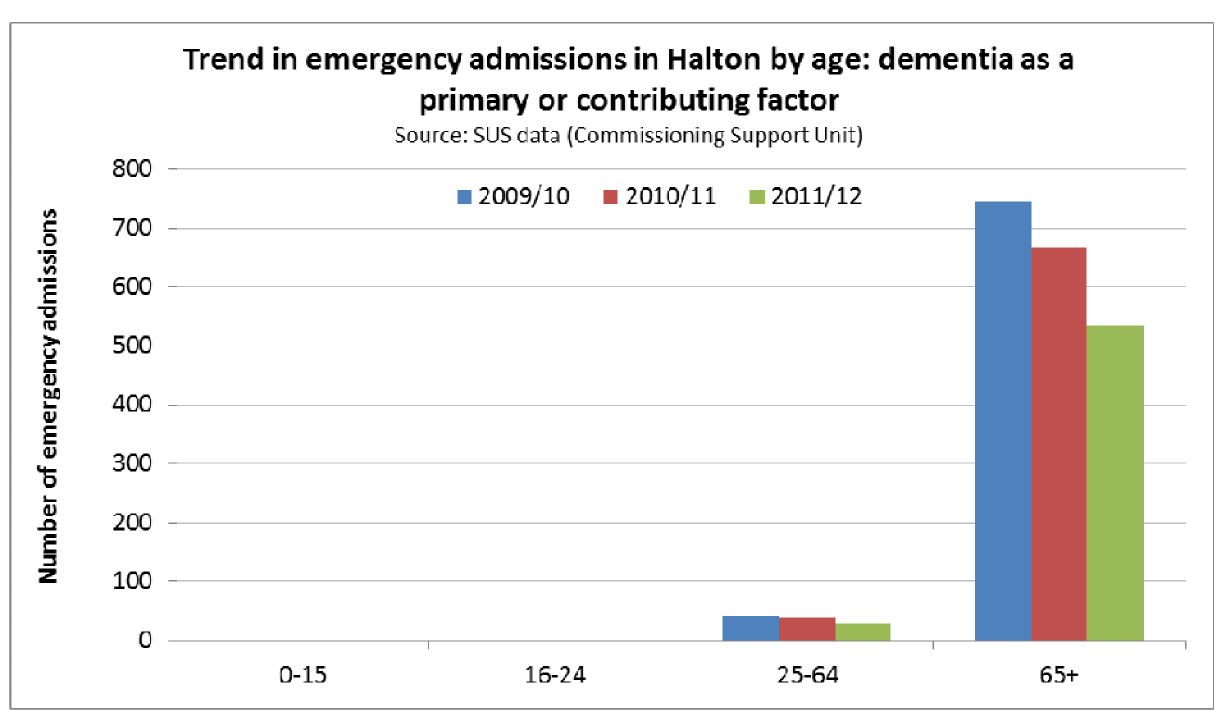


Mental Health

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



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

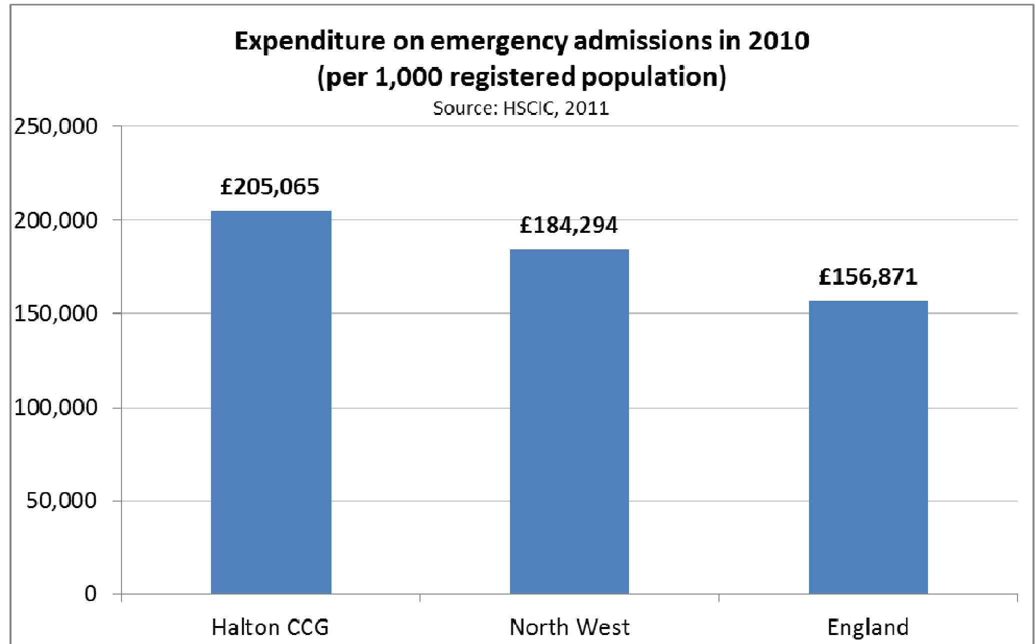


Dementia prevalence in those aged 65+: projection
Source: POPPI, 2012

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

Cost

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



4) PLAN OF ACTION

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

Our plan of action is below and details the overarching actions and key milestones associated with the delivery of our Better Care Fund plan. Within our plan of action and the schemes listed below, Halton's Strategy is focussed on prevention of ill health and poor emotional wellbeing, early detection of disease, support people to remain independent at home, manage their long-term conditions, wherever possible avoid unnecessary hospital admissions and in situations where hospital stays are unavoidable ensure that there are no delays to their discharge.

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

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

We also have a Working Document (***Annex 3***) that details both new and existing schemes within the BCF. This Working Document is used by the Better Care ECB to monitor progress with each scheme within the BCF. It is useful to note that some of the schemes are also funded from other sources. The expenditure plan within Template 2 gives a breakdown of the finances for each scheme stating area of spend and commissioner. The following information is a brief summary that describes the benefits that each scheme contributes towards. Schemes 1 – 9 are linked directly to the performance and finance associated with the 4 key metrics. Schemes 10 – 17 contribute to these but are not included in the Benefits section to avoid issues of double counting and over emphasis of performance.

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

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

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

The Board has adopted a membership that adequately reflects its key responsibility of providing an integrated response to local needs, which has early intervention and prevention at the forefront. The work of the Board is supported by a number of strategic partnership boards/groups which are intended to

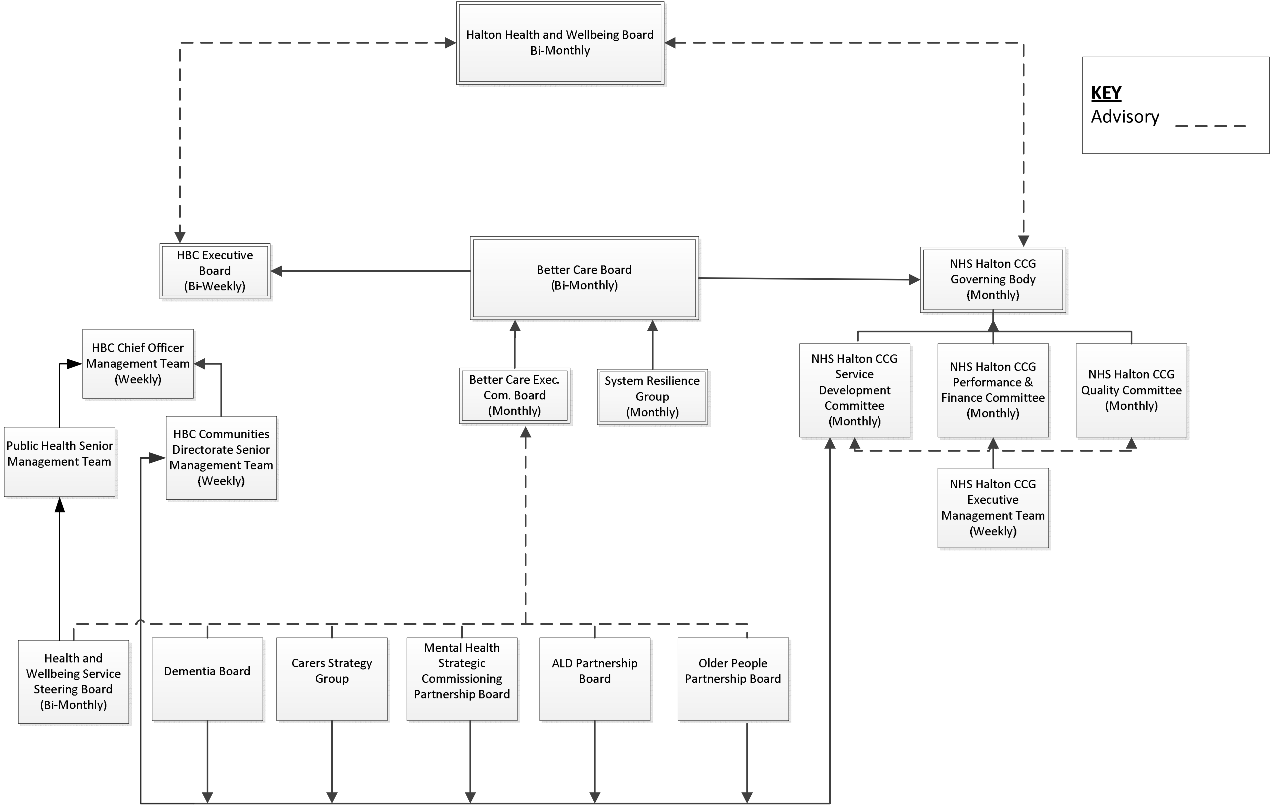
drive forward developments, particularly concerned with integration, within their respective fields.

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

The governance arrangements and accountability structures adopted demonstrate a significant level of trust and confidence in shared governance structures and a shared commitment to improving outcomes for service users and patients and their carers making effective and efficient use of public resources.

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

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



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

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

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

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

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

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

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

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

d) **List of planned BCF schemes**

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

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

Ref no.	Scheme
1	**Urgent Care Centres –** During 2014/15 the existing walk-in-centre and minor injuries units will be developed into Urgent Care Centres with a Clinical Assessment Unit and assessment bed capacity. These will form part of a wider approach to the development of ambulatory care pathways dovetailing with the work in secondary and primary care. Coupled with this is the on-going development of 7 day working across community and social care.
2	**Intermediate Care –** The service builds a multi-disciplinary team around the individual based on their needs and key areas of work to be undertaken. Personalised treatment, rehabilitation and care plans are agreed with the person and their significant other. Where long-term services are required following this period of care these are arranged by the Multi-disciplinary team.
3	**Telecare –** The existing community alarm and telecare service will be expanded to deliver a larger number of specialist sensors in people's own homes.
4	**Carers –** The strategic objective of this scheme is to Improve the quality of life for carers' in Halton, and prevent or delay the need for care and support.
5	**Falls Prevention -** The overarching strategic objective of this scheme is to enhance the provision of falls prevention services within the borough to reduce hospital admissions due to a fall, to reduce hospital admissions due to an injurious fall and to reduce readmissions when the first admission is due to a fall.
6	**Dementia -** The strategic objective of this scheme is to promote early diagnosis of

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

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

5) RISKS AND CONTINGENCY

a) Risk log

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

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

There is a risk that:	Associated schemes	How likely is the risk to materialise? *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	Potential impact *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	Overall risk factor *(likelihood *potential impact)*	Mitigating Actions	Responsible Officer	Time-scales
Improvements in the quality of care and in preventative services will fail to translate into the required reductions in the acute sector by 2015/16 because emergency admissions continue to rise due to Halton's demography, impacting the overall funding available to support core services and future schemes.	2, 3, 5, 8, 10, 13, 14, 15, 18	2	5	10	Our integrated commissioning process is engaging a clinical lead and economist to work through the activity of all our provider trusts. This work will highlight further efficiencies by determining the activity that brings best value. Activity below the criteria of significant impact may need to stop to achieve this.	Chair of Better Care ECB – Operational Director for Prevention and Assessment, HBC	On a quarterly basis
The introduction of the Care Act 2014 will have implications in the cost of care provision, partnership working, policies and procedures and skilled and informed workforce.	ALL	2	4	8	Strategic Group was established in October 2013 to begin to identify the implications of each element of the Care Act. A 12 month	Operational Director for Prevention and Assessment, HBC	On a monthly basis

					temporary Principal Policy Officer has been recruited to lead on this. Regular reports to both the NHS Halton CCG and HBC on progress.		
Financial fragility because of the ongoing efficiencies across both HBC and the NHS Halton CCG could results in schemes not being implemented.	ALL	2	5	10	Work on-going to forecast financial situation and continue to identify efficiencies across both organisations. BCF Action Plan monitored regularly through the BC ECB and reported directly to the HWBB.	Chair of Better Care Board – Portfolio Holder for Health and Wellbeing, HBC	Monthly and quarterly basis
The required cultural change in the workforce across HBC and NHS Halton CCG does not take place due to unwillingness or inability to work across organisations could result in staff feeling isolated; anxious and worried; and a reduction in job performance.	ALL	2	3	6	Building trust through effective communication, shared values, equal opportunities and effective leadership is crucial to the successful development of integrated teams.	Chair of Better Care Board – Portfolio holder for Health and Wellbeing, HBC	Quarterly basis
Shifting of resources to fund new joint interventions and schemes will destabilise current service providers, particularly in the acute sector.	ALL	2	4	8	Our current plans are based on the strategies we have in place covering all service areas and linking in to the priorities of the Joint Health and Wellbeing Strategy and Joint Strategic Needs Assessment. Providers are on Boards and contribute to decision-making.	Operational Director for Transformation, HBC and NHS HCCG	March 2015

Operational pressures will restrict the ability of our workforce to deliver the required investment and associated schemes to make the vision of care outlined in our BCF submission a reality.	ALL	2	3	6	Organisational development is an important factor in the successful delivery of health and adult social care outlined in our BCF submission. On-going evaluation of teams and skill mix will ensure the infrastructure and capacity to deliver the schemes identified.	Chair of Better Care ECB - Operational Director for Prevention and Assessment, HBC	On a quarterly basis
If we do not manage Communication carefully there is a risk that staff, public and stakeholders do not know what is happening, why and when. Relationships may suffer and have a negative effect on the implementation of the BCF.	ALL	2	3	6	• Joint Local Authority and NHS HCCG commissioning team meetings take place on a bi-monthly basis communicating the vision and plans for the future and involving staff at the outset. • Engagement plan set to include all relevant providers and acute trusts • Communication and media tools have been identified as a future scheme to ensure the public are fully aware and involved in all aspects of the BCF and integration.	Operational Directors for Transformation and Prevention and Assessment, HBC and NHS HCCG	Bi-monthly basis March 2015 March 2015
Failure with Information Governance, including informed consent to share	18	2	3	6	• Regularly monitor this project to ensure it is on	Divisional Manager for	March 2015

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

b) Contingency plan and risk sharing

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

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

The Better Care Board Performance Framework **(Annex 7)** incorporates a number of measures which help provide assurances to the Better Care Board that necessary outcomes are being met. Regular review of this dashboard will allow effective and timely responses to manage situations as they arise. In addition an early warning dashboard will provide an at-a-glance view of performance against a series of measures including, infection control, quality, risk and safety measures, these will provide effective early markers of possible provider problems or service failure and more can be added as and when appropriate. Actions identified will also report to an oversight group or be part of a new or existing programme of work. Where this is the case the performance will be reviewed by this oversight group.

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

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

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

Risk Assessment & Mitigation

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

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

Controls to mitigate against these risks fall into three categories.

1) **Financial systems**

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

2) **Internal governance**

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

3) Commissioner and Acute Provider Risk Sharing

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

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

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

6) ALIGNMENT

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

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

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

- Maintaining independence, good health and promoting wellbeing. Interventions include combating ageism, providing universal access to good quality information, supporting safer

neighbourhoods, promoting health and active lifestyles, delivering practical services etc.

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

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

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

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

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

- Commissioning and delivering consistent high quality care for every local resident;
- Care continuity for patients with Long Term Conditions;
- Reducing unwarranted variation;
- Strong local clinical leadership;
- Embracing the opportunity to offer services at scale, delivered locally to individual people;

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

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

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

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

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

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

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

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

NHS Halton CCG and Halton Borough Council are already working together and moving towards full integration of health and social care for the benefit of the people of Halton to improve outcomes for both patients and people receiving health and social care services. The BCF and the 5 year strategic plan **(Ref BCF 4)** have the shared vision 'to improve the health and wellbeing of Halton so they live longer, healthier and happier lives'. In addition to the endorsement of Halton Borough Council's Executive Board and NHS Halton CCG's Governing Body, our approach to integration has the full endorsement of the Health and Wellbeing Board. NHS Halton CCG's operational plan includes all the metrics developed for the BCF, including local measures. The commissioning intentions cross reference where those schemes fit with the Better Care Fund and the actions within the BCF plan of action cross reference where they align with the CCG operational plan **(Ref BCF 5).** Both CCG plan and the BCF action plan have been developed together as part of an integrated approach with the Local Authority and the CCG.

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

Local Government Planning documents

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

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

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

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

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

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

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

Outcome Ambition 4 - To Increase the proportion of people living

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

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

Outcome Ambition 7 - To reduce hospital avoidable

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

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

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

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

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

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

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

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

Governance

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

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

Sustainability

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

-All organisations within the health economy are financially viable in 2018/19

-System objectives are achieved

-Long term reduction seen in A&E activity

-Long term reduction seen in inappropriate non-elective admissions into secondary care

System Values and Principles

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

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

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

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

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

7) NATIONAL CONDITIONS

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

a) Protecting social care services

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

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

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

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

The BCF will help to protect these services by:

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

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

The population of Halton was 125,700 in the 2011 Census and is projected to reach 126,800 in 2014. It is

estimated that the total population will grow by 3% between 2011 and 2021. This growth will not be uniform across the age groups. It is projected that there will be:

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

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

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

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

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

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

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

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

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

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

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

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

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

Care Homes Teams - Building on the pilot work in 2013/14, the care homes team project aims to develop and commission a model of support into care homes to improve access to treatment, care and support for all residents. This will incorporate pro-active health and care planning and support the improvement in the quality of care within the sector and contribute to the reduction of non-elective admissions to hospital, reduced lengths of stay and a reduction in long-term care.

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

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

The information below shows the total amount from the BCF that has been allocated for the protection of adult social care service, including our proportion of funding for the implementation of the new Care Act duties.

Total amount from the BCF allocated to protecting adult social care services is **£1,756,000**. £1.7M is for protecting ***Eligibility Criteria*** and the remaining funds are used to maintain current social care services. Of that amount, the headings below show the new Care Act duties split.

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

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

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

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

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

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

In providing carer specific support services, the Council and CCG have pooled their budgets and agreed that the Council will take the lead on commissioning carers services. The total budget available in the BCF for commissioning carer specific support services is **£495,000**, although there is further funding for carers which sits outside of the BCF.

The pooled funding will be used in three ways:

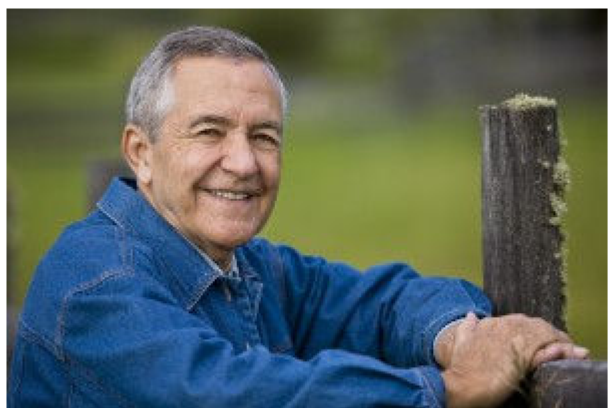
- To provide a budget for carers direct payments following assessment
- To re-design support services at Halton Carers Centre
- To widen the scope and availability of activities and peer support for carers in the Borough

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

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

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

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



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

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

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

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

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

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

b) 7 day services to support discharge

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

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

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

c) Data sharing

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The individual is discussed, usually following an assessment, by the person who knows them best within the team. Notes may have been prepared for discussion prior to the meeting by the other disciplines (e.g. social worker will usually have reviewed case history prior to meeting). Pre assessments usually

include dementia and depression screening and carer's information is updated at this point; carers' assessments are arranged as appropriate.

The lead professional (now referred to as care coordinator in AUA information) is decided and allocated at MDT. The lead professional will co-ordinate the treatment, care and support with the patient and organise regular reviews.

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

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

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

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

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

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

8) ENGAGEMENT

a) Patient, service user and public engagement

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

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

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

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

On 29 October 2013, two HPHF events were held with hundreds of local people attending to learn about healthcare commissioning intentions for 2014-15 as well as have their say on the future of local health

and social care services by taking part in a debate on NHS England's 'The NHS belongs to the people: a call to action' campaign, which is calling on patients and the public to talk about the future shape of the NHS, so it can plan how best to deliver services, now and in the years ahead.

The Better Care Fund was also highlighted at these two events and our direction of travel was shared. In January 2014, the draft "plan" was shared with the HPHF for their comment and input into the document. Feedback can also be seen at **http://www.youtube.com/watch?v=_tLdKCxyk9s&feature=youtu.be**

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

Making It Real

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

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

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

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

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

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

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

4. Workforce: my support staff

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

5. Risk enablement: feeling in control and safe

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

6. Personal budgets and self-funding: my money

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

b) Service provider engagement

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

i) NHS Foundation Trusts and NHS Trusts

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

There has been considerable engagement on this plan with a range of provider stakeholders including 5 Borough Partnership Mental Health Trust, Halton GPs and the System Resilience Group. There was also a specific meeting organised with the Director of Service Modernisation at St Helens and Knowsley Teaching Hospitals NHS Trust, and Chief Operating Officer and Deputy Chief Executive at Warrington and Halton

Hospitals NHS Foundation Trust to discuss the plan during August 2014. It has also been discussed at length with the operational adult social care team within the borough council. Providers have advised how pathways can be improved, teams reconfigured to increase quality and productivity, systems be more efficient and teams more integrated. These changes coupled with the introduction within care pathways of appropriate technology will enable people to live independently, avoid emergency admissions, benefit from reablement services if necessary and have a better patient experience.

ii) primary care providers

Systems Resilience Group provides multi-disciplinary strategic direction and guidance across health and social care in relation to non-elective and elective care. The group is responsible for ensuring that locally there are quality processes in place which are safe and efficient for patients and cost effective. Membership of the group is reflective of the whole system of health and social non-elective and elective care within Halton. This group has been fully engaged with the Better Care Fund. Terms of reference for the group can be found at **Annex 8**.

The ***Service Development Committee*** consists of CCG Commissioning Managers and all GPs within the area and ensures member practices are setting the commissioning agenda for the organisation and supporting the setting of operational delivery. It's remit is:

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

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

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

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

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

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

c) Implications for acute providers

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

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

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

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

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

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

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

Based on the above implications for the Acute Sector, the main metrics the BCF is focussed on is around the non-elective admissions. There are also other contributing factors towards this metric that do not form part of the BCF. The table below shows a summary of our baseline and targets over the coming months linked to the Payment for Performance. ***Further detail around this can be found in Template 2, under Tab 5 "HWB P4P Metric".***

Non-Elective Admissions (general and acute)	Q4 Jan 14 to Mar 14	Q1 Apr 14 to Jun 14	Q2 Jul 14 to Sept 14	Q3 Oct 14 to Dec 14
Baseline	4,242	4,220	4,133	4,164
	Q4 Jan 15 to Mar 15	**Q1 Apr 15 to Jun 15**	**Q2 Jul 15 to Sept 15**	**Q3 Oct 15 to Dec 15**
Numerator (Targets)	4,200	4,034	3,951	3,981

The figures above equate to a 3.5% decrease in non-elective admissions over the next 2 years, in line with the NHS Halton CCGs 2 year operational plan and 5 year strategic plan. The Payment for Performance saving is £883,570 which links in with the HWB Benefits Plan on Tab 4 of Template 2 for 2015/16.

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

ANNEX 1 – Detailed Scheme Description

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

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

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

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

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

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

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

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

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

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

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

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

<u>Design of the Scheme</u>

In 2012/13 NHS Halton Clinical Commissioning Group undertook a review of Urgent Care Services within Halton. This review combined with a winter pressures Accident and Emergency Department (AED) audit helped inform an options appraisal as to how urgent care services within the Borough could potentially be reconfigured to ensure it met local demand/pressures.

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

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

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

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

Assumptions on Impact and Outcomes

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

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

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

401 non-elective admissions in 2015/16

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

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

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

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

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

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

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

ANNEX 1 – Detailed Scheme Description

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

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

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

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

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

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

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

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

Evidence for Scheme Design

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

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

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

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

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

Assumptions for Impact and Outcome

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

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

we project this additional capacity will support:

Reduced Non-Elective Admissions by 148 in 2015/16 – 100 from bed based services and 48 from community services

Reduce Delayed Transfer of Care Bed Days by a minimum of 26 days

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

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

2014/15	**2015/16**
£0	**£795,000.00**

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

Outcomes as per Part 2, Tab 4

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

Performance form's part of the developed dashboard for the Better Care Fund and includes process, outcome, user satisfaction and experience; safety domains. This is reported through the Better Care Executive Commissioning Board.

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

Management of flows into, through and out of bed and community based services

Recruiting additional staff

Procurement of additional bed based capacity

ANNEX 1 – Detailed Scheme Description

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

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

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

Assumptions for Impact and Outcomes

National research drawn from 3 million lives highlights the key role of telecare in reducing the need for residential care, reducing hospital admissions and re-admissions, promoting quick and safe hospital discharges, reducing falls and promoting social inclusion. If achieved these will reduce costs in acute and residential care. The project will evaluate the impact of telecare against these key outcomes.

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

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

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

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

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

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

We project that the additional capacity will support:

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

Maintain the levels of long term care admissions by managing increased population demand
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
2014/15 **£0** | **2015/16** **£140,000**
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Anticipated outcomes are detailed in Part 2, Tab 4 Further anticipated outcomes are: Reduction in ambulance call-outs Reduction in A&E attendances
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
A full evaluation of the project will be undertaken annually. The Better Care ECB will monitor the project and ensure its delivery
What are the key success factors for implementation of this scheme?
• Identification and procurement of appropriate equipment • Ensuring increased demand in alarm activations and the need for human response

ANNEX 1 – Detailed Scheme Description

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

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

significant risk of carer 'breakdown'.

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

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

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

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

Design of the Scheme

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

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

RCGP Commissioning for Carers 2013;
- The challenge facing the NHS is to become truly patient-centred, where patients participate in designing services and are able to exercise choice as customers, whilst seeking always to ensure that no community or part of a community gets left behind

The legal duties as a consequence of the Care Act to;
- Provide advice and information
- Promote well-being
- Prevent, reduce or delay needs
- Provide both assessment of need and services to meet this need

Assumptions for Impact and Outcome

Data from surveys analysed at a national and local level show;
- Halton has the second highest prevalence nationally of unpaid care provision of 50 or more hours per week (ONS data)

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

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

We anticipate that the additional capacity will support:

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

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

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

2014/15	**2015/16**
£0	**£809,000**

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

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

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

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

Further anticipated outcomes include:

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

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

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

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

ANNEX 1 – Detailed Scheme Description

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

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

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

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

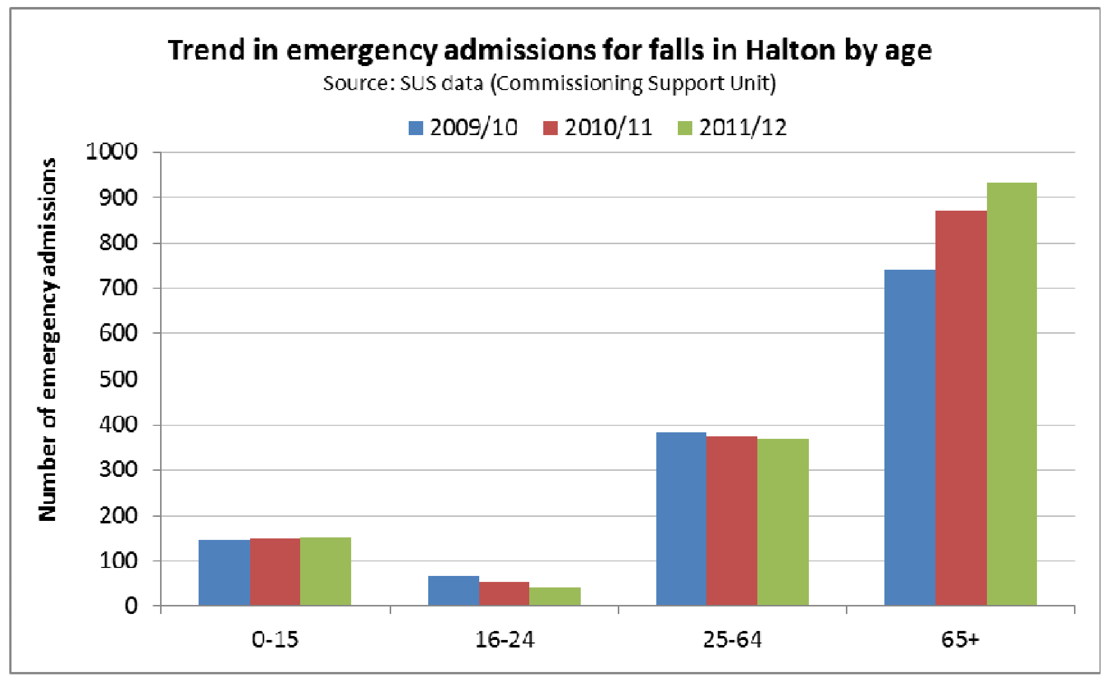
Scheme Design

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

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

Assumptions for Impact and Outcomes

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



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

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

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

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

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

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

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

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

2014/15	**2015/16**
£0	**£130,000**

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

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

Additional anticipated outcomes include:

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

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

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

Services are already integrated across the falls pathway.

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

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

• Hospital re-admissions, where original admission due to a fall (65+) (quarterly) • Number of Fracture of Femur (quarterly) • Top cause of hospital admission (quarterly) Service inputs, outputs, capacity, demand and patient satisfaction are also monitored to understand performance The Falls Strategy Board meets on a quarterly basis to oversee this area.
What are the key success factors for implementation of this scheme?
Uptake of training and information awareness. Recruitment and training of staff to undertake APEX courses Recruitment of additional staff into the Falls Service (nursing and physiotherapy)

ANNEX 1 – Detailed Scheme Description

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

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

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

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

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

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

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

xi. Providing and maintaining the Equipment Catalogue.

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

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

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

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

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

ONS population projections for Halton 2014

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

The delivery chain

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

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

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

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

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

The evidence base

Please reference the evidence base which you have drawn on

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

HBC Public Health document "Future Impact of Demographic changes on unplanned hospital care in Halton" identifies areas with potential for increased demand over the next five years in relation to changes in demographics of the borough.

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

Emergency admissions for:

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

Investment requirements

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

Impact of scheme

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

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

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

The desired outcomes are:

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

- Support carers to provide safe care

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

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

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

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

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

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

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

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

ANNEX 1 – Detailed Scheme Description

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

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

Hospital and do not necessarily wait for a formal referral.

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

Whiston Integrated Discharge Team (WIDT) at Whiston Hospital

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

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

Early Supported Discharge for Stroke

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

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

The delivery chain

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

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

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

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

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

The evidence base

Please reference the evidence base which you have drawn on

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

Scheme Design

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

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

Assumptions for Impact and Outcome

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

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

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

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

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

We project that the additional investment will:

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

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

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

2014/15	**2015/16**
£0	**£210,000**

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

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

ANNEX 1 – Detailed Scheme Description

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

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

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

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

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

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

We project that this expansion will:

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

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

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

2014/15	2015/16
£0	**£192,000**

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

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

Further anticipated benefits include:

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

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

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

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

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

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

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

ANNEX 1 – Detailed Scheme Description

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

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

care in the community.

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

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

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

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

Scheme Design

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

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

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

Assumptions for Impact and Outcomes

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

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

4.6% increase in 2014/15

1.8% increase in 2015/16

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

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

ANNEX 1 – Detailed Scheme Description

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

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

The target group for intervention includes:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2014/15	2015/16
£0	**£496,000**

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

This scheme contributes to:

- Prevention of deterioration
- Improved patient/service user experience

Other outcomes include:

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

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

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

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

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

Treatment		Local value	Eng. value	Eng. worst*	England Range	Eng. best*

Treatment and early intervention can help to minimise the impact of mental illness and improve overall wellbeing. A high number of people in contact with mental health services may indicate a particularly high prevalence in your geography, but it may also reflect good recognition and diagnosis of conditions and availability of appropriate treatment services. Therefore some of the indicators in this domain show high or low significance (using blue lines) rather than best and worst judgements (using red and green lines).

	Indicator	Local value	Eng. value	Eng. worst*	England Range	Eng. best*
15	Directly standardised rate for hospital admissions for mental health, 2009/10 to 2011/12	351	243	1,257		99
16	Directly standardised rate for hospital admissions for unipolar depressive disorders, 2009/10 to 2011/12	75.4	32.1	84.8		4.7
17	Directly standardised rate for hospital admissions for Alzheimer's and other related dementia, 2009/10 to 2011/12	226	80	226		5
18	Directly standardised rate for hospital admissions for schizophrenia, schizotypal and delusional disorders, 2009/10 to 2011/12	89	57	233		5
19	Allocated average spend for mental health per head, 2011/12	213	183	147		257

Levels of Mental Health and Illness

At any one time, roughly one in six of us is experiencing a mental health problem. mental health problems are also estimated to cost the economy £105 billion per year It's important to monitor and investigate the levels of mental health in order to target and improve mental health services at a local level.

	Indicator	Local value	Eng. value	Eng. worst*	England Range	Eng. best*
11	Percentage of adults (18+) with dementia, 2011/12	0.56	0.53	0.95		0.21
12	Ratio of recorded to expected prevalence of dementia, 2010/11	0.55	0.42	0.27		0.69
13	Percentage of adults (18+) with depression, 2011/12	14.66	11.68	20.29		4.75
14	Percentage of adults (18+) with learning disabilities, 2011/12	0.57	0.45	0.21		0.77

ANNEX 1 – Detailed Scheme Description

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

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

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

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

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

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

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

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

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

The PBSS services were founded on the principles of improving the lives of a small number of individuals that challenge services:

- Over a third of individuals with an Intellectual Disability under care of local authorities reside in out of borough placements (Whelton, 2009, see: McGill et al, 2010)
- Prominent in this group are individuals who exhibit behaviour that presents a challenge to services (Emerson & Robertson, 2008, see: McGill et al, 2010)
- The recent outcome of the Winterbourne View investigation highlights concerns about the quality and safety of such provision
- Such placements frequently occur as a reaction to crisis situation

The Mansell Report

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

Other relevant Department of Health publications:

- Valuing People (2001)
- Fulfilling and Rewarding Lives (2010)
- Winterbourne View Report (2012)
- Ensuring Quality Services (2014)

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

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

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

2014/15	2015/16
£0	**£256,000**

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

This scheme contributes to:
- The maintenance of long-term care
- Improved quality of life.

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

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

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

This scheme is monitored by the Better Care Board

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

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

ANNEX 1 – Detailed Scheme Description

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[4] Valuing People: A New Strategy for Learning Disability for the 21st Century (DH, 2001)
[5] Valuing People Now a new three year strategy for people with Learning Disabilities (DH, 2009)

behaviour which challenges

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

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

2014/15	2015/16
£0	£55,000.00

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

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

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

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

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

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

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

Key factors include:

- Supporting people with learning disabilities to live at home for longer;

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

ANNEX 1 – Detailed Scheme Description

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

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

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

Additional pharmacy staff will be employed to:

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

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

Joint Quality Assurance Team

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

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

The delivery chain

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

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

- Halton Safeguarding Adults Board
- Better Care ECB

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

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

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

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

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

Integrated Adults Safeguarding Unit
The Integrated Adult Safeguarding Unit has been based on a hub and spoke model in order to provide a specialist flexible and efficient safeguarding service for the borough. Following the publication of the Winterbourne Report and other high profile Serious Case Reviews, it was felt that the borough would benefit from a specialist safeguarding unit to meets the needs of Halton residents. The Unit will contribute to the safeguarding of adults across the borough by:-

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

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

Integrated Care Homes Support
Making our health and care systems fit for an ageing population. Kings Fund 2014

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

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

2014/15	**2015/16**
£0	**£761,000**

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

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

ANNEX 1 – Detailed Scheme Description

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

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

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

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

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

The evidence base

Please reference the evidence base which you have drawn on

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

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

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

Investment requirements

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

2014/15	**2015/16**
£0	**£100,000**

Impact of scheme

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

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

It is anticipated that there will be a number of other outcomes associated with the development and implementation of an IM&T strategy within Halton in line with the main objectives of improved communication, increased efficiency and enhanced integration. These will include:

- Improved patient pathways – via improved communication and reducing duplication between services and providers.
- Reduction in patient delays - via improved access to test results and up-to-date patient information
- Reduced admissions – particularly in services such as the palliative care in which

improved communication may avoid an out of hours admission.

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

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

Progress will be monitored by the Better Care ECB

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

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

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

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

ANNEX 1 – Detailed Scheme Description

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

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

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

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

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

This involves:

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

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

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

This scheme is the responsibility of the Better Care ECB

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

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

- Halton Healthwatch

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

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

The evidence base

Please reference the evidence base which you have drawn on

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

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

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

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

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

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

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

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

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

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

voluntary sector in making the most effective use of resources

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

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

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

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

Falls Evidence

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

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

Investment requirements

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

2014/15	2015/16
£0	**£566,000.00**

Impact of scheme

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

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

.Anticipated outcomes of this service include a contribution toward:

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

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

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

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

be made, in addition to the improvement in wellbeing and mortality rates there are real cash savings to be made. The POPPs project, Manchester[11] which included services providing information and advice about services a team to strengthen the voluntary sector and a network of services under a single framework would cost an estimated £1.5m a year, supporting people to live at home to a benefit of £3.1m a year, preventing the need for high intensity care by £1.4m a year and reducing avoidable, emergency admissions and bed days by £11k a year. Research identified that for every £1 spent, there is a benefit of £2.20. Schemes identified by the British Red Cross and Age Concern identified that by talking loneliness, emergency admissions can be reduced, saving between £586 and £2,514 per admission.
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Each service will have a service specification with a range of outputs and outcomes that will be relevant to their own area of work. This will be monitored through commissioning via Quality Assurance on a quarterly basis and will be supported by half yearly monitoring visits to complete an audit of the commissioned service. Overall governance of the scheme will be through the Better Care Board.
What are the key success factors for implementation of this scheme?
The success factors will be linked specifically to the outcomes of the service and will show a contribution towards reduction in the use of primary and secondary care services. It will also see an increase in the use of prevention services, lifestyle advice and overall information provision in the borough. Other key success factors will be reduction in number of hospital admissions due to falls, number of staff and residents attending falls awareness programmes, reduction in percentage of people reporting feelings of loneliness and an increase in successful outcomes, as defined by service users, through the information and advocacy hubs.

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

ANNEX 1 – Detailed Scheme Description

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

Scheme ref no.

16

Scheme name

Minor and Major Adaptations and Equipment

What is the strategic objective of this scheme?

In Halton we are committed to provide service in and as close to people's homes as possible to improve the health and wellbeing of the population. Timely access to equipment and adaptations to enable individuals to continue to carry out everyday tasks and maintain their independence in the community is an essential enabler to achieve this. Equipment also supports the delivery of care and nursing needs in the community setting by either paid or family carers.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The key components to providing equipment and adaptations to enable people to remain independent are:

xiii. Assessment of individuals need for specialist equipment or adaptation by an 'Approved Prescriber'. NHS staff may also prescribe equipment that supports the treatment or, maintains health or end of life care. Multi-professional collaboration may occasionally be required, where there is more than one prescriber from a different service area involved in dealing with the disabled person

xiv. Selection and order of equipment or adaptation including specialist or bespoke by prescriber with regard to the level of disability

xv. Procuring equipment as requested by Approved Prescribers to the standards and guidance as set out by the Medical and Healthcare Product Regulatory Agency (MHRA) and identified within the NHS Controls Assurance Standards;

xvi. Delivering appropriate items of equipment for daily living or nursing equipment to people's homes or community settings, within specified timescales

vii. Fitting, installing, adjusting and/or assembling equipment and demonstrating the safe use of.

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

xix. Collecting equipment from people's homes or community setting when no longer required within timescales as instructed by the service specification. xx. Cleaning and refurbishment of returned equipment to recycle as quickly as reasonably practicable in accordance with national guidelines. xxi. Safe disposal of all equipment collected from or returned by individuals where the equipment is unsuitable for re-use and beyond economic repair. xxii. Providing on-site technical advice, working with practitioners/clinicians, attending joint visits and advising clinicians on all aspects of minor adaptations and technicalities around equipment. xxiii. Providing and maintaining the Equipment Catalogue. xxiv. Providing and administrating the Disabled Facilities Grant to provided for works to adapt the homes of chronically sick or disabled persons to enable them to continue to live independently in their homes These arrangements are available to children and adults of all ages where it appears that a person has a permanent and substantial disability : • as defined by the Equality Act 2010 • A child in need as defined by The Children Act 1989 • Someone who is "ordinary resident" in the local authority area and meets the relevant criteria • Registered with a Halton GP
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
This scheme is the responsibility of the Better Care ECB and the Operational Directors for Complex Care and Prevention and Assessment. These are jointly commissioned services. Assessments are completed by nurses, therapists and rehabilitation officers working across health and social care. Bridgewater Community NHS Trust are commissioned to deliver the integrated community equipment service through a partnership agreement and pooled budget arrangement between Halton CCG and Halton Borough Council. The minor adaptations service is commissioned by Halton Borough Council and provided by Helena Partnerships Ltd The Disabled Facilities Grant works are managed by Halton Borough Councils Home Improvement Agency
The evidence base

Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes	
HBC Public Health document "Future Impact of Demographic changes on unplanned hospital care in Halton" identifies areas with potential for increased demand over the next five years in relation to changes in demographics of the borough. In Halton, more than 1 in 5 people (21.4%) are living a greater proportion of their lives with an illness or health problem that limits their daily activities. In November 2012, 7,780 (9.4%) working age adults were claiming Incapacity Benefit (now Employment Support Allowance). This is higher than the North West and England averages and most of these people have been receiving this benefit for more than three years. As more services are being delivered in people's own homes then it is self evident that changes to the physical environment and the provision of equipment is required to support this	
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan	
2014/15 **£0**	**2015/16** **£1,644,000**
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below	
This scheme contributes to: • Improved quality of life • Increasing a person's independence • Maintaining independence • Assisting recovery • Support carers to provide safe care • Reduction in falls and associated hospital admissions • Delaying need for more formal care • Improved wellbeing and mental health • Improved dignity and respect	
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?	
Monitoring of efficacy will be through monthly performance reports to the Better Care ECB including: • Total number of adaptations • Number/% completed within target timescales • Total number of equipment items delivered	

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

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

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

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

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

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

Managing increased complexity in the community

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

ANNEX 1 – Detailed Scheme Description

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

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

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

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

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

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

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

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

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

A review carried out by the Liverpool Public Health Observatory in 2010 highlights a number of benefits of providing a whole system integrated wellness service, including benefits to the service user, cost benefits,

The benefits to the service user

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

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

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

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

2014/15	**2015/16**
£0	**£20,000**

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

This scheme will contribute to:

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

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

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

ANNEX 2 – Provider commentary

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

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

For HWB to populate:

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

For Provider to populate:

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

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

PLEASE SEE ATTACHED ANNEX 2 (PDF)

Support from Acute Providers

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

Our Ref	EST/BCF
If you telephone please ask for	Emma Sutton-Thompson
Your ref	
Date	19th November 2014
Telephone	0151 511 7398

LETTER OF SUPPORT FROM ACUTE TRUSTS

In addition to the evidence supplied through the initial Annex 2 forms, we can confirm that both Warrington and Halton Foundation Trust and St Helens and Knowsley Hospitals NHS Trust are in support of the direction of travel within the BCF.

Following several discussions with both Trusts the initial 4.4% reduction in non-elective admissions that we had identified was reduced down to 3.5%. It has been agreed that we will work in partnership to achieve the reduction following assurance of Halton's Better Care Fund Plan.

We are in support of the above statement.

Mr Ian Stewardson
Director of Service Modernisation
St Helens and Knowsley Teaching Hospitals NHS Trust

Mr Simon Wright
Deputy Chief Executive and Director of Operations
Warrington and Halton Hospitals NHS Foundation Trust

Communities
Runcorn Town Hall, Heath Road, Runcorn, Cheshire WA7 5TD
Tel: 0303 333 4300
www.halton.gov.uk

 Agenda Item 6c

REPORT TO:	Health Policy and Performance Board
DATE:	10 March 2015
REPORTING OFFICER:	Strategic Director, Communities
PORTFOLIO:	Health & Wellbeing; Community Safety
SUBJECT:	Safeguarding Adults update
WARD(S)	Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To update the Board on key issues and the progression of the agenda for safeguarding 'vulnerable adults' (i.e. adults at risk of abuse) in Halton. This report outlines for the Board an analysis of financial abuse arising from the use of Direct Payments.

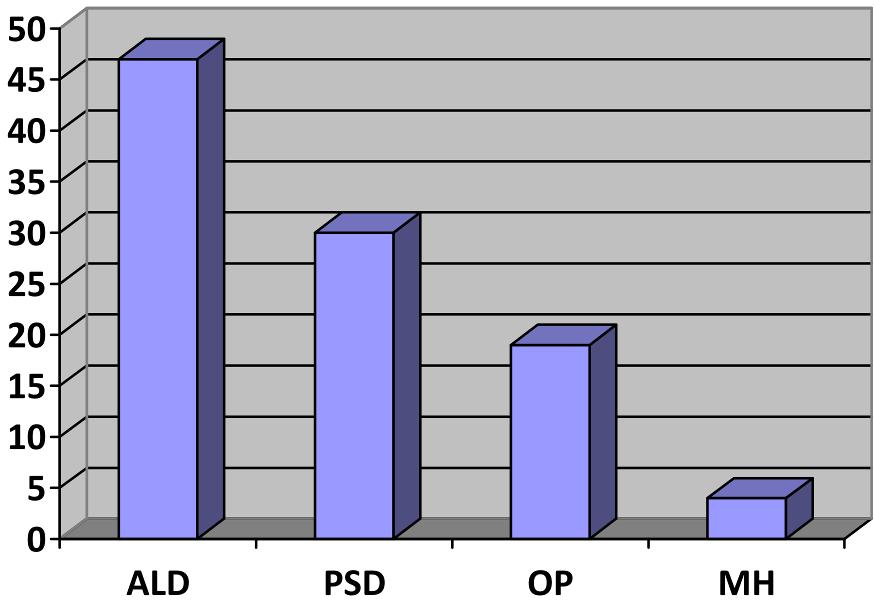
2.0 **RECOMMENDATION: That the Board note the contents of the report.**

3.0 **BACKGROUND INFORMATION**

3.1 One of the biggest shifts in social care over recent years has been the rise of 'personalisation' also known as 'self-directed support'. Instead of directly providing services, councils give cash payments directly to individuals to make their own care arrangements. The advantage of this is to increase individual's independence by giving people more choice, flexibility and control over the way services they receive are delivered. Direct payments are cash payments made in lieu, either fully or partly, of services from local authority social services.

3.2 As the personalisation agenda has grown it has expanded to include personal budgets, which are an allocation of funding given to users after a social service assessment of their needs. Users can either take their personal budget as a direct payment, leave councils with the responsibility to commission the services or they can have a combination of the two. Since October 2014 this has been further developed to include personal health budgets. This has been a duty placed on Councils since 2009 and is included in the Care Act 2014.

3.3 In Halton the numbers of people in receipt of a direct payment has increased from 311 in 2011/12 to 415 to date, representing an increase of 33%. In Halton there are more adults with learning disabilities receiving direct payments than any other client group. Of these people we have had no incidents of reports of financial abuse due to the use of direct payments.



3.4

There are stringent thorough procedures in place for all direct payment applications and subsequent payments are subject to monitoring by the Direct Payments Team (DPT) in accordance with CIPFA guidelines. Any discrepancies are thoroughly investigated. The whole process is also subject to internal audit review as part of the risk assessed audit plan.

The sums involved in direct payments can be significant. The main risks associated with direct payments are:

- Person controlling the direct payment account not using the money to pay for the care of the vulnerable adult;
- Family member gaining access to the direct payments account and misappropriating the money so that care costs could not be paid;
- False or exaggerated claims of care requirements which would include a person falsely claiming that they require care, using false identities or exaggerating the amount of the care that they require;
- Fraud perpetrated directly against the service user by someone managing their funds which would include misappropriation of funds made by way of direct payment to the service user, perhaps by a family member or other trusted person; and
- Fraud perpetrated by the provider of the care commissioned directly by the service user which might include under provision of services (e.g. not providing the hours of care contracted for), over-charging for services provided and duplicate invoicing to multiple invoices to local authorities.

3.5

The audit monitoring process in Halton is robust and limits the opportunity for fraud. Every person receiving a Direct Payment has a face to face audit monitoring visit twice yearly (in some instances this is quarterly). The benefit of these visits also allows the DP Officer to talk to the Client or Suitable Person managing the direct payment and to discuss in detail anything that causes concern to either party. If the

3.6 client feels that they need re-assessing or circumstances have changed, the DP Officer can then refer back to the Care Management Team accordingly.

DP clients need to keep detailed records, which are outlined in the Personal Budget/Personal Health Budget Agreement, including original invoices/receipts, original bank statements and each DP Officer receives detailed accounts including payroll information from each payroll company the client uses, to enable a detailed audit to be completed.

3.7 Part of the managed account audit monitoring process is to check invoices. Because the Client is not paying the invoice directly, the 3rd party Managed Account Provider is, there is a risk that hours of care provided could be inflated. Therefore to mitigate this risk, the DP Officer checks the hours against the support plan, and if the hours claimed exceed the hours in the support plan, this is thoroughly investigated with the agency/Personal Assistant and Care Management. Care Management Teams are aware of the stringent monitoring arrangements in place and regularly contact the DP Officers prior to reviewing a client's support plan to check that there are no issues from an audit perspective.

3.8 There is no single risk factor involved with financial abuse and when this type of abuse occurs it is extremely difficult to rectify. Preventative measures and public awareness are key factors to reducing this threat. Halton's Safeguarding Adults Board has recently requested a task and finish group be established with key partners to develop a toolkit to support staff in improving the safeguarding response to protect vulnerable people. The toolkit will cover preventative measures and guidance on how to signpost victims or potential victims to the appropriate support and advice.

3.9 The Safeguarding Unit is also working with the Marketing, Design and Communication department to refresh its safeguarding materials and devise a campaign for raising public awareness. Halton's Adult Safeguarding Board will continue to monitor the figures for financial abuse within Halton.

4.0 POLICY IMPLICATIONS

4.1 A review of all existing policies and procedures will be completed in light of the Social Care Act 2014.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 None identified.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

The Safeguarding Adults Board (SAB) membership includes a Manager from the Children and Enterprise Directorate, as a link to the Local Safeguarding Children Board. Halton Safeguarding Children Board membership includes adult social care representation. Joint protocols exist between Council services for adults and children.

The SAB chair and sub-group chairs ensure a strong interface between, for example, Safeguarding Adults, Safeguarding Children, Domestic Abuse, Hate Crime, Community Safety, Personalisation, Mental Capacity & Deprivation of Liberty Safeguards.

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

None identified.

6.3 **A Healthy Halton**

The safeguarding of adults whose circumstances make them vulnerable to abuse is fundamental to their health and well-being. People are likely to be more vulnerable when they experience ill health.

6.4 **A Safer Halton**

The effectiveness of Safeguarding Adult arrangements is fundamental to making Halton a safe place of residence for adults whose circumstances make them vulnerable to abuse.

6.5 **Halton's Urban Renewal**

None identified.

7.0 **RISK ANALYSIS**

7.1 Failure to address a range of Safeguarding issues could expose individuals to abuse and leave the Council vulnerable to complaint, criticism and potential litigation.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 It is essential that the Council addresses issues of equality, in particular those regarding age, disability, gender, sexuality, race, culture and religious belief, when considering its safeguarding policies and plans. Policies and procedures relating to Safeguarding Adults are impact assessed with regard to equality.

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

9.1 None under the meaning of the Act.

 Agenda Item 6d

REPORT TO:	Health Policy and Performance Board
DATE:	10 March 2015
REPORTING OFFICER:	Strategic Director – Communities
PORTFOLIO:	Health & Wellbeing
SUBJECT:	Care at Home Scrutiny Review 2014/15
WARD(S)	All Wards

1.0 PURPOSE OF THE REPORT

1.1 To present to PPB the report and recommendations of the Care at Home Scrutiny Review 2014/15

2.0 RECOMMENDATION: That the Board note the contents of the report attached at appendix 1

3.0 SUPPORTING INFORMATION

3.1 The report outlines the key findings and makes a number of recommendations for consideration by Health PPB.

3.2 The group sought evidence from a number of sources that enable people to remain living well within the community and provide care at home. Contributors included: Sure Start to Later Life, Community Nursing, HBC Quality Assurance Team, Lifeline/Community Warden Service, Enablement Team and Extra Care Housing.

The recommendations from the group were:

3.3 **Research the evidenced base for *predictive and assistive* technology tools that could be used as part of the prevention and early intervention agenda, and the cost/benefits to potential investment.**

3.4 Scoping of available, or developing, predictive and assistive technologies to:

- Utilise assistive technology to address loneliness
- Identify where these existing assistive technologies can be utilised within Halton and work with partners to achieve this.
- Support the Dementia Technology Charter by providing user friendly resources/information for people trying to access assistive technology

3.5 Outcomes that could be achieved through investment technology must be clear and evidence based. Outcomes should be as much about quality of life and added value, than just 'cost efficiency'.

Investment in predictive and/or assistive technology must be underpinned with investment in well trained quick responders and staff who are customer focused and appropriately skilled.

3.6 **Adult Social Care to be consulted on/contribute to any developments in the provision of tele*health* to help people maintain independence.**

3.7 Adult Social Care Telecare/assistive technology services should be consulted with in the development of *telehealth* technology in Halton, in light of the Integrated Technology Strategy, and the desire to have truly integrated systems. Any potential for integrated telecare/health systems should consider the funding implications and cost to the user in light of personal/health budgets.

3.8 **The Sure Start to Later Life Service (SSLL) should continue to have an important role in delivering personalised wellbeing outcomes.**

3.9 There continues to be a need to provide a range of preventative interventions later in life , ensuring that older people are targeted with active ageing opportunities. This should include the use of technology and maintaining links between health and social care to develop innovative ways to engage older people.

3.10 Members should be kept informed of progress against the actions contained in the Halton Loneliness Strategy.

3.11 **Attended care and support provision within extra care housing schemes**

3.12 Expectations about the role of staff in supporting tenants may vary between providers of extra care and so their role needs to be made explicit in the contract between the provider and the prospective tenant. This is especially relevant in schemes where there is currently no ‘on site’ provider during core hours.

3.13 As Naughton Fields continue to move towards the 30/40/30 ratio of care needs the model for care provision at that site should be monitored to ensure that the spot purchase approach continues to meet the needs of residents.

3.14 **Community Nursing Services**

3.15 In reviewing the service specification, Halton HHS CCG should consider the current and anticipated levels of activity and increasing demands to ensure that the appropriate level of funding is invested. Liaison with other professionals as part of the review may help identify gaps in the service and opportunities to promote integration between health and social care to further improve outcomes of people accessing the service.

3.16 **Quality Assurance**

3.17 The Council's Quality Assurance Team will have an increased role in market oversight, supporting quality improvements and preventing provider failure as a result of the Care Act.

3.18 There is, and should be, a continuous cycle of work with providers to improve quality and deliver person centred outcomes.

3.19 Health PPB should be updated on the implications of the Care Act on the Quality Assurance Team (market oversight) in Autumn 2015

3.20 The Care at Home Scrutiny report and recommendations will will go for information purposes to NHS Halton CCG, Bridgewater Community Health Care NHS Foundation Trust, Halton Housing Trust, Liverpool Housing Trust, Domiciliary and Residential provider's forum.

4.0 POLICY IMPLICATIONS

4.1 The policy implications of pursuing any course of action arising out of the recommendations will be highlighted, as appropriate, through the usual reporting channels.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 The financial/resource implications of pursuing any course of action arising out of the recommendations will be highlighted, as appropriate, through the usual reporting channels.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**
No implications

6.2 **Employment, Learning & Skills in Halton**
No implications

6.3 **A Healthy Halton**
The recommendations contained in this report relate directly to the health and wellbeing of individuals who access care and support within the community. Provision of high quality care, closer to home, supports independence and positive outcome for individuals.

6.4 **A Safer Halton**
No implications

6.5 **Halton's Urban Renewal**
No implications

7.0 **RISK ANALYSIS**

7.1 None identified at this time

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None identified at this stage.

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

None under the meaning of the Act.

Health Policy & Performance Board

Scrutiny Review of Care at Home

Report
March 2015

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1.0 PURPOSE OF THE REPORT

1.1 The purpose of the report is to present the findings of the scrutiny review, which:

Focused on the quality of Services provided to those who are supported to live at home within Halton. It examined the services that are already in place with a view to evaluating their effectiveness in meeting the needs of the local population. In addition the topic group examined access to other services e.g. Health Services that individuals supported to live at home have.

1.2 The full topic brief can be found at *Appendix 1.*

2.0 POLICY AND PERFORMANCE BOARD (PPB)

2.1 This review was commissioned by the Health PPB in June 2014. This report will be presented to Health PPB in March 2015. The report will also be presented to Communities Directorate Senior Management Team, Executive Board and boards or committees of stakeholders, as appropriate.

3.0 MEMBERSHIP OF THE TOPIC GROUP

3.1

Councillor Ellen Cargill (Chair)	Marie Lynch Divisional Manager, Care Management
Councillor Sandra Baker	Emma Bragger Policy Officer, Communities
Councillor Joan Lowe	
Councillor Pamela Wallace	
Councillor Chris Loftus	
Councillor Martha Lloyd-Jones	
Councillor Pauline Sinnott	
Mr Tom Baker (HealthWatch)	
Mrs Mary Baker (carer)	

4.0 METHODOLOGY

4.1 This scrutiny review was conducted through the following means:

- Information pack provided to Topic Group Members outlining national and local picture of care at home, summary of the key care at home services delivered in Halton, quality monitoring of care at home provisions, emerging issues facing care at home services and future delivery in Halton.
- Monthly meetings of the scrutiny review topic group;
- Presentations by various key members of staff ;
- Site visits, at which there was opportunity for service-user contribution.
- The final draft of this report was circulated to participating staff to check for accuracy.

4.2 The above methods enabled Member's to:

- Have an understanding of some of the elements of existing Care at Home provision in

Halton.

- Have an understanding of the role that partner agencies play in the provision of care provided to those living at home.
- Have an understanding of the different elements of service monitoring that take place in respect of this area of provision.

4.3 Which enabled Member's to consider, in making recommendations,

- National best and evidence based practice, and how it can be applied in Halton.
- Ways to continue to make improvements to services to ensure they continue to be effective in meeting the needs of the population of Halton.

4.4 The Chair and Members of the Topic Group would like to extend their thanks for the cooperation and contributions made by all those who have taken part in the review.

5.0 INTRODUCTION

5.1 As people get older, they are increasingly likely to need care at home.

5.2 In 2010/11, nationally an estimated 543,000 service users received home care of which 81 percent were aged 65 and over, and as our population ages, more people will inevitably need care at home in the future.

5.3 In terms of increases in the number and proportion of older people in the UK population, the percentage of persons aged 65 and over increased from 15 per cent in 1985 to 17 per cent in 2010, an increase of 1.7 million people. By 2035 it is projected that those aged 65 and over will account for 23 per cent of the total population.

5.4 Within Halton, the older people age group (65+) are projected to grow by 33% from 17,300 in 2010 to 25,700 in 2025.

5.5 Nationally, Councils with Adult Social Services responsibilities purchased or provided 200 million contact hours of home care during 2010-11, an increase of 13 per cent on 2005-06 and the percentage of contact hours provided by the independent sector (private and voluntary sectors) has been steadily increasing over the past few years, with 72% of hours being provided back in 2005-06 to 87% being provided in 2010-11.

5.6 Studies show that older people would prefer to stay at home until it is impossible for them to do so rather than move into residential care and that the benefits of home care are enormous, both to individuals and to the state. Home care provision also costs less than a place in residential or nursing care. In 2008-09 the national average weekly cost to local authorities for an older person in residential and nursing care was £497. In contrast, the average weekly cost of home care was £145[i].

6.0 EVIDENCE CONSIDERED BY THE SCRUTINY TOPIC GROUP

1) Overview by the Divisional Manager for Independent Living

6.1 The Divisional Manager presented an overview of the universal and targeted community services for people with low level needs, vulnerable people and those with complex needs.

6.2 Examples were given to illustrate how services are used to mobilise people in and around the community, support people to remain well at home, reducing social isolation and supporting people with complex needs within the community. Information about reablement services, assistive technologies and intermediate care facilities was also provided.

6.3 The Divisional Manager answered a number of questions about the effectiveness of these services, the impact on the individuals accessing the services and emerging issues and pilot work that is currently underway to further enhance care at home services.

Conclusion

6.4 As a result of the overview given the group were able to identify particular areas on which to focus their review. These areas were: The role of technology, extra care housing, reablement services, prevention and social inclusion, community nursing and quality assurance.

6.5 It was acknowledged by the group that despite the tough financial climate, and savings that have had to be made locally by the local authority and health partners, during 2013/2014 Halton has maintained a broad range of services to support people with a health and/or social care need to live well within the community.

2) Using technology to live well and independently

6.6 The Telecare Lead Development Officer and the Community Warden Service Officer provided information to the group about the service available in Halton. Telecare has been defined by the Department of Health as a service that uses 'a combination of alarms, sensors and other equipment to help people live independently. This is done by monitoring activity changes over time and will raise a call for help in emergency situations, such as a fall, fire or a flood ' (Department of Health 2009)

6.7 Halton Borough Council provides an accredited Telecare service delivered by a dedicated Telecare team and a Community Warden team, both supported by the Halton Borough Council Contact Centre. Halton has used Telecare since 1989. The service is audited by external organisation Telecare Service Association (TSA), and uses the Telecare Services key performance indicators. The service is currently accredited TSA Platinum and European Standard.

6.8 The teams provide 3 levels of service 24 hours a day, 365 days a year, supporting people with the use of Telecare sensors in their own homes. The service is able to provide remote and standalone monitoring technology.

1. **Service Level 1**
   Community Alarm Emergency Response Service
2. **Service Level 2**

Telecare Service Environmental Monitoring

3. **Service Level 3**
   Telecare Service Lifestyle / Environmental Monitoring

6.9 The types of conditions and situations that Telecare is currently supporting include; Reducing risk of, or notifying risk of falls, seizures, wandering, hyperthermia, health issues, reminder prompts, fire, floods and security (this is not an exhaustive list).

6.10 The benefits that Telecare service achieves includes:

- Promotes Independence and Choice
- Personalisation Agenda
- Manage Identified Risks
- Enables speedy discharges from hospitals
- Prevent Hospital Admissions
- Prevent / Delay Residential Placement
- Early Intervention and Prevention
- Enables people to remain in their own homes longer

6.11 During 2013/14 the Telecare Team saw a total of 1063 referrals with 188 connections to Telecare levels 2 and 3. There were 89,610 control centre /dwelling calls (to the contact centre), resulting in 8359 Community Warden call outs.

6.12 The service has been able to demonstrate a cost benefit to the NHS locally. During Quarter 1 2014, Community Wardens attended 183 falls at which they were able to assist the persons without any further involvement from the health service. Had the Telecare service not been installed then an ambulance would have been called to assist. Average cost of an ambulance call £247 X 183 cost saving of £45201 to NHS. (Source of Ambulance call cost Oxford Mail story 25/02/2013 Ambulance cost. NW Ambulance call out cost not available at this time).

6.13 A sample of 409 (20%) 'Service User Annual Review Questionnaires' and 'Post Installation Reviews: 2-6 weeks' were analysed for comments about the quality of the service provided[ii].

- **100%** of individuals reviewed considered that the Community Alarm Service met their needs, were satisfied with the service they were receiving and were given enough support using the equipment.
- **100%** reported that they would recommend the service to family and friends
- **99%** were pleased with the speed of the response they received from staff
- **99%** of those needing assistance found the staff friendly and helpful
- **100%** indicated it was Value for money service.
- Overall opinion of the service was:
  71% Excellent
  28% Good
  1% Adequate
  0% Poor

6.14 There is currently no issue with capacity of the service. Any significant increase in demand for lifeline services would have an impact on the lifeline infrastructure

(number of phone lines needed on the lifeline system), and operationally in delivering assessments and interventions to meet demand.

6.15 The cost of the Lifeline service is currently: level 1@ £5.64 , level 2 @ £6.75, level 3@ £9.00 per week.

Conclusion

6.16 Emerging issues for the team include investigating technologies to monitor daily living activities in the home and use this information as an early assessment tool, and investigating the use of mobile technologies to help support vulnerable people away from the home.

6.17 Service user feedback and involvement in the development of the Telecare service could be improved. It was noted that for one service user event, although 1000 flyers were circulated, only 3 service users attended. There needs to be some thought given to how customer views are gained, and where there is a use of marketing techniques, these should be suitable for the needs of the people who are in receipt of the service. One way of further promoting the service, and gaining user feedback, would be to engage at a greater level with community and support groups who may have members or carers who would benefit from understanding how technology can help maintain independence etc.

3) Planning for the use of technology to support health and wellbeing outcomes

6.18 Halton Borough Council and Halton NHS Clinical Commissioning Group Director of Transformation attended the September Scrutiny Review meeting to provide an update on the development of the Integrated Health and Social Care Technology Strategy.

6.19 A priority of the strategy is to enable health and social care IT systems to ‘talk’ to each other (intropability). By sharing patient information between agencies it is anticipated that this will support more efficient interactions. The strategy will also incorporate Tele health and Telecare.

6.20 The strategy will look at wider systems that could influence the provision of technology, including how financial investment can lead to increase usage.

6.21 The group were informed that the draft strategy will go to Health PPB and members will have opportunity to comment.

Conclusion

6.22 The group agreed that there is a need for greater emphasis on technology, including assistive technology, in the delivery of health and social care services to be able to meet the changing and complex demands of our local population. This may involve an ‘invest to save’ approach, and business cases will need to be robust to demonstrate cost /benefits of any investment in technology.

6.23 The benefits of having 'joined up' IT systems between health and social care partners in being able to provide seamless interventions is clear. However, some degree of caution will need to be exercised about the potential implications of data sharing. There will be wider reaching implications of 'intropability', which may mean modifying procedural ways of working. True integration of IT systems is likely to be some time away, but health and social care partners should approach negations with an open mind, with the joint vision of providing safe and quality services to health care patients and social care service users in Halton.

6.24 The use of assistive technology supports the personalisation of health and social care, and when used as part of an early intervention approach can be effective in reducing long-term demands on social care and increasing service capacity.

6.25 The group are clear that there are many potential benefits of the use of technology in supporting people to live independently and well within the community, but emphasise the need to put in place measures to ensure that technological advances in Tele health and Tele care do not come at the cost of human contact with patients and service users, where this would make the greatest difference to them. This could lead to the person being more socially isolated, which can affect emotional health. Recognising that difficult decisions relating to budgetary constraints will need to be made, the cost/benefit of human contact will require particular attention when faced with the situation where use of technology may be more cost effective than human resource.

4) Promoting active aging, independence and participation within community life.

6.26 The Principal Manager of the Sure Start to Later Life(SSLL) service gave the group an overview of the key activities of the service and how they are helping people remain independent, improve quality of life and in some cases, delay the need for more intense care and support. The service was initiated in 2006 as a government programme, but Halton are one of the few remaining authorities that still have a SSLL service.

6.27 The service provides information and support to people to reduce social isolation and improve quality of life for older people. Referrals come from a number of different routes. The aim of SSLL is to support relationships for service users, if that is what they wish, not replace social and emotional relationships or create dependant relationships with professionals. Being part of the Health Improvement Team, SSLL have access to a number of health prevention activities and services, along with wellbeing activities that SSLL signpost to.

The service offers:

Information Officers

6.28 Information officers undertake information needs assessments with people who are referred. They inform and sign post about the wide variety of local activities available to them. These officers visit people in their own homes.

Volunteer Befriending Service

6.29 The service has 6-13 volunteers at any one time. SSLL received referrals from Silverline – which is a telephone friending service for older people

Day Trippers

6.30 Around 36 trips out per year are offered to older people by the Day Trippers group. The group, of which there are approximately 300 on the register, decide where the trips are. There is door to door pick up/off. The trips are made affordable by working in collaboration with Halton Community Transport.

Care Home Activities

6.31 SSLL work closely with care homes by visiting residents to provide information and signposting and identifying with care homes what activities residents may wish to access. SSLL also work with the homes and residents to encourage take up of activities outside of the home. There is also a care home/school twinning project that SSLL supports.

Collaborative working with other teams and agencies to reduce social isolation

6.32 SSLL work with HBC Community Development and Health Improvement Team to look at how short term groups can have greater sustainability and bring positive outcomes to those who use them. SSLL is part of the Partnership for Prevention group, which brings together a number of key agencies who work on the prevention and early intervention agenda. SSLL are working with Community Development in the wards to speak to residents to see what they would make a difference to them in growing older in their area. Recent outcomes include the provision of benches in Windmill Hill.

Loneliness and Isolation screening and support

6.33 SSLL do screening for loneliness and social isolation, and have recently participated in the Living Well Pilot, which does memory screening, working closely with GPS who make referrals into the SSLL service.

Visbuzz

6.34 A 12 month pilot that uses easy use video calling for older people who are at risk, or experiencing, loneliness and/or social isolation. The aim of the pilot is not to replace human contact, but to make contact with loved ones, carers, professionals easier for people who may be vulnerable to social isolation/loneliness.

Measuring outcomes

6.35 There is an outcomes framework in place to capture qualitative information and case studies, to be able to show the impact of the services on outcomes for people. It is acknowledged that it is difficult to quantify the impact of preventative work, but the Principal Manager gave examples of recent outcomes for service users who have benefited from information provision and access to groups in improving their independence and quality of life. Case studies illustrating outcomes for SSLL users can be found in Appendix 2

Conclusion

6.36 Part of SSLL's success comes from having a single referral gateway to wide ranging services in the community, where potential problems are identified quickly and prevented from becoming worse.

6.37 Halton has an ongoing commitment in investment, strategy and activity to support the prevention and early intervention agenda. Local demographics and projected needs of our aging population suggest that the kinds of activities provided by the SSLL team will remain an important part of helping people live well in the community.

6.38 Increasing the number of volunteers and providing them with appropriate training would increase the capacity of the service to provide befriending services, but also other aspects of the service. Recruiting volunteers from the SSLL target demographic may enable the service to have an increased understanding of the needs and demands of the target profile, but also offer opportunities to the target demographic to take an active role in the community.

5) Enabling people to remain living in the community after a decline in health and End of Life Services

6.39 The Principal Manager for Enablement gave the group a verbal presentation on the reablement service. Reablement is a short and intensive service, usually delivered in the home, which is offered to people with disabilities and those who are frail or recovering from an illness or injury. The purpose of reablement is to help people who have experienced deterioration in their health and/or have increased support needs to relearn the skills required to keep them safe and independent at home.

6.40 The staffing structure is made up of a Registered Manager, Assistant Manager, Coordinators, Care and support staff. All staff are contracted with Halton Borough Council and undertake a comprehensive training programme.

6.41 Staffing levels to manage the 24 hour services were reported by the Principal Manager as being good. There is a bank of casual staff and regular agency staff (agency staff are used as infrequently as possible) which can be called on to cover periods of holiday and sickness cover.

6.42 As the 24 hour services are now managed by one management team, staffing resources can be shifted to cover high demand/emergencies. All casual/frequent agency staff have the same checks and training as permanent staff.

6.43 The 24 hour reablement services are made possible by the close working with Social Care and the CCG to be able to provide a holistic health and social care service to people within their own home.

6.44 The service is regulated for personal care and is subject to inspection by the Care Quality Commission (CQC).

6.45 The service receives referral from hospitals and community based professionals. Between April 2013- April 2014 the Reablement Service had 486 referrals, with 69% being for people aged 75+. 39% of referrals had their needs classified as 'high'. The average length of service was 31 days.

Early Supported Discharge

6.46 Early Supported Discharge is where carers provide care and support, as part of a multi disciplinary team, providing outreach specialists such as stroke rehabilitation in the patients home. This is a service for people who can be discharged from hospital with intensive support at home. Occupational Therapists and physiotherapists are among a range of professionals who support this service. Between April 2013-2014 the Early Supported Discharge Service had 32 referrals to the service, resulting in no readmissions to acute services, 248 acute bed days saved 25% discharged as independent and 50% discharged with reduced support from when originally referred.

Night Service

6.47 Night Service provides social care and health care checks for people .This service is for people who are assessed as needing support during the night, i.e. catheter care, continence needs. Providing this care at home can prevent the need for care home admission in many cases. Between April 2013 and 2014 the Night Service had 14 people on the caseload, with a length of stay on the service in excess of 12 months. 2 of the 14 have 2 visits per night.

End of Life Care

6.48 End of life care provides sensitive social care and comfort at home. It aims to enhance dignity and choice for those people who are at the end of their life. The CCG commissioned Community Nursing service delivers the health elements of end of life care. Between April 2013 and 2014 the End of Life Service had 122 referrals, with an average length of service being 36 days and 72% deceased at home (preferred place of care).

Conclusion

6.49 Preferred place of care and advanced care planning are priorities for the service.

5) Housing Providers , health and social care supporting people to remain living within the community.

6.50 A number of the Scrutiny Topic Group, made a planned visit to Dorset Gardens extra care housing scheme in Runcorn and Naughton Fields in Widnes. The visits were facilitated by the Registered Manager. The group had a tour of the buildings, spoke with the Senior Care and Support Workers on duty and people who have tenancies at the two schemes. A report from the visits can be found in Appendix 3

6.51 As a broad definition, extra care housing is a model that combines purpose-built and ergonomically-designed housing for older people with onsite flexible care that adapts to residents' changing needs and allows them to retain their independence. A 'home from home' feel is also a key aspect, which is achieved through the self-contained design of the housing units, as well as resident participation on management committees.

The main findings can be summarised as:

6.52 ***Care and Support*** –Care and support is delivered by different models in the two schemes. Dorset Gardens care and support is delivered by local authority staff based on site between core hours, with community warden and lifeline services available outside of these hours. In contrast, Naughton Fields care and support is delivered by a number of spot purchase providers. There is no care provider on site to deliver general care to tenants as and when required. The model at Naughton Fields was adopted based on the needs of residents when the scheme opened. There is a Housing Support Officer who provides support to tenants on housing related issues (whose role does not include the delivery of direct care).

6.53 Having the local authority carers on site at Dorset Gardens enables quick response to any needs that occur with little or no warning, and a consistency and knowledge of the dynamics between tenants to be able to identify when people's needs are changing.

6.54 The care given by providers at Naughton Fields is purchased on an individual basis, which is reflective of how domiciliary care is provided within the wider community. Those who are on the Life Line service have access to a quick response.

6.55 Within Dorset Gardens independence is promoted within the schemes and the 30%/40%/30% ratio of low, medium and high need tenants enables those with more complex requirements to live alongside those with no, or low needs, fostering pockets of peer support within the schemes. Naughton Fields is working towards a similar approach.

6.56 ***Integration with the wider community*** - The group were informed about the use of the facilities within both of the schemes by the wider community, which has been personally witnessed by members of the group. Enabling tenants to be integrated with the community was promoted by having a public access café and holistic therapy rooms. It was noted by the group the importance of providing opportunities for tenants of the schemes to engage in the wider community, and likewise, the importance of the scheme offering opportunities for the wider community to engage with tenants. Whilst this might largely be through planned activities and the scheme facilities (such as the cafes), it will contribute towards the wider community understanding the purpose of extra care housing and breaking down perceptions about how extra care housing operates, and the opportunities for people to remain living within the community with appropriate support. Members of the group felt that the housing schemes provided an opportunity to foster greater intergenerational integration through offering opportunities to link up with schools in the area, being encouraged to get involved in the activities taking place within the schemes, and supporting relationships with residents.

6.57 ***Quality of the physical environment*** - The group commented on the overall high standard of cleanliness, quality of the décor in communal areas and the lay out of the residential units throughout both of the schemes. Where applicable, housing adaptations have been undertaken to ensure that individuals homes can meet their needs. Members of the group commented that Riverside and Halton Housing Trust, as

the landlords, and Halton's Social Services should take pride in their achievements with these schemes. Tenants can influence the quality of environment through Tenants Committees, fund raising etc. This is encouraged and was viewed by the group as being an important part of the tenants' independence to have influence over the communal living areas, as well as within their own homes.

Conclusion

6.58 Overall the group felt that the environments support available and facilities were of a high standard, and that there were systems and processes in place to meet preventative and reactive support needs.

6.59 Whilst there were established quality and safeguarding processes in place within the extra care schemes, there is a risk that some cohorts of tenants, such as those with restricted mobility, cognitive impairment or learning disabilities, may be at similar risk of social isolation and safeguarding concerns, as those resident in the wider community in receipt of care and support.

7) Care provided within the home (Domiciliary care)

6.60 The Chair of the Health PPB and a Monitoring Officer from HBC Quality Assurance Team made a visit to clients who receive services from Just Care, a HBC commissioned domiciliary care provider, to gain an insight into the type of support available from domiciliary care providers.

6.61 The first client that was visited had a diagnosis of dementia and lived alone, with four visits from Just Care and support from family.
The client's daughter was present during the visit and both she and the client, expressed satisfaction with the Carers who attend to the client's support needs.

6.62 Through discussion, the Monitoring Officer identified that the client was not fully aware of the communication process if she were to become dissatisfied at any point in the future. Client's knowledge of the comments and complaints procedure is an important part of the quality process, and whilst the client and daughter did known the phone number of Just Care they did not have HBC contact details. These details were in place but they were at the back of the client's Care Plan Folder.
The Monitoring Officer arranged with the Just Care Office for this to be in a more prominent position in the Care Package Folder, as it is an important part of ensuring that clients are aware of the complaints process and how to notify HBC.

6.63 A second set of clients were visited (husband and wife). They were an elderly couple who were both receiving care in their own home. The wife had been diagnosed with dementia, although her husband had not got a dementia diagnosis, he had been diagnosed with memory problems. The couple were supported by their son and granddaughter, as well as having Care visits four times a day.
They both expressed that they were happy with care they received.
They praised the Just Care Staff, especially in the area of communication.

6.64 After some discussion it was apparent that the husband had been experiencing some falls, and although the Carer had been present at one of the fall's, there did not

appear to be any action plan in place. As a meeting with the Just Care Manager had been arranged for the following day, this was taken up with them at that time.

6.65 At the meeting with the Manager and Assistant Manager at the office of Just Care , it was discussed that the provider did not adopt any zero hours contracts. The majority of the care staff they employed were mothers who wished to work in the region of 16 hours per week, which would enable them to receive the benefits they were entitled to and was also convenient for the carer's with children in school.

6.66 The visits that were commissioned seemed to be adequate as carer's were recording that they were able to do medication visits in the time allotted. It was explained 'no user of the service would be left wanting' and that carers gave sufficient time with clients to ensure that they were happy and settled before they left.

6.67 They received all the required training, which is done in house and in conjunction with Halton Haven.

Conclusion

6.68 The role of carers inevitably means that a number of their clients may be nearing end of life. From discussions with the 3 clients on the visits undertaken, it was clear that for them, having the same carer each day made a big difference in building relationship and trust. This relationship should, wherever possible, be maintained during end of life care. This will require carers to have a suitable level of training and skill to enable them to deliver appropriate support at end of life. Awareness raising and training opportunities in other areas should continue to be promoted to providers through the Provider Forums. This can include promotion of services such as the Falls Prevention Service.

8) Health care nearer to home

6.69 The Clinical Manager of Halton Community Nursing and the Service Manager for Adult Community Nursing gave a presentation outlining the Community Nursing services that is delivered in Halton. The service is delivered by Bridgewater Community Health Care NHS Foundation Trust (Bridgewater).

6.70 The CCG are currently reviewing Community Nursing within Bridgewater. A revised specification is due in March 2015 to deliver a more integrated model of care that reflects the changes within primary care. Historically, commissioning of Community Nursing across the country has not always been activity based. This is now changing and the new specification will reflect the levels of activity undertaken by the Community Nursing teams in Halton.

6.71 Main services offered include: home visits to patients that are unable to leave their home and treatment room/clinics within the local community. Types of interventions include: assessment of needs, wound management, administration of medication (if an individual cannot self-administer) and end of life care. The service is not intended

to be a rapid or acute response service, and works with other partners to deliver services within the home (including intermediate care). Urgent response times during out of hours are within 4 hours.

6.72 The main finding are summarised below, further information about the service and activity levels can be found in the Community Nursing presentation in Appendix 4

6.73 ***Staffing*** - The Community Nursing Team consists of District Nurses, Community Matrons, Staff Nurses and Health Care Assistants. Teams are aligned to 17 GP practices in Halton. The teams operate out of treatment rooms within the community (ie GP practices and the Healthcare Resource Centre) and provide services within people's homes where people are housebound.

6.74 During times of high demand, holidays, sickness etc staffing levels are supported by offering part time staff within the service additional hours or reconfiguring resources from the other 4 boroughs services by Bridgewater. Where the staffing levels cannot be met this way, regular bank staff may be used.

6.75 Whilst there is capacity within the wider service to gain extra cover from existing part time staff or staff from the other boroughs services by Bridgewater, the current staffing levels in treatment room and out of hours service (due to sickness levels) mean that aspects of these services are not resilient (smaller staffing numbers). There is currently scoping taking place for demand against capacity within out of hours service. All current vacancies are being recruited to, to ensure that staffing levels are maintained.

6.76 ***Referrals* -** On average, the District Nursing Teams get 600 referrals per month. There is a high volume of work generated from a referral as the majority of patients are 'complex', including regular interventions, reviews, liaison with other health and social care professionals etc. Further details regarding referrals and activity can be found in the Bridgwater Presentation in Appendix 4

6.77 ***Quality and Safety* –** There is a robust competency based training and review schedule for all staff, including regular bank staff. There are systems in place to identify 'near misses' or incidents and staff report in 'real time'. There are systems in place to respond within the same day an incident occurs. It was reported that there is a culture of support, continuous development and learning from complaints, incidents and near misses when these occur. Managers work with staff to eliminate/reduce further risks through additional training and supervision, but there are formal competency procedures in place to manage staff who continue to pose a risk to safety or quality. There are weekly incident reports analysed by managers to identify any trends. There are quarterly reviews against The Care Quality Commission's 21 elements of the compliance declaration. There is no national published safer staffing levels for community nursing however Bridgewater Community Nursing have implemented an adapted version of the 'safer staffing' tool, (intended for hospitals and bed-based facilities).

6.78 ***Patient Feedback*** - Of 565 patient surveys there was a 60% return rate for Halton patients, which was noted as an excellent return rate, and higher than the return rates for the other boroughs serviced by Bridgewater. Ninety three percent (93%) of

respondents were satisfied when contacting the service, 97% were satisfied with the waiting times and 100% were satisfied with the remaining indicators. Overall satisfaction was reported at 99%. Bridgewater are the only community trust who are reporting against 'Open and Honest Care'. Their website publicises harm data on the 'open and honest' section of their website. http://www.bridgewater.nhs.uk/aboutus/openandhonestcare/

Conclusion

6.79 Members of the Health Policy and Performance Board would like to be kept informed on the progress of the specification development and investment in this service.

6.80 Any changes to the Bridgewater specification has the potential to have implications on social care services within Halton, and this must be carefully monitored to ensure services are able to manage existing and future demands.

6) Ensuring quality of care in the community

6.81 Quality Assurance Manager gave an overview of the role of the HBC Quality Assurance Team and how domiciliary care providers are supported and monitored in the delivery of care within the community.

6.82 The new domiciliary care contract was awarded in July 2014. Seventeen providers were awarded, 12 are currently delivering. There are 5 providers not currently delivering due to there not being sufficient care hours for them at this time.

6.83 Care packages are put in place through an assessment by HBC Care Management Team who then liaise with the HBC Care Brokers within the Quality Assurance Team to broker care packages within 3 or 4 days of referral. Individuals are prioritised and where there is a need for a care package to be in place sooner than the average of 3 or 4 days, this will be the case.

6.84 Providers operate within zones. Widnes and Runcorn are both split into two zones, to enable the most effective use of staff in travelling distances from call to call etc. There are 2 key providers and a spot purchase provider in each zone.

6.85 It is predicted that there will be a continued emphasis on providing care at home. The Market Position Statement has identified that commissioners will need to discuss opportunities to develop local services with providers that can meet highly complex needs.

6.86 All the HBC providers are registered with, and regulated by, CQC. CQC monitor the minimum care standards, with the HBC service specification detailing what the provider is commissioned to deliver and specific quality measures they must adhere to. Providers are subject to regular monitoring visits undertaken by the Quality Assurance Team where performance and quality measures are scrutinised.

6.87 In addition to monitoring visits, Electronic Care Monitoring (ECM) has been used for the last 18 months, and provides a retrospective picture (a month in arrears) of what care had been delivered and reports of any near misses or incidents. This information

is analysed for trends and quality/safety issues. In addition to providers having to input ECM data, providers must also report, in real time, any incidents or near misses (ie missed calls, variation's to care plans) to Quality Assurance Team, social worker, care management health partners etc.

6.88 As part of the contract monitoring process, providers must be able to evidence that they are using the ECM data themselves, as part of internal quality assurance processes, and take actions where necessary.

6.89 There is a 'care concerns' model in place in Halton, in the same way that there is in residential care. This is used to encourage and support **all** professionals engaged with individuals to raise concerns. Providers use this as part of their quality assurance processes. Interagency collaboration is essential in monitoring quality and performance. There is a schedule of enhanced monitoring activity that takes place, which also includes service user input and visits to service users.

6.90 Service users are informed, at the initial stages of care being initiated, about who to contact in the event of a complaint. This is also provided in written form in the front of their care folder that they keep within their home.

Conclusion

6.91 The Quality Assurance Team already have mechanisms in place to provide market oversight, however, with the Care Act, the Quality Assurance Team will have an increased role in managing the provider market, providing market oversight and preventing disruption to services (through market/provider failure).

6.92 There is lots of work going on locally to work with providers to make care more personal and person centred outcome driven. An invite has been extended to Member's of the Topic Group to attend the December 2014 provider forums to speak directly with providers to see how this is achieved locally.

7.0 RECOMMENDATIONS TO HEALTH PPB

1) Research the evidenced base for *predictive and assistive* technology tools that could be used as part of the prevention and early intervention agenda, and the cost/benefits to potential investment. Health PPB to receive an update in Autumn 2015.

Scoping of available, or developing, predictive and assistive technologies to :

- Utilise assistive technology to address loneliness
- Identify where these existing assistive technologies can be utilised within Halton and work with partners to achieve this.
- Support the Dementia Technology Charter by providing user friendly resources/information for people trying to access assistive technology

Outcomes that could be achieved through investment technology must be clear and evidence based. Outcomes should be as much about quality of life and added value, than just 'cost efficiency'. Investment in predictive and/or assistive technology must

be underpinned with investment in well trained quick responders and staff who are customer focused and appropriately skilled.

2) **Adult Social Care to be consulted on/contribute to any developments in the provision of tele*health* to help people maintain independence.**

Adult Social Care Telecare/assistive technology services should be consulted with in the development of *telehealth* technology in Halton, in light of the Integrated Technology Strategy, and the desire to have truly integrated systems. Any potential for integrated telecare/health systems should consider the funding implications and cost to the user in light of personal/health budgets.

3) **The Sure Start to Later Life Service (SSLL) should continue to have an important role in delivering personalised wellbeing outcomes.**

There continues to be a need to provide a range of preventative interventions later in life , ensuring that older people are targeted with active ageing opportunities. This should include the use of technology and maintaining links between health and social care to develop innovative ways to engage older people.

Members should be kept informed of progress against the actions contained in the Halton Loneliness Strategy.

4) **Attended care and support provision within extra care housing schemes**

Expectations about the role of staff in supporting tenants may vary between providers of extra care and so their role needs to be made explicit in the contract between the provider and the prospective tenant. This is especially relevant in schemes where there is currently no 'on site' provider during core hours.

As Naughton Fields continue to move towards the 30/40/30 ratio of care needs the model for care provision at that site should be monitored to ensure that the spot purchase approach continues to meet the needs of residents.

5) **Community Nursing Services**

In reviewing the service specification, Halton HHS CCG should consider the current and anticipated levels of activity and increasing demands to ensure that the appropriate level of funding is invested. Liaison with other professionals as part of the review may help identify gaps in the service and opportunities to promote integration between health and social care to further improve outcomes of people accessing the service.

6) **Quality Assurance**

The Council's Quality Assurance Team will have an increased role in market oversight, supporting quality improvements and preventing provider failure as a result of the Care Act.

There is, and should be, a continuous cycle of work with providers to improve quality and deliver person centred outcomes.

Health PPB should be updated on the implications of the Care Act on the Quality Assurance Team (market oversight) in Autumn 2015

Appendix 1 - TOPIC BRIEF

TOPIC BRIEF

Topic Title: Care at Home Provision in Halton

Officer Lead: Marie Lynch

Planned Start Date: July 2014

Target PPB Meeting: March 2015

Topic Description and Scope:

This topic will focus on the quality of Services provided to those who are supported to live at home within Halton. It will examine the services that are already in place with a view to evaluating their effectiveness in meeting the needs of the local population. In addition the topic group will examine the access to other services e.g. Health Services that individuals supported to live at home have.

Why this topic was chosen:

As people get older, they are increasingly likely to need care at home.

In 2010/11, nationally an estimated 543,000 service users received home care of which 81 percent were aged 65 and over,[1] and as our population ages, more people will inevitably need care at home in the future.

In terms of increases in the number and proportion of older people in the UK population, the percentage of persons aged 65 and over increased from 15 per cent in 1985 to 17 per cent in 2010, an increase of 1.7 million people. By 2035 it is projected that those aged 65 and over will account for 23 per cent of the total population.[2]

Within Halton, the older people age group (65+) are projected to grow by 33% from 17,300 in 2010 to 25,700 in 2025.[3]

Nationally, Councils with Adult Social Services responsibilities purchased or provided 200 million contact hours of home care during 2010-11, an increase of 13 per cent on 2005-06 and the percentage of contact hours provided by the independent sector (private and voluntary sectors) has been steadily increasing over the past few years, with 72% of hours being provided back in 2005-06 to 87% being provided in 2010-11.[4]

Studies show that older people would prefer to stay at home until it is impossible for them to do so rather than move into residential care and that the benefits of home care are

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[1] Health and Social Care Information Centre - Community Care Statistics 2010-11: Social Services Activity Report, England (2012)
[2] Office of National Statistics (ONS) - Population Ageing in the United Kingdom, its Constituent Countries and the European Union (2012)
[3] ONS - Population Projections 2010
[4] Health and Social Care Information Centre - Community Care Statistics 2010-11: Social Services Activity Report, England (2012)

enormous, both to individuals and to the state. Home care provision also costs less than a place in residential or nursing care. In 2008-09 the average weekly cost to local authorities for an older person in residential and nursing care was £497. In contrast, the average weekly cost of home care was £145.[5]

Key outputs and outcomes sought:

- An understanding of existing Care at Home provision in Halton.
- An understanding of the role that partner agencies play in the provision of care provided to those living at home.
- Ensure services provided take into consideration national best and evidence based practice.
- Consider ways to continue to make improvements to services to ensure they continue to be effective in meeting the needs of the population of Halton.
- An understanding of the different elements of service monitoring that take place in respect of this area of provision.

Which of Halton's 5 strategic this topic addresses and the key objectives and improvement targets it will be help to achieve:

A Healthy Halton

- To understand fully the causes of ill health in Halton and act together to improve the overall health and well-being of local people.
- To respond to the needs of an ageing population improving their quality of life and thus enabling them to lead longer, active and more fulfilled lives.
- To remove barriers that disabled people face and contribute to poor health by working across partnerships to address the wider determinants of health such as unemployment, education and skills, housing, crime and environment.
- To improve access to health services, including primary care.

Nature of expected/ desired PPB input:

Member led scrutiny review of Care at Home provision.

Preferred mode of operation:

- Meetings with/presentations from relevant officers from within the Council/Health Services, partner agencies and contracted providers to examine current provision.
- Desk top research in relation to national best and evidence based practice.

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[5] Equality and Human Rights Commission - Close to Home : An inquiry into older people and human rights in home care (2011)

Agreed and signed by:

PPB chair …………………………. Officer ……………………………….

Date ………………………………. Date ……………………………….

Appendix 2 – Sure Start to Later Life Case Studies

ASSESSMENT/ACTION (intervention by SS2LL)	**OUTCOME EVIDENCE (Effect on client/family/carer)**
• Due to relationship issues with husband an assessment away from the home as per client's request. • Husband has terminal cancer. • Not documenting case notes as usual, as information disclosed was very personal concerning clients home situation. • Discussed wanting to get out more to make herself feel better, and she said she would like to volunteer. • Explained how our service works and she said she would like to give it a go. Agreed to pass her details on to Volunteer coordinator to contact for interview for volunteering	• Client is now ready to be matched with a client to support via volunteering, • In receipt of IT tuition from another volunteer. Client has continued to develop her independence and confidence. • She feels she is preparing herself for the time when she will be on her own. • The volunteering, building relationship and learning new skills will aid in this transition when the time comes. In the meantime she is able to cope with her situation better
• Clients only family is a nephew, who lives nearby. • Does not get out much since losing his car. • Client finds it difficult to go out as needs to go the toilet often, which is one of the reasons he stopped going out • Client did not want to go to groups as he felt he was not very social, discussed the volunteer service. • Discussed other transport options but	• After liaising with HCT managed to arrange a regular booking to the shops for client, which he enjoyed. • A volunteer was matched with client to visit him and take him out in her car. • Client attending a group Christmas meal – volunteer supported. • Volunteer takes client to hospital appts. Shopping and trips. • Volunteer identified and issue with keysafe, which was dealt with.

still appeared apprehensive. However, agreed for us to liaise with the local community transport. • Client has cancer	• Client joined the DayTrippers group • Client has been welcomed into volunteer's life as she has no parents, he has no children, and they have become good friends. • The volunteer has acquired a position within HBC, but continues to support the client. • This client returns to the team as and when he needs support
• Client says she gets sad and lonely, husband passed away 30 years ago and partner 4 years ago. • The client's only family lives in London and has 1 friend in locality. • Client does not go out except to do shopping once a week. We discussed the clients desire to go out more but says she finds it difficult to go out on her own, so the Volunteer service was suggested and though reluctant at first, the client agreed for referral. • Client is diabetic but does not get her feet checked - explained the podiatry service. – referral made for podiatry service with transport, • We discussed with the client a problem she was having with her answerphone and her lifeline service. • Client interested in Whist groups and	• After some reluctance, the client initially agreed to receive phone calls from a volunteer which progressed onto visits and now a volunteer takes the client out. • Issue with answerphone and lifeline resolved. • Had problems with Freeview box - referral to Age UK helping hands – problem resolved. • Client is now attending Whist drive. • During reviews identified on-going problems i.e. needed new carpet, problem with heating etc – all resolved. • Client enjoying visit from volunteer, client attends Christmas meals, Volunteer makes phone calls to client over Christmas period so the client did not feel lonely. Volunteer assisted by taking client to family graves. • Client has had feet checked at podiatry clinic.

participation groups or Community Centre activities. • Also needs info on Transport – Dial a Ride. • Client also has an issue with answer machine and Lifeline. – liaised regarding both issues. • Problem with Freeview box – referred for Age UK for Helping hands service. • During reviews additional issues identified – needed new carpet , problem with heating, volunteer identified progressive memory loss issue – team liaised with Social worker and GP for dementia assessment. Financial issue identified by volunteer as client had been given a credit card and did not understand the implications of using one.	• Credit card issue - Client had been provided with a Credit Card thinking she did not have to pay any money back, this was raised to the team by the volunteer, and the volunteer accompanied the client to the bank to return the card. There where further issues around finance where the client was vulnerable and where resolved with support from the team and the volunteer. • Due to client's memory loss, a dementia assessment was carried out and package of care was agreed. • The Client had many issues over the period she has been with us as a client, but the issues have been identified upon reviews and resolved effectively. The client enjoys volunteer visits, as does the volunteer. The volunteer input has been paramount in supporting the client effectively, providing preventative support and referring back to the team when the client appears to have an issue. For example, this support and referral system was shown when there where issues with the vulnerability of a financial nature along with the client's memory loss. The client was diagnosed as having dementia and a package of care was set up.

Appendix 3 – Site visits to Dorset Gardens and Naughton Fields

Health Policy and Performance Board Scrutiny Topic Group – 'Care at Home'

Visit to Dorset Gardens Extra Care Housing Scheme

25th September 2014

Attendees	
Councillor Ellen Cargill	
Councillor Pamela Wallace	
Councillor Chris Loftus	
Emma Bragger	Policy Officer, Communities Directorate
Jane English	Principal Manager, Communities Directorate
Yvonne O'Reilly	Registered Manager, Halton Borough Council (HBC)
Lynne Moss	Assistant Manager, Halton Borough Council (HBC)
Apologies	
Councillor Pauline Sinnott	
Councillor Martha Lloyd -Jones	

A number of the Scrutiny Topic Group, focusing on care at home, made a planned visit to Dorset Gardens extra care housing scheme with a view to get an insight into how the scheme operates, what support is in place to enable residents with various levels of need to maintain their tenancies and remain within the community. The scheme has been open since 2007.

The visit was facilitated by the Registered Manager and Principal Manager of HBC the service. The group had a tour of the building, spoke with the Senior Care and Support Worker on duty and meet two people who have tenancies at Dorset Gardens.

The visit was 2 hours in duration.

The report below summarises the key findings of the group and some of feedback from the staff and residents spoken to on the day.

Tenancies

Tenancies are available for people aged 55+ with no, low, medium or high care and support needs.

There are 40 apartments within the scheme which are on a tenancy basis. Two apartments are 2 bedrooms, with the remaining being single bedroomed and disabled access.

At the time of the visit there were 2 vacant apartments which were going through the allocation process. There is a waiting list of potential tenants for Dorset Gardens.

Where possible, Riverside (who are the building owners) and Halton Borough Council (who deliver the care and support services within the scheme) operate a 30:40:30 principal. That is, 30% of residents have high level needs, 40% have medium level needs and 30% have no/low level needs. It is acknowledged by the management that people's care and support needs fluctuate, and do change. Currently 4 tenants have a diagnosis of dementia.

Facilities

The group were shown around the communal areas, including lounge area, café, landings and viewed the garden areas from inside. All doorways are a suitable width for wheelchairs or other mobility equipment.

There is a well-equipped lounge area with large television, comfortable seating combinations (including high backed chairs), piano, pictures, bookcase.

There is hairdressing room and holistic therapy room for use by the residents on a bookable/payable basis.

The café is not only for use by residents, but also the wider community. It was reported by staff that members of the community do visit the café.

Each apartment has its own front door. Staff reported that whilst many residents do use the communal areas and services (hairdressing, therapies, café), some choose not to and remain private, as is their preference.

There is a guest room, which can be booked out by tenant's friends and relatives for short visits.

There are mature gardens surrounding the building, which can be viewed from almost every aspect through large 'scenery windows' on every level, as well as direct access to the outdoors is available from the ground and verandas of the apartments on the front of the building.

The faculties appeared to be well maintained.

Apartments

The group were invited to look around two apartments; Resident 1's apartment which was a disabled access apartments, and Resident 2's which was a single bedroom standard apartment.

Resident 1's apartment had low level kitchen units enabling ease of use for wheelchair users. All apartment bathrooms are wet rooms, but with a fully equipped bathroom, with bath, on each landing.

Tenants bring their own furniture and belongings and are able to personalise their own space, including the space immediately outside their front door.

Care and Support

Care and support is provided by HBC staff based within the building between the hours of 7.30am-11.30pm. Outside of these times there is a Community Warden service that is based off site. Some of the tenants have telecare. The scheme manager, a Riverside employee, is in the building during Monday-Friday afternoons.

Care and support is provided to approximately 60% of the tenants (low, medium and high level needs). The remaining 40% do not have any assessed needs at this time, but *may* have a health condition that is progressive and/or expected to deteriorate, and anticipate that they may need care and support at a later date. By taking up a tenancy prior to having any care needs, they are in a suitable environment to access care and support that may be required in the future, to remain independent for as long as possible.

Care and support is provided by a Coordinator and 5 care and support staff, plus an additional 2 staff that come on in the afternoon.

Tenant's extra care needs are assessed on a 6 monthly basis, unless there is cause to do so at a different time.

There is a support rota for those tenants who do not require care, or do not have carers, but may benefit from some very low level assistance. Support may be a short social visit to the tenant, help with shopping etc.

Activities

A number of activities take place on a regular basis including reminiscence activity, bingo and access to the mobile library.

There is a Tenant's Committee which is active in arranging activities and developing the environment ie they purchased a television for the lounge, are looking at getting a greenhouse and attend the Area Forum meetings which are held at Dorset Gardens.

Feeback from Resident 1 and 2

Members on the visit would have liked to talk to residents who were not hand picked, but that was not possible, and it is recognised as being area of the scrutiny that is very difficult to achieve.

Resident 1 had been a resident at Dorset Gardens for over 6 years. Resident 1's care and support needs have changed since they first moved to Dorset Gardens, and they receive support from HBC care and support staff within their apartment. Resident 1 reported that they have had some additional health problems recently but has had access to their GP over the phone (Castlefields Practice), which they said has been very good. Resident 1's experience of Dorset Gardens has been very positive and they had praise for the staff. Resident 1 feels that, on the whole, they understand their needs. Resident 1 likes to "have a laugh and joke" with them, and they feel that they gets this from the interaction they have with the care and support staff .

Resident 2 has only been a resident at Dorset Gardens for a month. They reported that they were "slowly adapting" to their new home. Resident 2 was quite happy with their apartment, although did note that , as a wheel chair user, it was quite difficult to open their front door from the inside due to it opening inwards and the weight of it. Resident 2 was happy with the level of care and support they had received so far.

The staff advised that Resident 2's move into Dorset Gardens had been facilitated by Occupational Therapy who had done an assessment of their needs. An application had been put in for an adaptations grant to modify their kitchen to take account of the wheelchair.

Members thanked Residents 1 and 2 for letting them view their apartments. Members thought it was useful to see the two apartments, Resident 2's was a before the changes for their needs were in place (but they would happen and were in hand.) Resident 1's apartment was after the changes for their needs had been done and was a wonderful example of home from home.

Overall Findings

Privacy and independence of tenants was helped by them having their own front door and access to the building.

Enabling tenants to be integrated with the community was promoted by having a public access café and holistic therapy room, which do get used by non-tenants.

It was reported by the staff attending the visits that the relationship between Riverside and the Council is good .

The staff were attentive and appeared to accommodate each resident's needs.

The group were impressed by the standard of cleanliness throughout the building. Members of the group commented that Riverside, as the landlord, and Halton's Social Services should take pride in their achievements at this facility.

Riverside we were told, plan to update the décor. The Cafe could showed some signs of 'wear and tear', but it is so well used that this is only to be expected.

The group were informed about the use of the facility by the wider community, which has been personally witnessed by members of the group

Members of the group commented that it would be nice to see greater integration being achieved with the schools in the area, being encouraged to get involved in the activities taking place within Dorset Gardens, and supporting relationships with residents.

After speaking to residents, care staff and representatives of the landlord , overall the group left with the impression that providers and carers were going that extra mile to make the residents feel secure, involved with all aspects of their care and at home.

Appendix 3 cont. – Site visits to extra care housing schemes

Health Policy and Performance Board Scrutiny Topic Group – 'Care at Home'

Visit to Naughton Fields Extra Care Housing Scheme

1st October 2014

Attendees	
Councillor Pamela Wallace	
Councillor Joan Lowe	
Emma Bragger	Policy Officer, Communities Directorate
Angela Deakin	Scheme Manager, Halton Housing Trust
Yvonne O'Reilly	Registered Manager, Halton Borough Council (HBC)
Maggie Aspinall	Housing Support Officer, Halton Borough Council (HBC)
Michelle McDonough	Local Solutions
Representative (Dan)	PWD Consultants

Three members of the Scrutiny Topic Group, focusing on care at home, made a planned visit to Naughton Fields extra care housing scheme with a view to get an insight into how the scheme operates, what support is in place to enable residents with various levels of need to maintain their tenancies and remain within the community. The scheme has been open since 2012.

Aims & Objectives of Naughton Fields Extra Care Housing

Extra Care housing provides a secure environment in which older people wishing to retain control over their own lives have access to a combination of tailored care and support services, enabling them to live independently in their own homes.

Whilst Extra Care housing can provide a home for life for many people, when a change in circumstances requires an ongoing need for residential/nursing care it is no longer appropriate. Residents requiring this level of care and support will be supported in a move to a more appropriate setting.

The required outcomes of the service are to:

- Enhance the quality of life for people with care and support needs
- Delay and reduce the need for care and support and residential placement
- Ensure that people have a positive experience of care and support
- Safeguard adults whose circumstances make them vulnerable, and protect them from avoidable harm

For residents this means:

- Residents will be enabled to lead as independent a life as possible.
- Residents are able to exercise choice and opportunities to achieve personal fulfilment will be maximised.
- The right of the resident to make their own decisions, exercise choice and incur calculated risks will be respected and supported.
- Linked Care and Support Plans will be developed in full discussion and with the full

  agreement of the resident

The visit was facilitated by the Scheme Manager and Registered Manager. The group had a tour of the building and spoke with a representative from Local Solutions, one of the main care providers delivering at that site and the Housing Support Officer . Members also met meet three people who have tenancies/ownership at Naughton Fields.

The visit was 2.5 hours in duration.

The report below summarises the key findings of the group and some of feedback from the staff and residents spoken to on the day.

Tenancies /ownership

Tenancies or shared ownerships are available for people aged 55+ with no, low, medium or high care and support needs.

There are 47 two bedroom apartments within the scheme. .

Where possible, Halton Housing Trust (HHT) (who are the building owners) and the Property Pool Plus Partnership try to operate a 30:40:30 principal. That is, 30% of residents have high level needs, 40% have medium level needs and 30% have no/low level needs. It is acknowledged by the management that people's care and support needs fluctuate, and do change.

Allocation criteria

For Naughton Fields the intention was to prioritise Halton residents given the significant capital investment being made by the Council, but in reality it was a struggle to identify sufficient numbers of local people with support/care needs. A small number of people from out of borough were accommodated but they were ones who fulfilled the 'local connection' criteria contained in the Property Pool Plus allocations scheme e.g. they had previously been residents of Halton, and/or needed to move to receive support from family/friends in Halton, and they demonstrated a need for a supported environment.

Facilities

The group were shown around the communal areas, including lounge area, bistro, landings and viewed the garden areas from outside. All doorways are a suitable width for wheelchairs or other mobility equipment.

There is a well-equipped lounge area with large television, fireplace, comfortable seating combinations pictures, bookcase.

There is hairdressing salon and spa therapy room , both operated as a commercial interest by external companies. They are open to residents and non residents.

The bistro is not only for use by residents, but also the wider community. It was reported by staff that members of the community do visit the bistro.

There is a guest room, which can be booked out by tenant's friends and relatives for short visits.

There are gardens surrounding the rear of the building, which can be viewed from through large 'scenery windows' on every level, as well as direct access to the outdoors is available from the ground and verandas of the apartments on the upper floors.

The faculties appeared to be well maintained.

Apartments

The group were invited to look around two apartments.

Apartments were spacious with open planned kitchen and living areas and natural light in the main living space through large windows.

Residents are permitted to smoke within their own homes, but not in communal areas.

Care and Support

There are three types of organisations on site at Naughton Fields:

Halton Housing Trust – Scheme Manager on site, manages the housing facility

Halton Borough Council – Housing Support Worker – providing support to residents, signposting, providing information, assisting with transport arrangements etc. The Housing Support Worker is on site Monday – Friday 9am-5pm, who also responds to life line calls during this time. Outside of these hours the lifeline service is transferred to community wardens.

Care Providers – Local Solutions is the main provider, but there are a number of other providers who provide domiciliary, personal care etc to residents. Care providers have access to the building 24 hours to meet the needs of their clients. Initially the scheme was to offer care on site from 7am-11pm, but the hours of required care where not identified prior to the opening and there had been issues with Local Solutions (the main provider) and HBC immediately prior to the opening, and it was evident that on site care could not be provided. Care is provided by Local Solutions, and others , on a 'spot basis'. There is currently no general on site care provision, however, HHT and Property Pool Plus are working o re balance the care needs levels to warrant on site care.

Approximately 12 residents have signed up to the Visbuzz pilot to aid them in reducing their social isolation through the use of the simple video calling.

Activities

A number of activities take place on a regular basis including singing for the brain, bingo, residents committee, visits from Age UK, Halton Borough Council Bridge Builders.

There is a Tenant's Committee which is active in arranging activities and funds to improve their environment such as equipment for the garden.

Feeback from Resident 3&4 and Resident 5

Members on the visit would have liked to talk to residents who were not 'hand picked', but that was not possible, and it is recognised as being area of the scrutiny that is very difficult to achieve.

Resident 3& 4 had been residents at Naughton Fields since it opened in 2012 and shared a two bedroom apartment. Both Resident 3 & 4 said that they were very happy with the facilities and environment that Naughton Fields provided. They had praise for the extensive support that was provided to them by the Housing Support Worker with form filling, appointment arranging etc.

Resident 3 & 4 did state that they felt there had been some difficulties in the delivery of their care packages since they took up residence at Naughton Fields. These concerns were reported though the appropriate channels for further investigation, where it was evident that Residents 3 & 4 were receiving care appropriate to their care package and identified needs, and number of professionals were engaged with them to ensure their needs were met.

Resident 5 had been resident in Naughton Fields for almost 2 years. She moved in with her husband who has mixed dementia. Another family member also lives in Naughton Fields. As her families care and support needs were changing she felt that Naughton Fields offered them the safe environment that could accommodate the changing needs. Currently Resident 5 provides care to her husband, but she is awaiting a social care assessment of her husband's care needs. She praised the support she has had from the Housing Support Worker, who has provided practical and emotional support to her during a hard transition period with her husband's declining health. Support provided by the Housing Support Worker included respite (where the Housing Support Worker took her husband and other family member to the on site Bistro for a drink, while Resident 5 was able to go out to the shops or bingo), signposting, emotional support.

Resident 5 was clearly very satisfied with the facility, but was experiencing trouble with disruptive neighbours, which was being dealt with by Halton Housing Trust.

Resident 5 also mentioned her disappointment with the Bistro now being closed at a weekend. The Bistro is a commercial operation, ran by an external company who have stated that it is not cost effective for them to run the café at a weekend. Resident 5 observed that for many of the residents this has had a negative impact and has resulted in isolation, particularly for her family member, and others who are unable or not wishing to leave Naughton Fields. There was some discussion as to the role of the residents committee to generate interest in the weekend service to make it viable to open at a weekend.

Members felt that the apartments, and communal areas of Naughton fields, were high quality and promoted a sense of independence, but provided reassurance through the access to the life line service.

Overall Findings

Privacy and independence of tenants was helped by them having their own front door and access to the building.

Enabling tenants to be integrated with the community was promoted by having a public access Bistro and Spa therapy room, which do get used by non-tenants.

It was reported by the staff attending the visits that the relationship between Halton Housing Trust and the Council is good .

The support provided by the Housing Support Officer, which was validated by the residents which the group spoke to, seemed to be key to those residents. The Housing Support Officer was attentive to the residents needs and provided a quality service to those who the group spoke to. The lack of on site, daily care is being addressed through the allocation process (to generate more care hours), but in the interim 'spot contracts' are in place for those who require care.

The group were impressed by the standard of cleanliness throughout the building. Members of the group commented that Halton Housing Trust, as the landlord, should take pride in their achievements at this facility.

After speaking to residents, care staff and representatives of the landlord, overall the group left with the impression that whilst there had been some 'teething' problems with residents settling into the scheme – due partly to advertising the scheme as having access to on site care during the day time, which is not in place, many of the residents moving into communal living for the first time, and a new residents committee being formed – a corner was being turned.

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[i] Equality and Human Rights Commission - Close to Home : An inquiry into older people and human rights in home care (2011)
[ii] Halton Community Alarm Service Annual Report 2014

Appendix 4 – Community Nursing Presentation

Halton Policy & Performance Board Topic Group Care at Home: Community Nursing Overview and monitoring arrangements

Diane Evans - Service Manager, Community Nursing
Jacqui Tudor - Clinical Manager, Community Nursing, Halton

Bridgewater
Healthcare at the heart of your community

Community Nursing Overview

- Community Nursing comprises of: District Nurses, Community Matrons, Staff Nurses and Health Care Assistants.
- The service operates across 365 days covering 24 hours. (Staffing levels reduce in the out of hours to match demand).
- Teams are located within a number of bases, and are aligned to Halton GP practices.
- Care is delivered across a range of community locations, including the service user's home (housebound), clinics, care homes.
- The service provides assessment, treatment, maintenance and support for service users who have acute, chronic, continuing healthcare including palliative and end of life care needs.
- The complexity of service users requires co-ordination across a number of organisations including health, social care, intermediate care and voluntary organisations.

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Team Structures

Service Manager
Diane Evans

Clinical Manager
Jacqui Tudor

Chapelfields Team
DN Claire Regan
GP Practices
Beeches Medical Centre
Hough Green Surgery
Upton Rocks Surgery
Community Matron
Faye Roylands

Peel House Plaza
DN Loraine Downey
GP Practices
Peelhouse Plaza Medical Centre
Appleton Village Surgery
Community Matron
Brian Kirman

Beaconsfield Road
DN Karen Burge
GP Practices
Beaconsfield Road Practice
Community Matron
Darron Lomax

Health Care Resource Centre
DN Tracey Maskell
GP Practices
Newtown Surgery
Oaks Place Medical Centre
Westbank Medical Centre
Community Matron
Faye Roylands

Castlefields
DN Carrie Hunt
GP Practices
Castlefields Health Centre
Halton Health
Community Matron
Sheena Harris

St Pauls
DN Lesley Hough
GP Practices
Grove House Practice
Tower House Prastice
Community Matron
Mary Quinn

Hallwood
DN Liz Irvine
GP Practices
Weavervale
Brookvale
Mrrdishaw Health Centre
Community Matron
Emma Richards

District Nursing Out of Hours
DN Diane Whittle and Danita Sayle
Based at the Health Care Resource Centre

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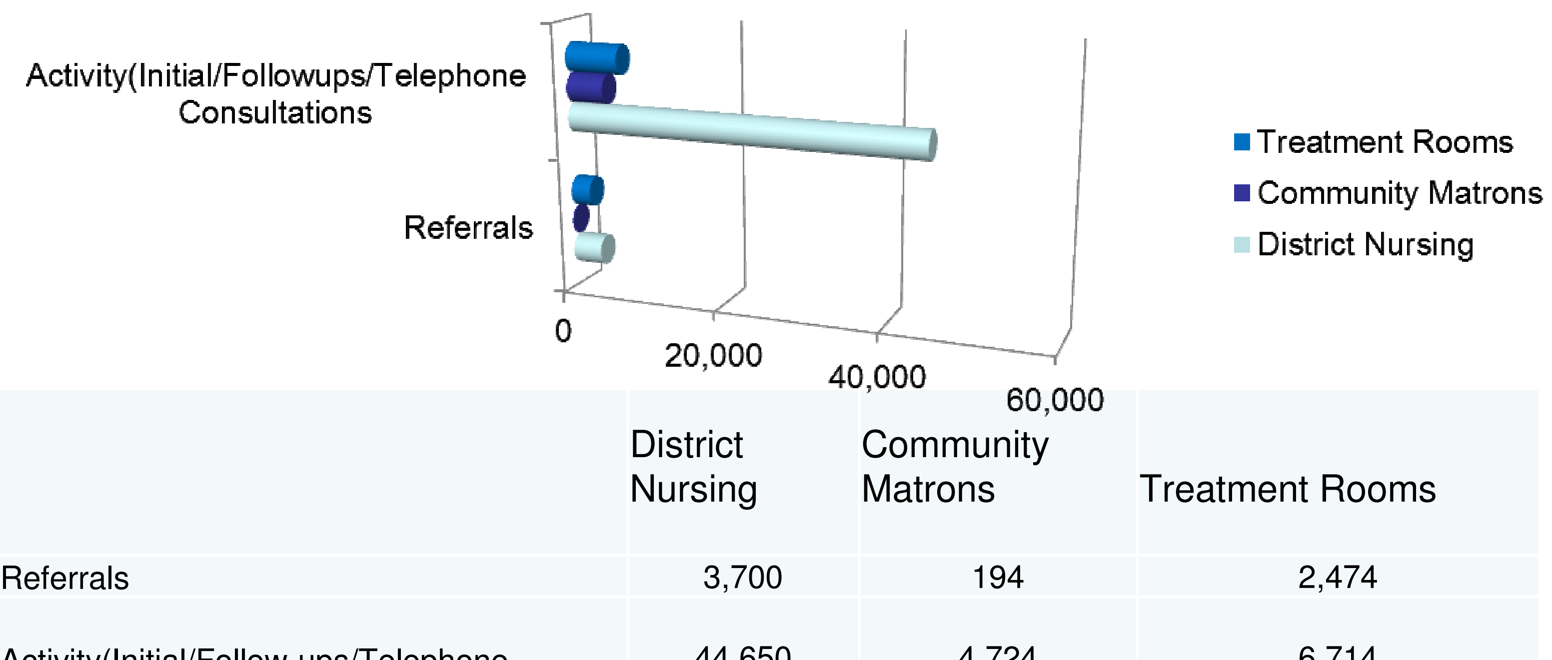
Referrals and activity 2014-15 YTD (Sept 14)



	District Nursing	Community Matrons	Treatment Rooms
Referrals	3,700	194	2,474
Activity(Initial/Follow-ups/Telephone Consultations)	44,650	4,724	6,714

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Safety & Quality

Incidents/Risks:

•Incidents/risks reported on Ulysses, the trust risk management system

•All incidents seen by senior managers daily - ability to escalate in day to Director level.

•Clinical Managers investigate within 7 days

•Service Manager reviews all incidents weekly

•Themes and trends identified via specialist groups e.g. medicines management, pressure ulcers, and the Trust Quality Management Group

•The National Patient Safety Agency (NPSA) Root Cause Analysis (RCA) report is completed for all Serious Untoward Incidents (SUIs) and reported to the Clinical Commissioning Group (CCG)

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Safety & Quality

Competencies/training:

- Annual mandatory/statutory e-learning
- Safeguarding adults and children training
- Dementia training
- Clinical e-learning (e.g. medicines)
- Clinical skills (e.g. wound care, palliative care, prescribing, moving/handling)
- Workbooks/competencies (e.g. medicines, IV therapy, wound care, catheter, syringe drivers, flu vaccination)

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Clinical Effectiveness: E.g. Pressure Ulcers

Bridgewater Community Healthcare NHS
NHS Foundation Trust

Halton Pressure Ulcer Quality Indicator Audit Results 2014 - 2015

Audit Criteria	Q1 - April to June		Q2 - July to Sept	
	Number	Comp %	Number	Comp %
Total number of pressure ulcers in quarter	48		35	
Photographed at 1st Assessment or within 7 days	41	100%	24	89%
Waterlow assessment conducted at first contact visit	41	100%	27	100%
Waterlow assessment reviewed	48	100%	35	100%
Has a MUST been completed	48	100%	35	100%
Evidence of assessment by Specialist Practitioner	48	100%	35	100%
Evidence of a weekly review by Specialist Practitioner	48	100%	35	100%
Patient has current wound care plan	45	94%	34	97%
Evidence of at least 4 weekly wound assessments	48	100%	35	100%
Pressure ulcers showing no deterioration (Target = 95%)	47	98%	34	97%
Pressure ulcer deteriorated	1	2%	1	3%

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Healthcare at the heart of your community

Safety & Quality

Bridgewater Community Healthcare NHS
NHS Foundation Trust

Governance:

CQC compliance declaration (quarterly)

•Compliant with all 21 outcomes apart from staffing which is partial compliance, action plan in place to address

Safer Staffing tool (quarterly)

•Amber for vacancy rate 9.6% and sickness rate 6.2%

HR key performance

•PDR – 91.57%

•Mandatory/Statutory training – 92.77%

•Safeguarding - 96.77%

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Patient Experience

- 'Talk to us'
- Census day
- Service satisfaction surveys
- PALs/Complaints
- Quality walk –rounds
- Governors/members
- Stakeholder feedback

Current Issues

Treatment Rooms

Staffing sickness levels, multiple sites and variable hours of delivery, not a resilient service impacting on District Nursing care at home

Out of Hours

Small number of staff, not resilient, scoping demand against capacity

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Future developments

- Closer working with GPs to deliver the primary care strategy
- Integrated IT systems – sharing information
- Remote technology
- Promote self management and support telehealth
- Redesign to ensure teams are effectively led, resilient and responsive to needs

 Agenda Item 6e

REPORT TO:	Health Policy & Performance Board
DATE:	10 March 2015
REPORTING OFFICER:	Strategic Director - Communities
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Scrutiny Topic 2014/15 : Discharge from Hospital
WARD(S):	Borough-wide

1.0 **PURPOSE OF REPORT**

1.1 To present the Board with details of the Discharge from Hospital Scrutiny topic as outlined in the attached topic brief.

2.0 **RECOMMENDATION**

RECOMMENDED: That the Board

i) Note contents of the report;
ii) Approve the Topic Brief outlined at Appendix 1; and
iii) Nominate Members of the Board to form part of the Scrutiny Topic Working Group

3.0 **SUPPORTING INFORMATION**

3.1 Discharge planning is a routine feature of the Health and Social Care system and consists of the development of an individualised discharge plan for the patient prior to leaving hospital, with the main aim of improving a patient's outcome.

3.2 Planning for discharge helps reduce hospital length of stay and unplanned/emergency readmissions to hospital, relieves pressure on hospital beds and improves the co-ordination of services following discharge from hospital.

3.3 This topic will focus on the quality of the Discharge planning process and associated pathways to those Halton residents who have been admitted to the local Acute Trusts for both elective or emergency care. It will examine the services that are already in place with a view to evaluating their effectiveness in meeting the needs of the local population.

3.4 Subject to agreement by Board to accept the topic brief; this report seeks nominations from members of the Board to form a member led scrutiny working group.

4.0 **POLICY IMPLICATIONS**

4.1 The recommendations from the resulting scrutiny review may result in a need to

review associated policies and procedures.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 None identified.

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

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

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

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

6.4 **A Safer Halton**
None identified.

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

7.0 **RISK ANALYSIS**

7.1 None identified.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None identified.

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

9.1 None under the meaning of the Act.

Appendix 1: Discharge from Hospital Scrutiny Topic Brief

TOPIC BRIEF

Topic Title: Discharge from Hospital

Officer Lead: Damian Nolan – Divisional Manager

Planned Start Date: April 2015

Target PPB Meeting: March 2016

Topic Description and Scope:

This topic will focus on the quality of the Discharge planning process and associated pathways to those Halton residents who have been admitted to the local Acute Trusts for both elective or emergency care. It will examine the services that are already in place with a view to evaluating their effectiveness in meeting the needs of the local population.

Why this topic was chosen:
Discharge planning is a routine feature of the Health and Social Care system and consists of the development of an individualised discharge plan for the patient prior to leaving hospital, with the main aim of improving a patient's outcome.

Discharge planning should ensure that patients are discharged from hospital at an appropriate time in their care and that, with adequate notice, the provision of other services are organised.

There are some common key elements when planning for discharge, regardless of whether a patient is receiving emergency or elective care. These are:

- Specifying a date and / or time of discharge as early as possible
- Identifying whether a patient has simple or complex discharge planning needs
- Identifying what these needs are and how they will be met
- Deciding the identifiable clinical criteria that the patient must meet for discharge

About 20 per cent of patients[1] have more complex needs and may need additional input from other professionals. The involvement of additional people makes effective co-ordination and planning even more critical.

As the older people age group (65+) within Halton are projected to grow by 33% from 17,300 in 2010 to 25,700 in 2025[2], it is anticipated that the percentage of those

[1] NHS Institute for Innovation and Improvement
[2] ONS - Population Projections 2010

patients experiencing more complex needs and thus requiring more complex discharge planning processes will also increase.

Planning for discharge helps reduce hospital length of stay and unplanned/emergency readmissions to hospital, relieves pressure on hospital beds and improves the co-ordination of services following discharge from hospital.

Within Halton we experience a high number of emergency readmissions at both 30 and 90 days for people aged 65 and over and this has presented challenges to the Health and Social Care system. As outlined above, effective discharge planning can contribute to helping reduce the number of unplanned/emergency readmissions to hospital and as such there is a need to ensure that current discharge planning processes and associated pathways in place are having a positive impact on Halton's emergency readmission rates.

Key outputs and outcomes sought:

- An understanding of existing Discharge Planning processes and associated pathways in respect of Halton residents that are admitted to Warrington and Halton Hospitals NHS Foundation Trust and St Helens and Knowsley Teaching Hospitals NHS Trust.
- An understanding of the role that all agencies (both statutory and voluntary/community sector) play in the discharge planning process.
- Ensure services provided take into consideration national best and evidence based practice.
- Consider ways to continue to make improvements to Discharge Planning processes to ensure they continue to be effective in meeting the needs of the population of Halton.
- An understanding of the different elements of service monitoring that take place in respect of this area of provision.

Which of Halton's 5 strategic this topic addresses and the key objectives and improvement targets it will be help to achieve:

A Healthy Halton

- To understand fully the causes of ill health in Halton and act together to improve the overall health and well-being of local people.
- To respond to the needs of an ageing population improving their quality of life and thus enabling them to lead longer, active and more fulfilled lives.
- To remove barriers that disabled people face and contribute to poor health by working across partnerships to address the wider determinants of health such as unemployment, education and skills, housing, crime and environment.
- To improve access to health services, including primary care.

Nature of expected/ desired PPB input:

Member led scrutiny review of Discharge Planning and associated processes/pathways.

Preferred mode of operation:

- Meetings with/presentations from relevant officers from within the Council/Health Services and partner agencies to examine current processes/provision.
- Desk top research in relation to national best and evidence based practice.

Agreed and signed by:

PPB chair ………………………….. **Officer ……………………………….**

Date ………………………………… **Date ………………………………….**