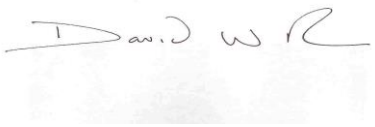
Public Document Pack

Health Policy and Performance Board

Tuesday, 7 February 2017 at 6.30 p.m.
Council Chamber, Runcorn Town Hall



Chief Executive

BOARD MEMBERSHIP

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

Please contact Ann Jones on 0151 511 8276 or e-mail ann.jones@halton.gov.uk for further information.
The date of the next meeting of the Board is to be confirmed.

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

Part I

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2.	**DECLARATIONS OF INTERESTS (INCLUDING PARTY WHIP DECLARATIONS)** 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.

HEALTH POLICY AND PERFORMANCE BOARD

At a meeting of the Health Policy and Performance Board held on Tuesday, 15 November 2016 at Council Chamber, Runcorn Town Hall

Present: Councillors J. Lowe (Chair), S. Baker, M. Bradshaw, E. Cargill, Dennett, C. Gerrard, M. Lloyd Jones, Osborne, Parker and Sinnott

Apologies for Absence: None

Absence declared on Council business: None

Officers present: S. Shepherd, S. Wallace-Bonner, A. Jones, D. Nolan, L Wilson and M. Vasic

Also in attendance: D. Sweeney, Dr M. O'Connor, L. Thompson-Greatrex, L. McHale – NHS Halton CCG and A. Ryan – 5 Boroughs Partnership NHS Trust

ITEMS DEALT WITH UNDER DUTIES EXERCISABLE BY THE BOARD

Action

HEA20 MINUTES

The Minutes of the meeting held on 20 September 2016 having been circulated were signed as a correct record.

HEA21 PUBLIC QUESTION TIME

It was confirmed that no public questions had been received.

HEA22 HEALTH AND WELLBEING MINUTES

The Health and Wellbeing Board minutes dated 6 July 2016 were submitted to the Board for information.

With reference to minute HWB8 – Well North Programme – the Chair requested a report be submitted to this Board with an update.

Councillor Charlotte Gerrard declared a Disclosable Other Interest in the following item as her stepmother works for 5 Boroughs Partnership.

HEA23 IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES

The Board received a report from the Director of Adult Services, and an accompanying presentation from Angela Ryan, Assistant Director for Halton 5 Borough Partnership NHS Foundation Trust and Sheila McHale, Head of Children and Families, Adult Mental Health, NHS Halton CCG, that provided an update in respect of Improving Access to Psychological Therapies (IAPT) delivery and development of the service in Halton.

The presentation included information such as the conditions that were treated; the numbers of people in Halton experiencing these disorders; their recovery rates; and patient feedback. Members requested a copy of the presentation which would be emailed following the meeting.

It was noted that the onward plan for the IAPT was to increase productivity; maintain and improve clinical quality; and maintain high levels of client satisfaction.

Following the presentation Members' queries provided the following additional points of clarification or information:

- Clients were monitored closely as they progressed through Steps 2 and 3 of IAPT services and would be referred to Step 4 if no recovery was made;

- Re-referrals did occur and although they were re-admitted to the service, other interventions could be looked at and provided alongside the IAPT to support the client;

- Comparisons with other areas were requested – these could be provided for the other two Boroughs, as the service was only offered in 3 out of the 5 Boroughs;

- E-therapy was now provided to clients through 'Silvercloud' and was being accessed by people of all ages. Clients decide themselves to go on the review and the information they provided was constantly analysed. This service had only been offered since August so an analysis was still to be made; this would be shared with the Board once available;

- Each Cognitive Behaviour Therapy (CBT) trainee worked alongside a supervisor in a team for 3 months; they also had to pass their exams to qualify, these would be at the end of this year.

RESOLVED: That the Board notes the report and comments made. — Director of Adult Social Services

HEA24 TELEHEALTHCARE STRATEGY

The Board received an update on the Telehealthcare Strategy, which was attached to the report as an appendix.

By way of introduction Members were advised that the development of technology was affecting and extending the way care could be delivered in the health and social care arena. As the population was ageing there was a significant strain on healthcare resources, with an increasing number of people affected by long term chronic conditions.

The report discussed the unsustainability of the situation and the potential use of hi-tech home healthcare solutions which would support people to live at home or in extra care housing schemes.

Members commented that this type of technology would provide people with long term health conditions the security of knowing that they would be remotely monitored in their own homes. It was noted that patients' health issues differed and therefore individuals could access certain parts on the Telehealthcare service to suit their illness. It was commented that there were pockets of deprivation that existed in Halton and this may hinder the availability of the technology to some people.

RESOLVED: That the Board notes the contents of the report and Telehealthcare Strategy.

Councillor M Lloyd Jones declared a Disclosable Other Interest in the following item as her husband was a Governor of Warrington and Halton Hospital.

HEA25 STROKE UPDATE

The Director of Transformation NHS Halton CCG and Dr Mike O'Connor – Clinical Lead for Long Term Conditions NHS Halton CCG, updated the Board on Stroke Reconfiguration in Mid Mersey.

Members were provided with some background information on the situation at Warrington and Halton Hospitals over the past 3 years, with regards to stroke patients. The report also discussed the National Stroke Direction and explained that there was a national shortage of stroke consultants, speech and language therapists and clinical psychologists.

Members were advised that Mid Mersey had created a Stroke Board, with representation from CCG's, primary care, local authorities and acute providers. This Board had agreed the vision that St Helens and Knowsley Trust (SHKT) would be a single stroke provider of acute services and that in a phased approach, all Warrington and Halton Hospital acute stroke patients would be transferred to SHKT for the first 72 hours of care, and then repatriated either through Early Supported Discharge (ESD) teams or back to the acute trust for longer more complex patients.

Dr O'Connor explained the Sentinel Stroke National Audit Programme (SSNAP) ratings; mimic strokes; and how an 'A' rated hospital was important when recruiting consultants in the stroke field. It was commented that with regards to the 16 extra beds needed for SHKT, the Stroke Board would be meeting to discuss the process of obtaining these.

RESOLVED: That

1) Members understood the current clinical discussions and solutions to ensure Halton patients received high quality stroke services;

2) agreed with the development of Telemedicine service across both sites for out of hours provision;

3) a Quality Impact Assessment be undertaken by Warrington Trust; and

4) Early Supported Discharge (ESD) and community provision across the patch be reviewed and uplifted as part of the discharge process and repatriation process from Whiston Hospital.

HEA26 WINDMILL HILL GENERAL MEDICAL SERVICES

The Director of Adult Services provided an update to the Board on the commissioning of a general practice service at Windmill Hill from April 2017.

It was reported that before a final decision could be made on the options for Windmill Hill Medical Centre being presented to the Board in June, the CCG's Primary Care Commissioning Committee (PCCC) requested that the following actions be undertaken: an Equality Impact Assessment (EIA); patient engagement; and market testing. The results of these actions were discussed in the report and the Chair of the PCCC subsequently approved the recommendation to procure a branch surgery at the Windmill Hill site; to carry out a mini procurement amongst existing providers in Halton; and to disperse the smaller element of the contract at the Widnes site.

Members were reassured that Runcorn patients would see no difference in the service they received and would continue as is; Widnes patients would be dispersed to practices in Widnes and extra support would be provided for any patients that had a particular concern with this.

RESOLVED: That the Board noted the update on the contracting of general medical services at Windmill Hill.

Councillor J Lowe declared a Disclosable Other Interest in the following item as her son's partner works for a Care Home in Halton; and Councillor Osborne declared a Disclosable Other Interest in the following item as his wife was an employee of Halton Borough Council.

The Chair was taken by the Vice Chair, Councillor Osborne, for the following item at the request of the Chair, Councillor J Lowe.

HEA27 DOMICILIARY AND CARE HOMES QUALITY REPORT

The Board received an update on the quality of provision within the care home and domiciliary care market in Halton.

It was reported that it was a key priority for Halton Borough Council to ensure the provision of a range of good quality services to support adults requiring support in the Borough. The Care Act had put this on a statutory footing through new duties regarding the promotion of effective and efficient operation of the care market in which there must be a choice of diverse high quality services that promoted wellbeing.

It was noted that in Halton there were 27 registered care homes that provided 788 beds operated by 16 different providers. The capacity within the care homes ranged from homes with 66 beds to small independent providers with 6

beds. There were 9 domiciliary care providers within this number supporting 610 service users across the Borough.

The report went on to discuss quality monitoring and assurance and the quarter one position. Additionally, appended to the report were the key challenges within care homes in Halton, which were noted by Members.

Following the update and Members' queries, the following points were made:

- The category of the care home mentioned by Councillor Parker which was in his Ward would be confirmed;
- With regard to the CQC's definition of 'harm' this was usually relating to falls and missing of a dose of medication;
- With regard to the CQC's definition of 'other' this was varied and could relate to for example environmental issues, safety procedures, fire certificates etc;
- Care home providers were encouraged to report any incident no matter how small.

RESOLVED: That the Board notes the report and the challenges identified in Appendix 1.

Councillor Sinnott declared a Disclosable Other Interest in the following item as she was a Trustee of Halton Disability Partnership who is commissioned to deliver support to the take up of Direct Payments.

HEA28 PERFORMANCE MANAGEMENT REPORTS QUARTER 2 2016/17

The Board received the Performance Management Reports for Quarter 2 of 2016-17. Members were advised that the report introduced, through the submission of a structured thematic performance report, the progress of key performance indicators, milestones and targets relating to Health in Quarter 2, which included a description of factors which were affecting the service.

Members were requested to consider the progress and performance information and raise any questions or points for clarification, and highlight any areas of interest or concern for reporting at future meetings of the Board.

Members queried the annual review of the Homeless Strategy in June 2017 as commented on page 54 of the

report and it was confirmed that a paper would come to this Board with an update on the February 2017 agenda.

RESOLVED: That the Board receives the Quarter 2 Priority Based report.

Meeting ended at 7.55 p.m.

HEALTH POLICY AND PERFORMANCE BOARD

At a meeting of the Health Policy and Performance Board held on Tuesday, 13 December 2016 at Council Chamber, Runcorn Town Hall

Present: Councillors J. Lowe (Chair), Osborne (Vice-Chair), S. Baker, M. Bradshaw, Dennett, Horabin, Parker and Sinnott

Apologies for Absence: Councillor E. Cargill, C. Gerrard and M. Lloyd Jones

Absence declared on Council business: None

Officers present: S. Wallace-Bonner, A. Jones, D. Nolan and L Wilson

Also in attendance: D. Sweeney and S. Banks – NHS Halton CCG, Mr F. Finley, Dr D. Watson and A. Ryan – 5 Boroughs Partnership NHS Trust

ITEMS DEALT WITH UNDER DUTIES EXERCISABLE BY THE BOARD

Action

HEA29 PUBLIC QUESTION TIME

It was confirmed that no public questions had been received.

HEA30 OLDER PEOPLES MENTAL HEALTH & DEMENTIA CARE

The Board received a presentation from Angela Ryan, Assistant Director for Halton 5 Boroughs Partnership NHS Foundation Trust, which provided Members with an update in relation to the consultation of the proposal for the re-provision of organic inpatient beds for later life and memory services. She was accompanied by Dr David Watson and Mr Frank Finley, also from 5 Boroughs Partnership NHS Foundation Trust.

The meeting was called to address the concerns that the Board had raised at the previous Health Policy and Performance Board, held on 20 September 2016. The report that was presented at this meeting was attached at Appendix 1.

The presentation outlined: what the proposed change was and the reasons for the change; the key messages in

relation to later life and memory services; the facilities at Atherleigh Park; and the next steps following consultation and feedback. Feedback from the consultation process was not yet available as it was still open until 30 December 2016; however it was reported that 89 questionnaires had been received so far. Members were presented with a copy of the consultation documents which included information on the Care Home Liaison Service and the Knowsley and Halton Admiral Nurse Service, which were outlined in the presentation.

Members' concerns that were raised at the last meeting were addressed during the presentation and assurances were provided to the Board in respect of these as follows:

- The overall bed base at the Brooker Centre would remain and improvements would be made to the environment of the inpatient ward, which would be used for mental health patients with complex needs;

- Patients, carers and their families would be supported with their transport requirements to Atherleigh Park from both Runcorn and Widnes; and

- The care navigator role would remain in place for the duration of the patient's intervention to support the multi-disciplinary professionals involved in the patients care, eg. Social Workers.

At the conclusion of the meeting Members requested that the Halton 5 Boroughs Partnership NHS Foundation Trust be invited back in 12 months' time to present an update on progress made and outcomes to date. This was noted and agreed.

RESOLVED: That the Board notes the presentation on Halton's later life and memory service and consultation results update and supports the proposed bed based model, pending the result of the consultation process.

Meeting ended at 7.20 p.m.

REPORT TO: Health Policy & Performance Board

DATE: 7 February 2017

REPORTING OFFICER: Strategic Director, Enterprise, Community & Resources

SUBJECT: Public Question Time

WARD(s): Borough-wide

1.0 PURPOSE OF REPORT

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

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

2.0 RECOMMENDED: That any questions received be dealt with.

3.0 SUPPORTING INFORMATION

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

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

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

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

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

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

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

- Requires the disclosure of confidential or exempt information.

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

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

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

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

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

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

4.0 POLICY IMPLICATIONS

None.

5.0 OTHER IMPLICATIONS

None.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

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

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

6.3 **A Healthy Halton** – none.

6.4 **A Safer Halton** – none.

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

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

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

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

REPORT TO: Health Policy and Performance Board

DATE: 7 February 2017

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 Social Care Portfolio which have been considered by the Health and Wellbeing 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, 12 October 2016 at Bridge Suite, Halton Select Security Stadium

Present: Councillors Polhill (Chair), T. McInerney, Woolfall and Wright and S. Banks, R. Brisley, S. Constable, G. Ferguson, T. Hill, M. Holt, S. Johnson-Griffiths, M. Larkin, A. Marr, A. McIntyre, D. Nolan, D. Parr, R. Patel, C. Samosa, S. Semoff, R. Strachan, T. Tierney, H. Teshome, S. Wallace Bonner and S. Yeoman

Apologies for Absence: Colin Scales, Chief Inspector Fairclough, Marie Sedgewick and Eileen O'Meara

Absence declared on Council business: None

ITEM DEALT WITH
UNDER DUTIES
EXERCISABLE BY THE BOARD

Action

HWB11 MINUTES OF LAST MEETING

The Minutes of the meeting held on 6th July 2016 having been circulated were signed as a correct record.

HWB12 PRESENTATION BY JBA CONSULTING: VULNERABLE COMMUNITIES CLIMATE CHANGE AND HEALTH EFFECTS

The Board received a presentation from Rachel Brisley on behalf of JBA Consulting which outlined the company background and current and future climate risks in the UK and in Halton. The presentation also contained information on vulnerable communities and climate change and potential action to address those issues.

On behalf of the Board the Chair thanked Rachel Brisley for her presentation.

RESOLVED: That the presentation be noted.

HWB13 ADULT HEALTH AND SOCIAL CARE – ACCOUNTABLE COMMISSIONING SYSTEM

The Board considered a report of the Director of Adult Social Services, which presented a Project Initiation Document (PID), which outlined a proposal and associated mechanisms of how the further alignment of systems and services across Health and Social Care Services would improve the quality and efficiency of services provided to Adults in Halton.

In Halton, Adult Services had a long history of collaboration and integration. In April 2013 a Joint Working Agreement and associated pooled budget arrangements were introduced between the Council and NHS Halton Clinical Commissioning Group (CCG). Examples of successful Joint Working/Integration in respect of Adult Services were outlined in the report. As the management of the pooled budget had been extremely successful, improving outcomes for individuals, in addition to moving from a position of overspend for both Halton Clinical Commissioning Group and the Council to financial balance, the Council and NHS Halton CCG had entered into a new Joint Working Agreement which ran until 31st March 2019.

It was noted that both organisations believed it was an appropriate time to review current arrangements in place in respect of joint working and aligned organisational structures, leadership and governance arrangements across Adult Social Care and Health, in order to deliver more effectively on the desired outcomes for the residents of Halton. Consequently, a PID had been produced which outlined the aim of the project, rationale expected outcomes and process to be undertaken. A Project Board had also been established to take this forward and had met on a number of occasions. It was anticipated that the model, which would be developed as part of this project, would provide the necessary infrastructures for a sound basis to build upon when moving forward on the integration of front line services and the commissioning of services to support community hubs.

RESOLVED: That the report be noted.

HWB14 TRANSFORMING DOMICILIARY CARE

The Board considered a report of the Director of Adult Social Services, which presented proposed developments in relation to Domiciliary Care delivered through the Council. A review of the current Domiciliary Sector in the Borough had commenced which had led to understanding the key principles at the centre of an outcome based domiciliary

service which included:-

- Moving away from a one size fits all approach;
- Adopting a preventative model;
- Keep people independent;
- Improve quality of life;
- Increase community participation; and
- Improve Health and Wellbeing.

As part of the review there had been engagement with people who use the service and carers. Details on the views expressed were outlined in the report. In addition, an initial meeting with providers, the voluntary sector, social work teams, GPs and CCG colleagues had also been held.

It was clear from the feedback that there was a need for change, too many pressures on times, limited capacity, poor recruitment, financial pressures and waiting lists were concerns.

It was reported that one of the opportunities for new ways of working was a bid to the National Lottery for a Social Impact Bond. The National Lottery had opened up a new funding initiative aimed at Local Authorities developing changes within existing service provision to realise significant improvements in outcomes, both for an individual and financial for health and social care. The application was in three stages and, to date, the Council's bid had been successful at stages 1 and 2 and a full application would be submitted on the 22nd September 2016.

RESOLVED: That the report be noted.

HWB15 SYRIAN REFUGEE RESETTLEMENT HEALTH AND WELLBEING NEEDS ASSESSMENT

The Board considered a report of the Director of Public Health, which provided information on the findings and recommendations of a prospective Health and Wellbeing Needs Assessment for the Syrian Refugee Resettlement Programme. The UK Government had committed to resettling 20,000 Syrian refugees over the next five years. The Syrian refugees would be part of the Vulnerable Persons Resettlement Programme and had five years humanitarian protection.

Across the North West, local authorities, including Halton Borough Council, had committed to supporting the Syrian Refugee Resettlement Programme. Liverpool City Council was co-ordinating the Resettlement Programme of

510 refugees on behalf of other local authorities in Merseyside. It was expected that Halton would host 100 of these refugees. The Local Authority would deliver housing provision, initial reception arrangements, casework and orientation support with English for Speakers of Other Language classes, in line with Central Government's Statement of Requirements.

A multi-agency forum had been established with stakeholders in Halton to assess, plan and implement local delivery for the Syrian Resettlement Programme.

The report outlined key issues from the prospective Health and Wellbeing Needs Assessment and also recommendations in respect of housing, health, education and training, employment and language, culture and social connections.

RESOLVED: That

(1) the report be noted; and

(2) the recommendations contained in Section 3.3. be supported.

HWB16 HALTON AFFORDABLE WARMTH STRATEGY 2016/20

The Board considered a report of the Director of Public Health, which provided a background to a new Affordable Warmth Strategy. The Strategy outlined Halton's approach to tackle fuel poverty and living in cold homes over the next five years. It would build upon a wide range of support that the Council and partners already provided for households to address fuel poverty and living in cold homes.

It was reported that in collaboration with other agencies, a vision, objectives, required actions and outcomes to further reduce the harms from living in cold homes in Halton had been agreed. A copy of the Halton Affordable Warmth Strategy 2016/20 had previously been circulated to Members of the Board.

RESOLVED: That

(1) the Affordable Warmth Strategy be approved; and

(2) the implementation of the Action Plan be supported.

HWB17 HEALTH AND WELLBEING BOARD STRATEGY

The Board received an update report on the development of the new One Halton Health and Wellbeing Strategy 2017/2022. The new strategy was being developed using a partnership approach and a multi-agency Health and Wellbeing Steering Group had been established to oversee its development. The Steering Group had used available evidence of health needs to identify issues of particular significance for the Borough. They included:-

- Continue to improve levels of early child development;
- The generally well, focussing on physical activity, healthy eating and alcohol reduction;
- Long term conditions, focussing on heart disease;
- Prevention and early detection of mental health problems and improved access to treatment;
- Ageing well, including falls prevention; and
- Prevention and early detection of cancers and improved access to treatments.

It was reported that success in delivering against the strategy could only be achieved by working in partnership with local people. Therefore, consultation with a wide range of Halton residents to ensure that the principles and priorities were reflective of the experience and needs of the local communities would take place. In addition, consultation would be undertaken by the voluntary sector, Health Watch and One Halton Portfolio Directors using pre-existing networks and forums for engagement. The final version of the One Halton Health and Wellbeing Strategy would be presented to the Board for approval in January 2017.

RESOLVED: That the Board supports the development of the new Strategy.

HWB18 HALTON STRATEGIC PARTNERSHIP RESTRUCTURING

The Board considered an update on the work that had taken place to restructure the Halton Strategic Partnership. On the 2nd March 2016 the Halton Strategic Partnership held a consultation event, attended by over 70 delegates from across the partnership, to discuss a proposed restructuring of the various strategic boards that sat under the partnership banner.

As there was a statutory requirement to have a Health and Wellbeing Board it was considered to merge the Halton Strategic Partnership with the Health and Wellbeing Board under the banner of the Health and Wellbeing Board.

However, it was recognised that it would be important to ensure that within the new expanded role of the Health and Wellbeing Board that it still remained focussed on the wider elements of health and its formal statutory role.

The new structure also saw several of the other Boards being dissolved or combined, with a new Economic Prosperity Board being created whose remit would include some of the areas of responsibility covered by the Liverpool City Region Combined Authority and thus providing a partnership forum for feeding into the wider LCR agendas. A copy of the proposed new partnership arrangements had previously been circulated to the Board

RESOLVED: The report be noted and the revised arrangements be supported.

Meeting ended at 2.50 p.m.

REPORT TO: Health Policy & Performance Board

DATE: 7th February 2017

REPORTING OFFICER: Strategic Director, People

PORTFOLIO: Health & Wellbeing

SUBJECT: Performance Management Reports, Quarter 3 2016/17

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 2016/17. 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, 2016/17.

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 to 31st December 2016

1.0 Introduction

This report provides an overview of issues and progress against key service area objectives and milestones and performance targets, during the second quarter of 2016/17 for service areas within the remit of the Health Policy and Performance Board. These areas include:

- Adult Social Care (including housing operational areas)
- Public Health

2.0 Key Developments

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

Adult Social Care

Domiciliary Care

We are about to launch the new domiciliary care tender process that will run from December 2016 to July 2017. This will see a significant change in service provision and will be supported by a reduction in the number of providers from the current level of 9 providers who cover a number of different zones, to a town based provision that will require one provider to operate in each town.

We have an agreement in principal for funding from the European Union to support delivering new technology solutions within the Domiciliary Care market. We are still working on the detail of how this funding could work and the parameters that the funders will be operating under.

Mental Health Services:

Review of the 5Boroughs Acute Care Pathway and Later Life and Memory Services (the Tony Ryan review): following the completion of the Tony Ryan review earlier in 2016, the CCG have been leading two local work streams which aim to redesign the delivery of services for people with mental health problems in the community. Two approaches are being taken:

- Prevention and early intervention: becoming involved with people at an earlier stage in their condition, to reduce the impact of the condition and potentially reduce the numbers of people who have to be referred thought to hospital-based mental health services
- Supporting the transfer of people's care from secondary to primary care services as their condition improves.

A successful multi-agency workshop was held in November 2016, to support the development of a model of service delivery to match these approaches and it is expected that this will be finalised in the next three months.

Additional work is taking place within the 5Boroughs on redesigning the support provided to people with complex needs and challenging behaviour, and the proposals for redesign of local inpatient services are out for formal public consultation.

Community Bridge Builders

- BB has worked with people with disabilities in a person centered way to find meaningful employment in their local community

  Voluntary work from April 2015

  219 people supported into voluntary work

  Paid Work/Permitted from April 2015

  47 people with Disabilities supported into Paid/Permitted work

Learning Disability Nursing Team

- There has been a significant increase in referrals and also the complexity of cases – thus increasing pressure on the team and increasing waiting times
- The team have recently completed SPACE training – preventing violence in the workplace and lone working. Pro-active approaches to conflict. The team have also completed first aid and personal safety training, along with 3 member s of the team recently completing a 2 day Autism awareness training.
- The team are continuing to look at completing sexual health training via the Family Planning Association; this is much needed due to the trend in referrals for this type of work.
- The team continue to provide men's and women's sexual health and relationship groups.
- The team are currently working with Susan Gallagher (Diabetes essential Lead) to work with people with Learning Disabilities accessing clinics with reasonable adjustments.
- We currently have a patient on Byron Ward, Hollins Park and we are offering weekly support.

The Community Multi-Disciplinary Team Model

A number of legislative and policy developments have contributed to the development of the community multi-disciplinary approach in Halton, further integrating health and social care in the borough.
The model for Community MDTs in Halton consists of staff from several different professional backgrounds, including GPs, Social Workers, Community Care Workers District Nurses, Social Care in Practice (SCiP) workers, Community Matrons, Continuing Health Care Nurses, and Wellbeing Officers, who are able to respond to people who require the help of more than one kind of professional. The MDT will work in an integrated way, aligned to GP practices.

The model works with four GP Hubs: Widnes North, Widnes South, Runcorn West and Runcorn East. Each Hub has clusters of GP surgeries. Each GP surgery has a single MDT, working with an identified GP patient population. A full report will be submitted to HPPB and Halton NHS Clinical Commissioning Group, Service Development Committee in early 2017.

Homelessness
The Syrian Refugee Programme is underway and Halton forms part of the Merseyside Sub Region. Collectively the 6 Merseyside Authorities have agreed to accommodate 510 refugees, with Halton taking 100 individuals. . The required procurement process has been completed and each authority has agreed what services will be commissioned. The Sub Region has appointed a LCR coordinator, who will work directly with the Merseyside Authorities and oversee the Vulnerable Person programme.

Gypsy Travellers
The new residential site officially opened November 2016, with occupancy at 75%. The Local Authority administered a phased allocation process and the final interviews will be held late January 2017.

PUBLIC HEALTH

0 to 19 Healthy Child Pathway.

Halton is developing a new service specification to commission an integrated 0 to 19 Healthy Child Pathway. This is being informed by a series of workshops that have taken place. It will include health visitors, school nurses, Family Nurse Partnership, and early help and support.

World Mental Health Day
Halton Borough Council celebrated World Mental Health Day on Monday 10 October with a conference and social event for residents and local professionals to inform and entertain. There were owls, dancers, bands and discussion groups.

The conference at Riverside College (Centre Stage, Kingsway) was attended by over 100 people and tied in with the theme of 'Building a Mentally Healthier Halton' - an ongoing theme for the Health Improvement Team.

150 local residents also attended the 'feel good' social event in the evening at The Studio in Lacey Street, Widnes. Performers included SJ Pure Dance, Hearts and Voices Choir and poet Clive Little.

The events were a partnership with Riverside College and The Studio, with support across local services and teams including health, education, housing and police, with the aim of finding ways to make people healthier and happier.

Girls and Women's Health

The Public Health England report 'Recent Trends in Life Expectancy at Older Ages' identified a potential risk of falling life expectancy trends in Halton amongst those aged 65 and over, with the changes being slightly more significant amongst females than males.

The World Health Organisation and the Chief Medical Officer Report in 2014 advocate a life course approach to women's health focusing on key priority areas; Child & Maternal Health, Mental Health, Cancer, Lifestyles, Violence and Reproductive/Sexual Health.

The public health services team are leading a girls and women's health work programme across the thematic areas Start Well, Live Well and Age Well. Since September 2016, there has been a review of public health intelligence, consultation with key stakeholders and community engagement via local radio, social media and one-to-one or group discussions. An engagement event with girls and women will be held on 24th January 2017 at Select Security Stadium, Widnes, 1.30pm to 4.30pm. Findings will support ongoing strategic development and commissioning plans. The 2016/17 Public Health Annual Report will focus on Girls and Women's Health in Halton.

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:

Adult Social Care

Mental Health Services:

Social Work for Better Mental Health: this national programme has been designed to help local authorities to be clear about the roles and functions of social workers when they are working in integrated mental health services. Halton, jointly with Sefton Council, is one of the first implementers of this programme, which is sponsored by the Department of Health and the Chief Social Worker, and which will be rolled out throughout the country. The self-assessments have been completed and a final report is due to be written. This will then be used to refresh the partnership arrangement between Halton Borough Council and the 5BoroughsPartnership.

People with complex mental health conditions who are placed out of borough: a number of people complex mental health conditions have in recent years been placed by the health services in specialist placements some distance from Halton, either in private hospitals or specialist rehabilitation placements. Apart from the impact on the people themselves, who will find it hard to maintain their local links, there is often a high cost associated with these placements. The CCG, 5BoroughsPartnership and Borough Council are working together to develop local services and supports that can better meet the needs of this group of people, with the aim of supporting a number of them to return to the area.

Mental Health Serious Incidents: following a number of serious incidents in the summer of 2016, a number of processes are taking place to identify any lessons that can be learned and applied to service improvements. These processes are being overseen by a multiagency group which is considering the issues arising from each of the incidents.

The development of a progression policy, for Social Care Occupational Therapists, (SCOT) is underway which follows on from the work undertaken around the Social Work Progression Policy developed in 2015 and stems from a need for similar arrangements for Social Care Occupational Therapists (SCOTs).
Formal consultation begins in January 2017.

PUBLIC HEALTH

No emerging issues with Public Health.

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 2016/17 Directorate Business Plans.

5.0 Progress against high priority equality actions

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

6.0 Performance Overview

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

"Rate per population" vs "Percentage" to express data
Four BCF KPIs are expressed as rates per population. "Rates per population" and "percentages" are both used to compare data but each expresses the same amount in a different way. A common guide used is that if a percent is less than 0.1 then a rate (e.g. per 100,000) is used. For example, permanent admissions to residential care expressed as a rate (50 admissions per or for every 100,000 people) makes more sense when comparing performance with other authorities rather than as a percentage (0.05%) which is quite a small number and could be somewhat confusing. More examples below:

Location	Rate per 100,000 population	Percent
Region A	338.0	0.34%
Region B	170.5	0.17%
Region C	225.6	0.23%

Prevention and Assessment Services **Key Objectives / milestones**

Ref	Milestones	Q2 Progress
PA 1	Monitor the effectiveness of the Better Care Fund pooled budget ensuring that budget comes out on target (**AOF 21, 25) March 2017**	✓
PA 1	Integrate frontline services with community nursing (AOF 2, 4, & 21) **March 2017**	✓

Supporting Commentary

PA 1 - Monitor the effectiveness of the Better Care Fund pooled budget ensuring that budget comes out on target
Budget is monitored effectively, work is progressing to ensure the budget is balanced at the end of the year.

PA 1 - Integrate frontline services with community nursing
A dedicated Steering Group with membership from Adult Social Care, Bridgewater Community NHS Trust, Halton NHS Clinical Commissioning Group and IT services from NHS and the HBC, have developed a model for Multi-Disciplinary Team working, to provide better communications and coordination of care across health and social care and improving outcomes for people with complex needs. Following development of system wide information sharing agreements and promising indications that Halton will receive regional NHS information technology grants that will make the joining together of information technology systems easier.

Key Performance Indicators

Ref	Measure	15/16 Actual	16/17 Target	Q3 Actual	Q3 Progress	Direction of travel
PA 2	Percentage of VAA Assessments completed within 28 days	85% (estimated - further data quality work ongoing to confirm this)	85%	84%	✓	↑
PA 6a	Percentage of items of equipment and adaptations delivered within 7 working days	97%	95%	94%	✓	↓
PA 11	Permanent Admissions to residential and nursing care homes per 100,000 population,65+ (ASCOF 2A1) *Better Care Fund performance metric*	541.7%	637.3	236.8	N/A as no target	↓
PA 12	Delayed transfers of care (delayed days)	2475	236 per month	1104.9 per 100,000 pop	?	

Ref	Measure	15/16 Actual	16/17 Target	Q3 Actual	Q3 Progress	Direction of travel
	from hospital (average per month) *Better Care Fund performance metric*			Total for Aug/Sep/Oct 2016 1438 (Delayed Days)		
PA 14	Total non-elective admissions in to hospital (general & acute), all age, per 100,000 population *Better Care Fund performance metric*	15231 V plan 16668 (Feb 16)		3398 Per 100,000 figure (all ages)	?	
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*	685.1	TBC	N/A	N/A	N/A
PA 16	Proportion of Older People (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (ASCOF 2B1) *Better Care Fund performance metric*	63.3	Data published for 15/16, figures have remained stable from 14/15. This is an annual collection figures for 16/17 will be available late 2017			
PA 20	Do care and support services help to have a better quality of life? (ASC survey Q 2b) *Better Care Fund performance metric*	93.3	Data published for 15/16, figures have remained stable from previous years. This is an annual collection figures for 16/17 will be available late 2017			

Supporting Commentary

PA 2 - Percentage of VAA Assessments completed within 28 days
We are on line to meet this target. We are a head of target compared to last years figures.

PA 6a - Percentage of items of equipment and adaptations delivered within 7 working days
This figure is slightly down on last years position but is on course to meet the target.

PA 11 - Permanent Admissions to residential and nursing care homes per 100,000 population,65+
Figure are until the end of Nov placed 51 compared to 81 people as of last year we are coming in as red which is positive for this particular target.

PA 12 - Delayed transfers of care (delayed days) from hospital per 100,000 population
The target is the number of days per month not a rate per 100,000 per population.

The number of delayed days is only available until October so a Q3 position would be August, September and Octobers figure.

We are above target. This is due to a small number of very long delays patients at 5BP.

PA 14 - Total non-elective admissions in to hospital (general & acute), all age, per 100,000 population
The Q3 figure reported here is the latest available and covers the period (Aug to Oct 16) this number is based on 4422 non-elective admissions and a population of 130147. Non-elective admissions are above plan for the year by 1.9%, this has been attributed to increased admissions at Warrington hospital following the opening of the new ambulatory care unit, however an increase in admissions at Whiston has also been seen. This increase in admissions appears to indicate an increase in acuity of patients rather than increased demand as the number of Halton residents actually attending A&E at Warrington and Whiston has fallen

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+)
The performance data is only being collected on an annual basis, the next date that data will be available is May 2017.

PA 16 - Proportion of Older People (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
Annual Collection

PA 20 - Do care and support services help to have a better quality of life?
Annual Collection

Commissioning and Complex Care Services

Key Objectives / milestones

Ref	Milestones	Q2 Progress
CCC 1	Continue to monitor effectiveness of changes arising from review of services and support to children and adults with Autistic Spectrum Disorder. **March 2017** (AOF 4)	✓
CCC 1	Continue to implement the Local Dementia Strategy, to ensure effective services are in place. **March 2017** (AOF 4)	✓
CCC 1	Continue to work with the 5Boroughs NHS Foundation Trust proposals to redesign pathways for people with Acute Mental Health problems and services for older people with Mental Health problems. **March 2017** (AOF 4)	✓
CCC 1	The Homelessness strategy be kept under annual review to determine if any changes or updates are required. **March 2017** (AOF 4, AOF 18)	✓
CCC2	Ensure Healthwatch is established and consider working in partnership with other Councils to deliver this. **March 2017** (AOF 21)	✓
CCC3	Undertake on-going review and development of all commissioning strategies, aligning with Public Health and Clinical Commissioning Group, to enhance service delivery and continue cost effectiveness, and ensure appropriate governance controls are in place. **March 2017** (AOF 21 & 25)	✓

Supporting Commentary

CC1 - **Continue to monitor effectiveness of changes arising from review of services and support to children and adults with Autistic Spectrum Disorder**

CC1 - Continue to implement the Local Dementia Strategy, to ensure effective services are in place

During Q3 Halton has contributed to the North West Dementia Perspectives State of the Region report, which makes a number of recommendations to facilitate quality through evidence based examples of good practice. These recommendations and the implications for Halton will be considered as part of the Dementia Delivery Group's refresh of the Dementia Delivery Plan in early 2017.

During Q3 Halton has supported the Department of Health Funded 'Beyond the Front Door' project, led by Life Story Network. A stakeholder workshop took place in December, the findings of which will contribute to the final project report and suite of resources to support professionals to raise awareness of and how to respond to specific transition points in people's care.

The Halton dementia diagnosis rate stands at 72%.

During Q3 the Halton Admiral Nurse Service continued to establish itself and work with partners to build caseloads. The service is delivering tailored support to approx. 90 cases with complex.

CC1 - 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

This work continues and is taking place alongside NHS Halton and the 5BoroughsPartnership. Two work-streams are developing proposed models for the delivery of early intervention and prevention services in mental health, and for services which support people who are recovering to be managed appropriately within primary care services. A final model is expected to be put forward early in 2017.

CC1 - The Homelessness strategy be kept under annual review to determine if any changes or updates are required

The annual homelessness strategy review event took place in December 2016 and was well attended. The action plan is presently being reviewed and will be updated to reflect key priorities.

The homelessness strategy is due to be fully reviewed June 2017 and consultation events with partners will be arranged. A five year action plan will be completed to determine the LA priorities and to ensure it reflects economical and legislative changes.

CC2 – Ensure Healthwatch is established and consider working in partnership with other Councils to deliver this

Halton will be meeting with Warrington & Knowsley in February to explore the options for improving cooperation between the 3 Healthwatches.

CC3 - Undertake on-going review and development of all commissioning strategies, aligning with Public Health and Clinical Commissioning Group, to enhance service delivery and continue cost effectiveness, and ensure appropriate governance controls are in place.

Work continues on the further alignment of system and services across Health and Adult Social Care in line with the associated project brief previously approved by Halton Borough Council, NHS and Halton Clinical Commissioning Group.

Key Performance Indicators

Ref	Measure	15/16 Actual	16/17 Target	Q3 Actual	Q3 Progress	Direction of travel
CCC 3	Adults with mental health problems helped to live at home per 1,000 population	3.21	3.00	3.35	✓	↑
CCC 4	The proportion of households who were accepted as statutorily homeless, who were accepted by the same LA within the last 2 years (Previously CCC 6).	0	0	Figures not available	✓	Q3 Figures not available
CCC 5	Number of households living in Temporary Accommodation (Previously NI 156, CCC 7).	15	17	Figures not available	✓	Q3 Figures not available
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)	5.1	5.5	Figures not available	✓	Q3 Figures not available

Supporting Commentary

CCC3 - Adults with mental health problems helped to live at home per 1,000 population
This continues to be a challenging target, because a reconfiguration within the 5Boroughs reduced the numbers of people who could be counted in this cohort. The work to develop new care pathways into and out of long term care should increase the numbers however.

CCC4 - The proportion of households who were accepted as statutorily homeless, who were accepted by the same LA within the last 2 years
The Authority places strong emphasis upon homelessness prevention and achieving sustainable outcomes for clients.

The Authority will continue to strive to sustain a zero tolerance towards repeat

homelessness within the district and facilitate reconnection with neighbouring authorities.

CCC5 - Number of households living in Temporary Accommodation
National and Local trends indicate a gradual Increase in homelessness, which will impact upon future service provision, including temporary accommodation placements.

The changes in the TA process and amended accommodation provider contracts, including the mainstay assessment, have had a positive impact upon the level of placements and positive move on process.

The Housing Solutions Team is community focused and promote a proactive approach to preventing homelessness. There are established prevention measures in place which are fully utilised by the Housing Solutions team to ensure vulnerable clients are fully aware of the services and options available.

The emphasis is focused on early intervention and empowerment to promote independent living and lifestyle change.

CCC6 - 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)
The Housing Solutions Team promotes a community focused service, with emphasis placed upon homeless prevention.

The officers now have a range of resources and options that are offered to vulnerable clients threatened with homelessness. The tea strives to improve service provision across the district. Due to the early intervention and proactive approach, the officers have continued to successfully reduce homelessness within the district.

Public Health

Key Objectives / milestones

Ref	Milestones	Q2 Progress
PH 01a	Work with PHE to ensure targets for HPV vaccinations are maintained in light of national immunisation Schedule Changes and Service reorganisations. **March 2017**	✓
PH 01b	Working with partners to identify opportunities to increase uptake across the Cancer Screening Programmes by 10%. **March 2017**	✓
PH 01c	Ensure Referral to treatment targets are achieved and minimise all avoidable breaches. **March 2017**	✓
PH 02a	Facilitate the Healthy Child Programme 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 2017**	✓
PH 02b	Maintain the Family Nurse Partnership programme **March 2017**	✓

PH 02c	Facilitate the implementation of the infant feeding strategy action plan. **March 2017**	✓
PH 03a	Expansion of the Postural Stability Exercise Programme. **March 2017**	✓
PH 03b	Review and evaluate the performance of the integrated falls pathway. **March 2017**	✓
PH 04a	Work in partnership to reducing the number of young people (under 18) being admitted to hospital due to alcohol. **March 2017**	✓
PH 04b	Raise awareness within the local community of safe drinking recommendations and local alcohol support services through delivering alcohol awareness campaigns, alcohol health education events across the borough and ensuring key staff are trained in alcohol identification and brief advice (alcohol IBA). **March 2017**	✓
PH 04c	Ensure those identified as having an alcohol misuse problem can access effective alcohol treatment services and recovery support. **March 2017**	✓
PH 05a	Monitor and review the Mental Health Action plan under the Mental Health Governance structures (covering actions to promote mental health and wellbeing and the early detection and effective treatment of mental health conditions).**March 2017**	✓
PH 05b	Implementation of the Suicide Action Plan. **March 2017**	✓

PH 01a **Work with PHE to ensure targets for HPV vaccinations are maintained in light of national immunisation Schedule Changes and Service reorganisations**.

The throughput of clients accessing Halton Stop Smoking Service in April to September 2016 compared to the same period of 2015 - 2016 is showing an increase. This is against the national trend of services experiencing a reduction in their client throughput

The Halton Service quit rate for April to September 2016 has also increased by 11% compared to the same period in 2015. Again, historically this is against the national trend of services delivering lower quit rates when their throughput increases.

Halton's smoking prevalence at time of delivery for pregnant women has also reduced; by 4.8% in the period April to September 2016 compared to the same period of 2015.

PH 01b **Working with partners to identify opportunities to increase uptake across the Cancer Screening Programmes by 10%**.

No new data since last report.

In line with national trends we have seen a very slight decline over time in the uptake of both cervical and breast screening. Halton has worked very hard to identify and tackle the causes of low uptake espcially within the Bowel Screening programme. Wehave undrtake some local and regional work to increase participation and have begin to see a trend of increasing uptake in the Bowel Screneing programme. Halton continues to engage with partners, through the Memoradum of Understanding with the Cancer Task Group at Public Health England and Cheshire and Merseyside

authorities, to raise awareness and attendance across all screening programmes.

PH 01c Ensure Referral to treatment targets are achieved and minimise all avoidable breaches.

Individual breaches continue to be investigated alongside the trusts so that the root causes for the delays can be assessed and mitigated. Public Health and Halton CCG are currently working with Trusts to improve reporting and system wide assurances. This will also be a key focus within the development of a regional Cancer Alliance, and part of the STP approach going forward. 62 day targets continue to fluctuate and while patient choice is one reported factor, systems must be better equiped to manage choice

PH 02a Facilitate the Healthy Child Programme 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.

Child development is a priority area for One Halton, and a working group is developing and refreshing an action plan. The commissioned independent report into child development and the outcomes from the themed Ofsted visit have been used to form the framework for the action plan. Recently published school readiness data for 2015/16 shows a 7% improvement in Halton, narrowing the gap with England.

The Health Visiting Service is delivering all the new components of the national Healthy Child Programme, including assessing mothers' emotional health at 6-8 weeks and completing an integrated developmental check at 2-21/2. The early years setting and health visitors share the findings from the development checks to identify any areas of concern, so that services can collaboratively put in place a support package as required. A group is working to further develop the integrated check, improve data sharing and consistency of plans following the check.

The CCG has invested in perinatal mental health, including training of health visitors and community staff to support mothers to bond with their baby and support parents experiencing perinatal mental illness (during pregnancy and immediately after birth). Perinatal pathways are in the process of being agreed, to improve consistency of care.

The new Parent Craft programme (Your Baby and You) is now available for all pregnant mothers. This has been developed and delivered in partnership with the Family Nurse Partnership, Health Visitors, Midwifery, children centres and our own breast feeding support team. Sessions are delivered in Runcorn Town Hall and Ditton Library on a weekly basis. The programme has recently been positively evaluated by families and demand is high.

PH 02b Maintain the Family Nurse Partnership programme

Family Nurse Partnership is fully operational with a full caseload; it continues to work intensively with first time, teenage mothers and their families. The service hosted its annual review event on December 16th, where families on the programme and partner agencies were invited to come along, learn more about Family Nurse Partnership and the journey that families have been on, and to reflect on progress over the last year.

PH 02c Facilitate the implementation of the infant feeding strategy action plan.

The implementation of the infant feeding action plan is underway, with oversight from the Halton Health in the Early Years group.

Breastfeeding support continues to be available across the borough in community and health settings. The infant feeding coordinator and children's centres are working towards achieving BFI (Unicef Baby Friendly Initiative) in the children's centres and are

due to be inspected in the summer of 2017, alongside a Bridgewater inspection. This involves training children's centre staff, and auditing their practice.

The team continue to maintain baby welcome premises and are refreshing the Halton Early Years award, which encourages healthy living practices in early years settings, and includes breastfeeding.

PH 03a Expansion of the Postural Stability Exercise Programme.

Key activity this quarter:

- Currently delivering six Age Well exercise classes per week, three in both towns, level 1, 2 and 3 (level 1 being for most complex clients). Level 3 classes have become a maintenance class – 'Keep it Moving'. Classes work on a rolling programme with a review every 15 weeks up to 45 weeks in total.
- A total of 85 individual clients have attended and been supported through the service in quarter 3.
- The service is building stronger links with Sure Start to Later Life in an attempt to raise awareness of events and helping people to stay in touch with friends that they have made as part of the class.
- The service has been rebranded and is now called "Age Well exercise"

PH 03b Review and evaluate the performance of the integrated falls pathway.

The review of the falls pathway has been scoped and will be implemented over the remainder of the year. Initial work has focussed on the interaction between low-level services who support falls awareness and prevention. As a result a telephone health initial assessment will begin in the New Year which should reduce the number of assessment visits for clients and will help to improve the efficiency of the pathway.

PH 04a Work in partnership to reducing the number of young people (under 18) being admitted to hospital due to alcohol

Good progress continues to be made in reducing the number of young people being admitted to hospital due to alcohol. Key activity includes:

- Delivery of alcohol education within local school settings (Healthitude, R U Different, Amy Winehouse Foundation, Cheshire Police, Alcohol education Trust, wellbeing web magazine).
- Delivery of community based alcohol activity.
- Delivering early identification and brief advice (alcohol IBA) training and resources for staff who work with children and young people).
- Running the Halton Community Alcohol Partnership which brings together partners to reduce underage drinking and associated antisocial behaviour.
- Working closely with colleagues from Licensing, the Community Safety team, Trading Standards and Cheshire Police to ensure that the local licensing policy helps prevent underage sales and proxy purchasing.

PH 04b Raise awareness within the local community of safe drinking recommendations and local alcohol support services through delivering alcohol awareness campaigns, alcohol health education events across the borough and ensuring key staff are trained in alcohol identification and brief advice (alcohol IBA)

Work continues to raise awareness among the local community of safe drinking recommendations and to train staff in alcohol identification and brief advice (alcohol IBA). The Chief Medical Officer has updated the low risk weekly guidelines (men and women are advised not to regularly drink more than 14 units a week). Work has been undertaken to update resources and communicate this message to the public at community events across the borough.

PH 04c Ensure those identified as having an alcohol misuse problem can access effective alcohol treatment services and recovery support

CGL continue to support individuals with alcohol misuse problems in Halton and support their recovery. During the last 12 months to September 2016, a total of 283 individuals underwent alcohol treatment. A further 98 individuals underwent treatment for alcohol and drug misuse (alcohol and non-opiate drugs).

Performance continues to be good, with outcomes remaining higher than the national figures:

- Successful alcohol treatment completion rate was 41% locally, compared to 38% nationally (Oct 2015 to Sept 2016).
- Individuals leaving alcohol treatment successfully and not returning within 6 months was 92% locally, compared to 91% nationally (Oct 2015 to Sept 2016).

PH 05a Monitor and review the Mental Health Action plan under the Mental Health Governance structures (covering actions to promote mental health and wellbeing and the early detection and effective treatment of mental health conditions).

The action plan and activity reports from sub groups are reviewed at the Mental Health Oversight Board.

A review of the Mental Health Strategy and refresh of high level indicators based on new national policy drivers has been completed and approved by the Mental Health Oversight Group. This is currently being taken to the subgroups for a refresh of the individual action plans required to achieve the objectives.

PH 05b Implementation of the Suicide Action Plan.

The action plan continues to be overseen by the Halton Suicide Partnership group.

Activity towards becoming a Suicide Safer Community is underway and a series of training programmes have been rolled out to multiple partners and agencies acorss a multi disciplinary footprint.

Key Performance Indicators

Ref	Measure	15/16 Actual	16/17 Target	Q3	Current Progress	Direction of travel
PH LI 01	Mortality from all cancers at ages under 75 Directly Standardised Rate, per 100,000 population *Published data based on calendar year, please note year for targets.*	167.0 *(2015)*	176.0 *(2016)*	163.7 *(Q4 2015 – Q3 2016)*	✓	↑
PH LI 02	A good level of child development	54.7% *(2014/15)*	54.6% *(2015/16)*	61.9% *(2015/16)*	✓	↑
PH LI 03	Falls and injuries in the over 65s. Directly Standardised Rate, per 100,000 population (PHOF definition).	3360.0 *(2014/15)*	3294.1 *(2015/16)*	Annual data only	?	↑
PH LI 04	Alcohol related admission episodes - narrow definition Directly Standardised Rate, per 100,000 population	767.2 *(2014/15)*	808.4	834.85 *Q2 2015/16 – Q1 2016/17*	?	↑
PH LI 05	Under 18 alcohol-specific admissions Crude Rate, per 100,000 population	51.0 *(12/13 to 14/15)*	55.0	Annual data only	?	N / A
PH LI 06	Self-reported wellbeing: % of people with a low happiness score	11.8% *(2014/15)*	12.4%	Annual data only	?	↑

Supporting Commentary

PH LI 01 Mortality from all cancers at ages under 75 Directly Standardised Rate, per 100,000 population
Data used is rolling annual, based on calendar year of date of death registered.
The rate has seen an improvement up to September 2016 and is on track to hit the 2016 target.

PH LI 02 A good level of child development
This indicator has seen an improvement in 2015/16, narrowing the gap between Halton and England.

PH LI 03 Falls and injuries in the over 65s. Directly Standardised Rate, per 100,000 population (PHOF definition)
Data used is annual, published data. 2015/16 data is not yet available.

This will remain the case until a solid source of local data can be attained.

PH LI 04 Alcohol related admission episodes - narrow definition Directly Standardised Rate, per 100,000 population
Although an increase was seen between 2014/15 and 2015/16, the provisional quarterly rate to Q1 2016/17 shows a slight decrease.

PH LI 05 Under 18 alcohol-specific admissions Crude Rate, per 100,000 population
No update from previous quarter available

PH LI 06 Self-reported wellbeing: % of people with a low happiness score
No update from previous quarter available. This is based on annual published survey data for Halton residents calculated from the question "Overall, how happy did you feel yesterday?" Respondents answer on a scale of 0 (not at all happy) to 10 (completely happy) and this indicator is a percentage that scored 0-4.

APPENDIX 1 – Financial Statements

Financial Statements are not currently available, however will be circulated in an updated report for PPB.

ADULT SOCIAL SERVICES & PREVENTION AND ASSESSMENT DEPARTMENT

Comments on the above figures:

Comments on the above figures:

COMPLEX CARE POOL

Comments on the above figures:

Comments on the above figures:

COMMISSIONING & COMPLEX DEPARTMENT

Comments on the above figures

Comments on the above figures.

PUBLIC HEALTH & PUBLIC PROTECTION DEPARTMENT

Comments on the above figures:

Comments on the above figures.

APPENDIX 2 – Explanation of Symbols

Symbols are used in the following manner:

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

Direction of Travel Indicator

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

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

REPORT TO:	Health Policy Performance Board
DATE:	7th February 2017
REPORTING OFFICER:	Strategic Director, People
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Domiciliary Care in Halton
WARD(S):	Borough-wide

1.0 PURPOSE OF REPORT

1.1 To receive a joint presentation from Halton Borough Council and Victoria Community Care, a domiciliary care agency, regarding domiciliary care provision in Halton.

2.0 RECOMMENDED: that the Board

1. **Note the contents of the report and associated presentation.**

3.0 SUPPORTING INFORMATION

3.1 One of the main drives over the past decade both locally and nationally has been to offer support to people in their own home for as long a period as is possible. One of the most effective ways to do this has been through offering care and support to people in their own home through a domiciliary care agency. In Halton there are currently 9 providers who offer personal care and support to approximately 800 people every day.

The current service is split into four different zones, 2 in Widnes and 2 in Runcorn. Care calls are delivered by care staff in blocks of 15, 30, 45 or 60 minutes, depending on an individual's level of need.

3.2 The purpose of the presentation will be to provide Board Members with details of how the current system of Domiciliary Care provision works in Halton, but from the perspective of the providers.

The presentation will include an overview of the challenges that are encountered and how the Borough Council and providers work together to maintain the delivery of high quality services to our local population, the rewards for providers, how the service has changed over the years etc. and their views of what the future may hold.

3.3 The role of a domiciliary care provider is challenging. It has significantly changed and there is far greater need to deliver clinical tasks as well as operating in a far more pressured and

competitive market. It is in some way a testament to the local relationships that have been fostered that allow Halton to continue to deliver the high quality service it does despite all of the day-to-day pressures.

4.0 **POLICY IMPLICATIONS**

4.1 None identified.

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**

Domiciliary Care provision in Halton supports the Council's strategic priority of Improving Health.

6.4 **A Safer Halton**

None identified.

6.5 **Environment and Regeneration in Halton**

None identified.

7.0 **RISK ANALYSIS**

7.1 No risks associated with this report have been identified.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 An Equality Impact Assessment is not required for this report.

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

9.1 None identified.

REPORT TO: Health Policy & Performance Board

DATE: 7th February 2017

REPORTING OFFICER: Strategic Director, People

PORTFOLIO: Health and Wellbeing

SUBJECT: General Practice Alignment/Care Home

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To share with the Board, an update on NHS Halton Clinical Commissioning Groups (CCG's) project to align General Practice with care homes in Halton.

1.2 To ask the Board to review and comment on the recommendations listed below.

2.0 **RECOMMENDATION: That:**

i) The Board notes the update provided in the 'General Practice Alignment/Care Home – Options Appraisal Paper', attached at Appendix 1.

ii) The Board and the CCG discuss and agree whether the proposal amounts to substantial variation.

iii) Pending the above discussion the Board supports the proposed approach to consultation.

3.0 **SUPPORTING INFORMATION**

3.1 NHS Halton CCG with the support of Halton Borough Council is proposing to align care homes within the Borough with identified General Practice/s. Care home residents have very complex and considerable health needs, and are entering the final stages of their lives. In Halton the length of stay in a nursing home is 0.8 years, and residential home 1.2 years. These individuals require consistent high quality care that is tailored to specific individual needs. It is expected that care home numbers will rise significantly in response to our ageing population. Currently, individuals remain with their existing GP when they move to a care home, this results in care homes having to liaise with multiple GP Practices. Both the care homes and GP's report that this has an impact on developing close working arrangements which are essential in providing the care that these individuals require. It is also anticipated that an alignment of General Practice to care homes would result in releasing time currently being spent by Practices visiting multiple care homes, and care homes liaising with several practices that could be converted into direct care.

3.2 The report 'GP Alignment/Care Home – Options Appraisal Paper' was presented to the CCG Service Development Committee on the 14th December, where it received full support.

3.3 Early conversations with care homes in the Borough and Teams with input into care homes have been positive.

3.4 The CCG is working with NHS England's National Lead for Enhanced Health in Care Homes Vanguard Lead, and has been assured that this alignment work is in keeping with forthcoming NHS England guidance.

3.5 The Report, consultation outline and the Equality Impact Assessment are being submitted to the Local Medical Committee meeting on the 6th February 2017, for support. NHS Halton CCG's LMC link GP is supportive of the project.

4.0 POLICY IMPLICATIONS

4.1 The commissioning of quality, safe and effective general medical services is critical to ensuring improved care and outcomes for residents and supports NHS Halton CCGs Sustainability and Recovery Plan.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 There is no financial implication to the initial aligning of GP Practice to an identified care home/s. The development of a service model of care would require additional financial support, possibly through a CCG Local Enhanced Service Scheme.

5.2 There is a national guidance expected from NHS England in the New Year with associated funding for a local scheme planned, though not guaranteed at this point.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**
Not applicable.

6.2 **Employment, Learning & Skills in Halton**
The alignment of General Practice to care homes in Halton will help to support and maintain healthy and resilient workforces both within General Practice and within care homes.

The Board may wish to note that there is a separate programme of work underway led by NHS Halton CCG Chief Nurse and Halton Borough Council's Assistant Director of Adults Social Care which seeks to address further, training and retention of staff within care homes.

6.3 **A Healthy Halton**
An alignment model is expected to support improved care and outcomes for residents as well as the alleviation in pressures for both workforces.

6.4 **A Safer Halton**
A closer working rapport between care homes and General Practice will strengthen

relationships; reduce medication/prescribing issues and support early identification of issues that may require support or action from another agency, thus improving care.

6.5 **Halton's Urban Renewal**
Not applicable.

7.0 **RISK ANALYSIS**

7.1 The main risks for this project relate to potential non-engagement of stakeholders. It is anticipated that this will be mitigated through the consultation period.

7.2 There is a risk that national funding may not follow in the New Year and the CCG are reviewing local options to support new model development as an alternative option.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 An initial Equality Impact Assessment has been carried out. This has been reviewed and accepted by the CCG Equality Lead.

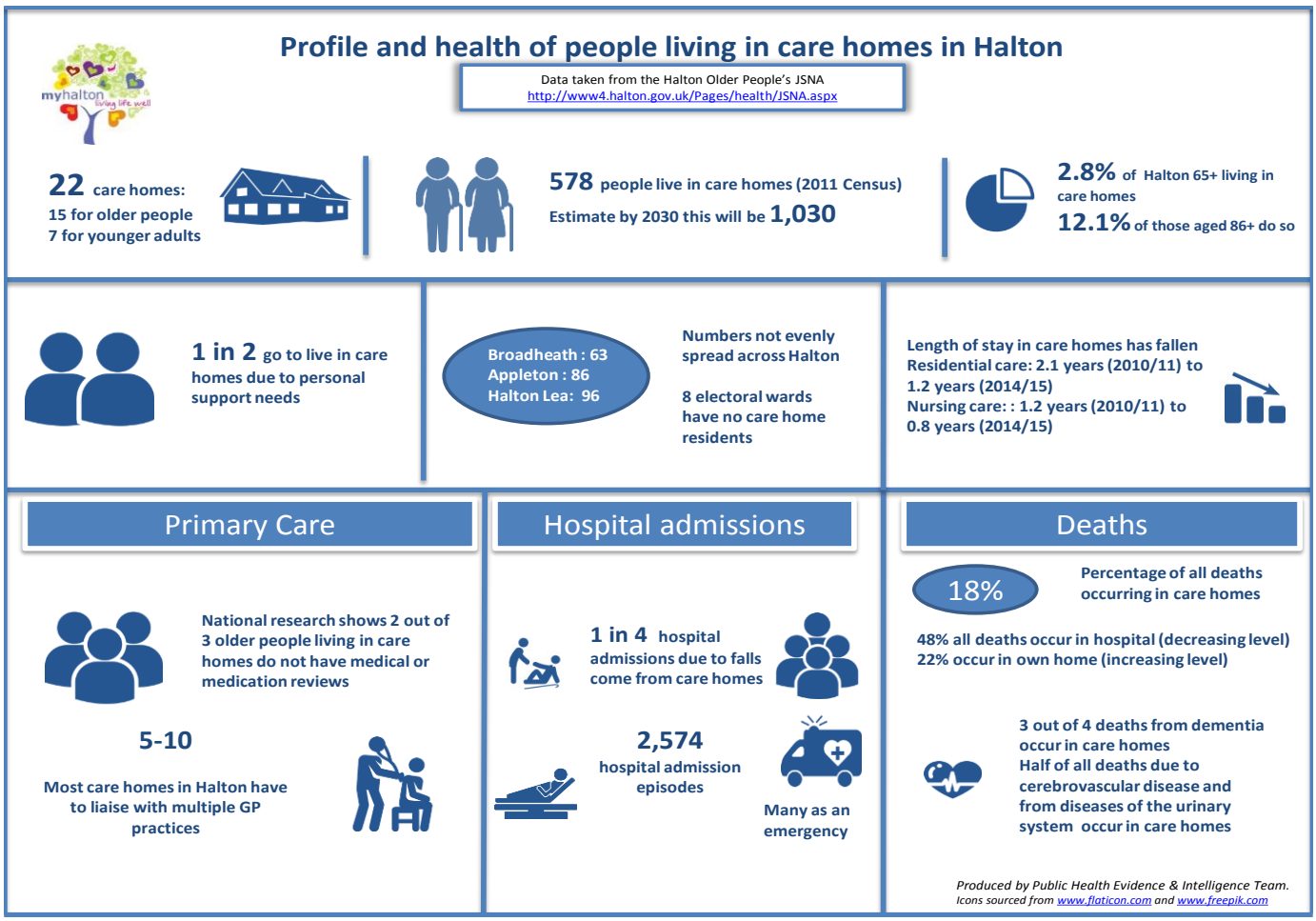
8.2 On completion of consultation the CCG will finalise the Equality Impact Assessment.

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

GP Alignment/Care Home – Options Appraisal Paper



Care homes now provide more beds than NHS hospitals, for a predominately older population, with increasingly complex needs.[1]

Under the terms of NHS Constitution, Equality Act and current GP contract ***care home residents have the same rights to NHS services as the rest of the population.***

NHS England guidance (2014) states 'Healthcare for care home residents should be an actively commissioned service, with clear specifications linked to quality, outcomes and contractual obligations'.[2]

Due to the complex health and social needs of individuals in care homes, standardised health care meets the needs of care home residents poorly, but well-tailored services can make a significant difference. [3]

In the recent Quality Watch (2015) report, a number of key findings were recorded[4]:

- Care home patients were much older (86.3 compared to 82.1) and were 40-50% more likely to have emergency admissions. There were also significantly fewer

[1] CQC The state of health care and adult social care in England 2013/14
[2] NHS England (2014) Safe, compassionate care for frail older people using an integrated pathway
[3] British Geriatrics Society (2013) Commissioning Guidance High Quality Health Care for Older Care Home Residents
[4] Quality Watch (2015) 'Focus on: Hospital admissions from care homes'

elective admissions and outpatient appointments compared to the general population aged 75 and over.

- Care home patients admitted to hospital tended to be at the end of their lives. Around 40% of care home residents admitted as an emergency died within 6 months of admission.
- The health problems recorded on admission to hospital were different for patients living in a care home. Pneumonia, dementia and epilepsy were 3 times more common compared to the general population aged 75 years and over. Other more common reasons for admission from care home residents included sepsis, head injury and hip fracture.
- In areas containing care homes where hospital admissions were high, there was a greater proportion of instances where patients had 3 or more admissions in a year (as opposed to the higher rates being because more patients had single admissions)

It is widely accepted that good quality preventative care can reduce the frequency of health crises in the population that require hospital admission[5]', and according to British Geriatrics Society, (2015) [6] there is no reason why this concept is not applicable in care homes.

Despite the complex and high level of need of people living in care homes, there is wide variation in their access to necessary health services. In the British Geriatric Society (2012a) [7] report the following findings were noted:

- 68% of care home residents do not get a regular planned medical review by their GP
- 44% were not getting a regular planned review of their medication
- 41% could not access specialist dementia services

'It is anticipated that alignment, will reduce the workload in general practice whilst supporting improvements in patient care. Thus, care home alignment fulfils a key requirement of the 5 Year Forward View'[8]. – *Dr David Lyon, GP Clinical Lead and Governing Body Member.*

On 27th January 2016, a CCG/HBC Care Home Summit was held with support from the Director of Adult Services for HBC and the CCG Chief Nurse.

The event had a wide representation from care homes, Health Watch, the NHS and HBC. An item on the agenda for discussion was a 'Primary Care/Care Home Model' which was led by Dr David Lyon.

Key recommendations from the Summit for future action included:

- ***GP Care Home Model development***

Further to the Summit, a 'Care Home Conversations' Forum was established by Damian Nolan, Divisional Manager HBC, to enable discussions across a wide range of stakeholders including care home providers. In these discussions the alignment of GPs to Care Homes has been extremely well received.

On 21st April 2016 a PMS Review meeting was held with GPs across Halton and the alignment of GPs to Care Homes ***was supported by a majority of Members***.

The CCG is proposing initially to align GP services across all care homes in the Borough of which there are currently 22.

[5] D.Oliver et al (2014) Making our health and care systems fit for an ageing population
[6] According to British Geriatrics Society,' Hospital admissions from care homes' (2015)
[7] British Geriatrics Society (2012a) Failing the frail
[8] https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

With agreement of Practices and with the understanding from the care homes, this will be managed in a ***phased approach***.

As part of the Engagement Plan, initial discussions have taken place with care homes, via the HBC Care Home Provider Forum, Care Home Conversations Forum and through direct visits to care homes. The purpose of these discussions was to:

- Establish with care homes the current state of play
- Explore opportunities for improvement
- To gauge whether there was an appetite locally for alignment

Discussions so far have been very positive, and care homes wish to be involved in this work.

Of note, Managers who had worked with the single GP/single care home alignment were very positive about this approach, and reported an unfavourable comparison with the current model in Halton.

In these discussions with care homes directly, there have been a number of reoccurring themes:

- As a consequence of multiple GPs supporting care homes, there are often competing demands made on nursing resources to accompany visiting GPs, which is very difficult to manage
- Inconsistency of GP wards rounds and frequency
- Variation in quality and method of communication between care homes, GPs, Pharmacy and Hospitals
- Medication issues
- Prescription issues (EPS)

During the GP Practice engagement events, the following outcomes from a GP/Care Home alignment model were identified and agreed:

- Improved quality and access of care
- Reduced unwarranted variation
- Improved quality of life
- Reduced unplanned hospital admissions
- Reduced prescribing wastage
- Improved communication
- Strengthened relationships

There have been discussions with members of the wider care home support teams including; Care Home Liaison Team, Care Home Medicines Team, the Local Authority Safeguarding Lead, and Continuing Healthcare Lead to understand their role within care homes. Universally, a GP/ Care Home alignment type model was received in a very positive manner.

There have also been discussions with Dr David Wilson LMC Representative around patient choice and Information Technology. ***The issue of patient choice is the most important element of this work*****.** It has been made ***explicitly clear*** in all discussions with all stakeholders that patient choice is ***paramount and is to be upheld.***
An Equality Analysis has been undertaken, and it is recommended that a further discussion takes place at HBC Overview and Scrutiny Committee.

Dr Wilson is also happy to ensure that any communications that may be developed are presented to General Practitioners Committee (GPC) for comment.

Current provision in Halton

Currently there are 2 Practices within Halton who undertake proactive ward rounds supported by the 'Over 75s £5 per head' scheme. These are Tower House Practice in Runcorn for Beechcroft and Simonsfield Care Homes and Bevan Group in Widnes for St Patricks Care Home and prior to closure, Lilycross Care Home.

Whilst there is no formal evaluation available at this time from Bevan Group, anecdotal evidence from the Practice Manager is that a proactive approach creates a better rapport with care homes and has decreased the number of visits.

The remaining Halton Practices implement mainly a reactive care home model.

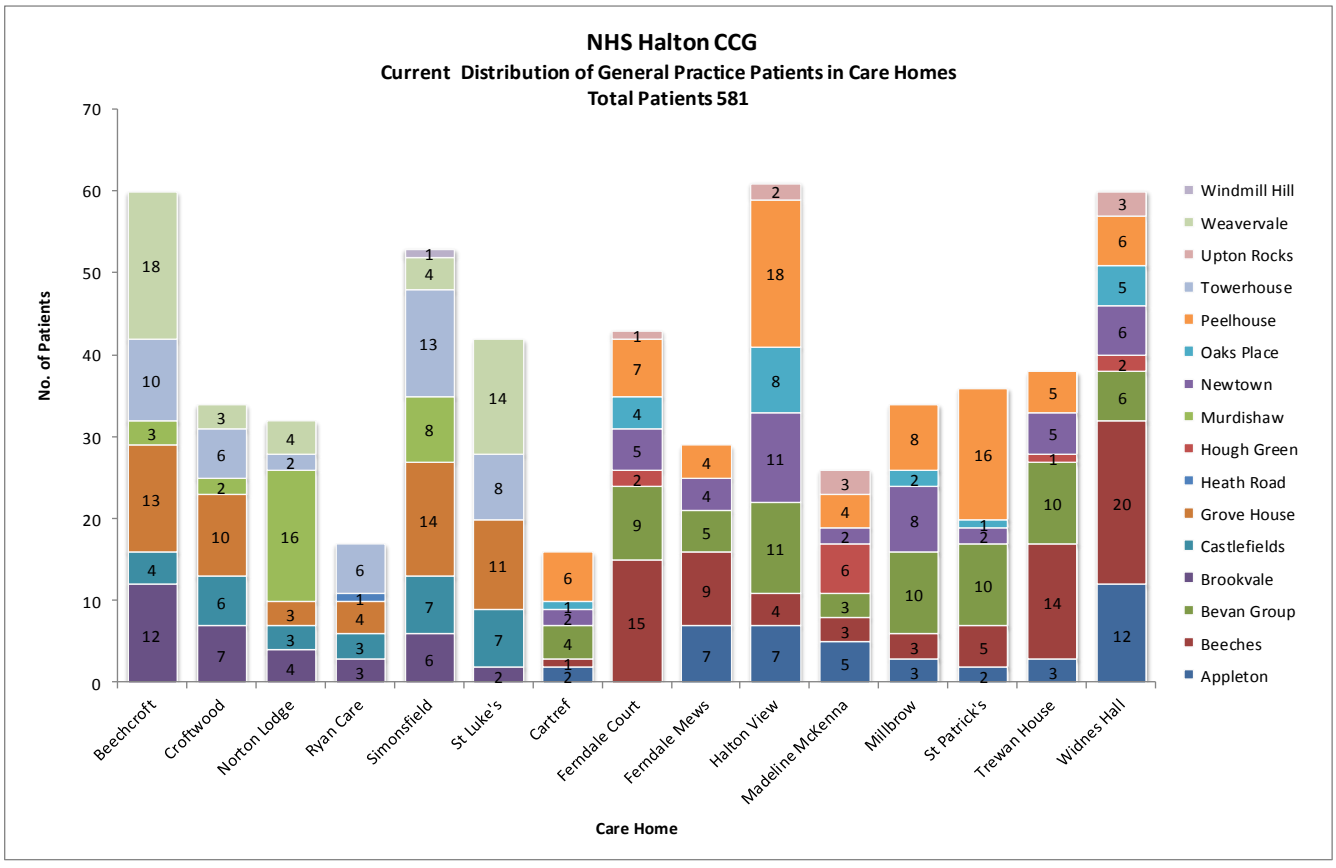
Tower House Practice has shared positive evaluations of the proactive approach which reported reductions in:

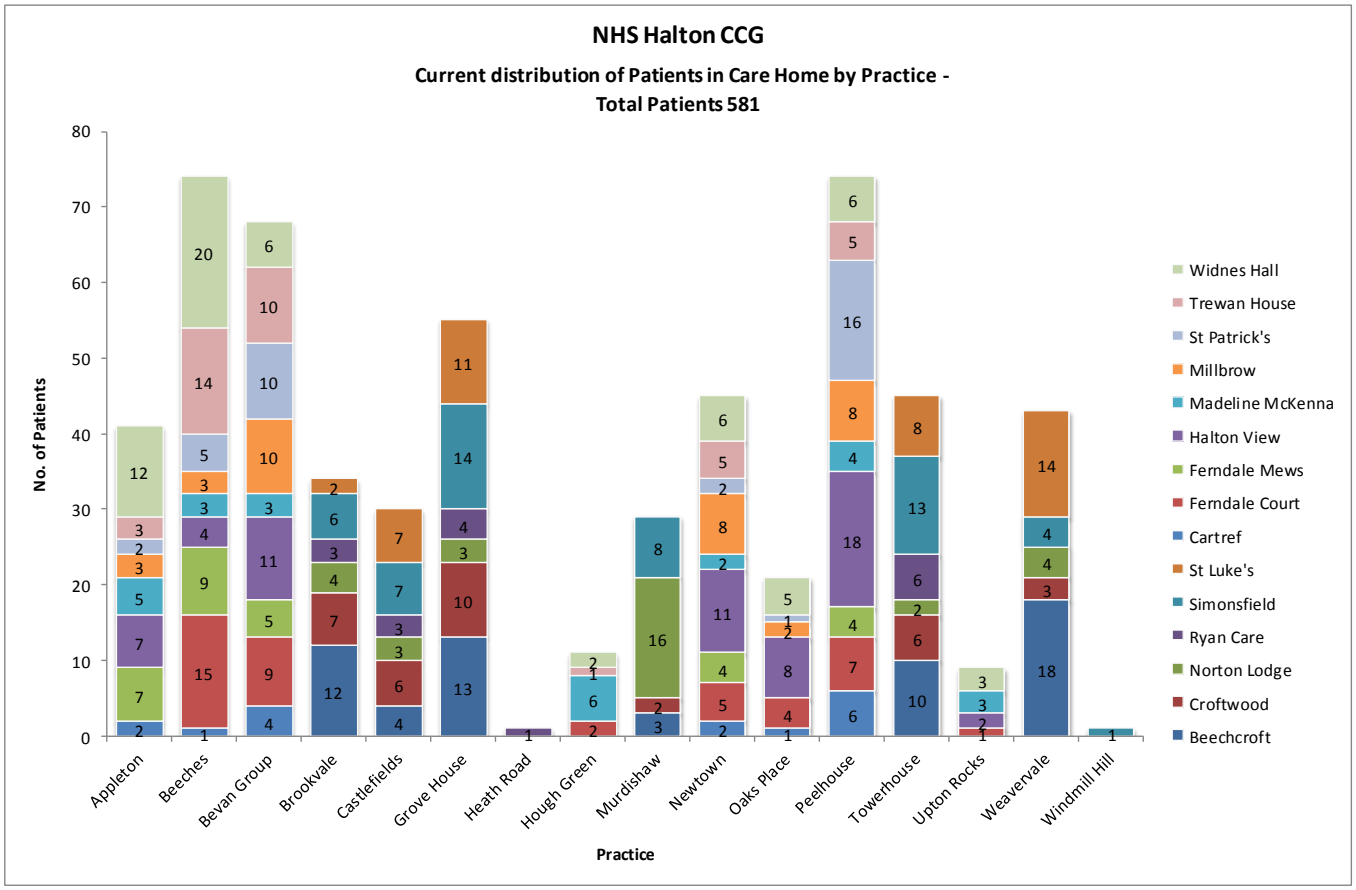
- Home visits
- Hospital admissions
- Out of Hours visits
- Telephone consultations

Model Options
For the purpose of discussion, an outline of 4 potential models has been included.

Model 1 - Current GP/Care Home Model – NHS Halton CCG
The current model is a mixture of reactive and proactive service delivery. There is no agreed service model that drives quality, promotes equity in access and delivers favourable outcomes.

An absence of GP alignment results in a distribution of GP Practices providing healthcare in each Care Home as described in the following charts.





There is a level of funding currently available to Practices within the 'Over 75s, £5 per head' allocation, to support nursing home ward rounds. As described earlier, this allocation is being utilised by Tower House Practice and Bevan Group. Other 'Over 75s' schemes are also in place and funded but do not directly relate to care homes. The list of schemes is due to be reviewed shortly in line with 2017/18 planning and no formal agreement has yet been established as a paper for approval will be presented to the November Primary Care Commissioning Committee.

Model 2 – Single Practice to Care Home Model – NHS Ipswich and East Suffolk CCG
There are numerous models available nationally that focus on the delivery of proactive care model within the care home setting; these contain commonalities such as strong joint vision/purpose between stakeholders, a multi-disciplinary approach to working, defined and measurable outcomes.

Many also describe the alignment of a single GP Practice to a single care home as the enabler to improved care for patients through consistency of approach and greater care planning and a pivotal in the development of strong and effective communication.

This type of model is in use at NHS Sheffield CCG which has reported a 9% reduction in admissions and also at NHS Sutton CCG which is host to a Care Home Vanguard.

In our discussions with multiple stakeholders (GP's, care homes, Medicines Management Team, Care Home Support Team, Safeguarding, Continuing Healthcare) there was universal support for this model. In analysing national evidence the Authors of this report have concluded that his model would best meet the needs of the care home population in Halton.

It is worth noting that the initial alignment of General Practice to care homes would be cost neutral, however further development of a GP/Care Home Model such as the one in place at NHS Ipswich and East Suffolk, may require additional funding.
NHS Ipswich and East Suffolk CCG Service Specification

Model 3 – Virtual Triage – NHS Warrington CCG
NHS Warrington CCG has commissioned a virtual care model approach for any nursing or residential home patient over 18 years of age. There is a dedicated phone line for referrals in which are then triaged and dealt with by a member of the Team which includes GPs. More details can be seen here; http://www.bridgewater.nhs.uk/warrington/carehomesupport/

Model 4 – Single Provider – NHS Salford CCG and NHS Southend CCG
The Salford model is based on an agreement that a single Practice in a geographical area has responsibility for the entirety of primary care services exclusively for care home patients.

Anecdotally, some local care home residents elect to remain with their existing GP but most do register with this Practice. This arrangement is made with the full cooperation of the local GPs and LMC.

In January 2016 there were over 1000 patients registered with the Salford Care Homes Medical Practice. There is little in the way of documentation available on this service or its outcomes but contact has been made to try and understand this model better. An overview can be seen within the Kings Fund report:
http://www.kingsfund.org.uk/publications/new-care-models

NHS Southend CCG are also exploring the use of a similar single provider type model which is within the first 12 months pilot phase, having been agreed at their CCG Board in late 2015. A summarising article within Pulse can be seen here: www.pulsetoday.co.uk 7th October 2015

Financially a model of this type would suggest that a movement of existing funding from General Practice is reviewed in line with the transfer of patients.

Dependent on the agreed service model and outcomes, there may also be a requirement for additional funding to support improved patient outcomes in the delivery of services over and above that of the existing GP contract.

Report Author: Ann Nolan, Community Commissioning Manager
Clinical Lead: Dr David Lyon
Report Date: 6/1/2017

REPORT TO: Health Policy and Performance Board

DATE: 7th February 2017

REPORTING OFFICER: Strategic Director, People

PORTFOLIO: Health & Wellbeing

SUBJECT: Scrutiny Review of Carer Services

WARD(S): Borough wide

1.0 **PURPOSE OF REPORT**

1.1 To present to the Board the report and recommendations of the Carer Services Scrutiny Review 2016.

2.0 **RECOMMENDATION: That**

(i) The Board note the contents of the report and the recommendations attached at Appendix 1

3.0 **SUPPORTING INFORMATION**

3.1 Due to the potentially wide remit of the scrutiny topic brief, the Board decided to focus their review on the responsibilities of the Council to Carers under the Care Act, the role of Halton Carers' Centre and the role of NHS Halton Clinical Commissioning group.

3.2 The report attached at Appendix 1 outlines the evidence received by the Health Policy and Performance Board group from a range of partners, in relation to services provided to carers in Halton.

3.3 Participating organisations and services included: Carers, Halton Carers' Centre, Halton NHS Clinical Commissioning Group, Adult Social Care and Hospital Discharge Team (Warrington).

3.4 The recommendations made to the Health Policy and Performance Board as a result of the review are:

3.5 **There should be a continued focus on provision of information and support at the right time for the carer, to avoid carer breakdown and use of high cost services.** Prevention and early intervention services and organisations across health and social care should consider how they can proactively identify and engage with carers to be able to sign post them to/provide information that can support their caring role. Services should be able to demonstrate how they do this.

3.6 **Continued efforts to engage with people currently hidden from carer services.** Key stakeholders, including Social Care, NHS Halton CCG, GP practices, local acute trusts, Halton Public Health, the Halton Integrated Wellbeing Team and providers such as Wellbeing Enterprises should work collaboratively to:

- Identify carers and promote available support to all parts of the community.
- Develop innovative approaches to delivery of services in the community, in order to appeal to the diverse needs of carers in Halton.
- Raise awareness, not only of information and service provision to support carers and professionals, but also of what constitutes a carer.
- Work with partners in Children's and Adult's Services to embed the newly developed 'transition protocol', engaging with children at an earlier stage to plan for their transition into adult services, including carers support services where they are identified as being a 'young carer'.

3.7 **A renewed focus on relationships with health, in particular the Hospitals, to encourage identification and support of carers.**

3.8 Whilst acknowledging that the Carers' Centre and GP Practices have well established and successful relationships in identifying and supporting carers, efforts need to be focused towards working with the local acute trusts.

3.9 Carers are frequently identified through social care assessments, but less so for carers of people with health conditions.

3.10 Health and Social Care Senior Management should consider carers, as a standing agenda item at existing meetings. This may include how to work with partners, including the acute trusts, to build awareness of the role of, impact on and needs of carers, promote what support is available locally and strengthen relationships between the hospitals and carer support services.

3.11 Services and agencies that support carers should work with acute trusts to help them better understand how hospitals can identify and support carers whilst their loved one is in hospital, and throughout the discharge process.

3.12 **Assessment of long term carers needs at regular intervals.**
Consider the scope within the annual review of cared for people to systematically offer an assessment to their carer, where previously it had been declined by the carer or they were previously not eligible.

3.13 **Involving carers in coproduced service development.**
Examining and adopting different ways of engaging with carers in consultation and co-production of service developments. This may involve training and support for carers to take part in consultation and coproduction exercises.

3.14 **Ensure that within carer provision there are a range of different interventions to meet diverse and changing needs of carers.**

3.15 Whilst there are no immediate plans to reduce the level of investment in carer services, Commissioners of carer support services and carer support organisations should consider how available resources are invested to be able to continue to deliver *different types of support* (i.e. 1:1, personal budget, carers breaks, peer support social groups). Services should also consider post caring support needs of carers i.e. after a bereavement.

3.16 The variety of support not only needs to provide information and practical help for carers

in their caring role, but should also consider wider factors including the mental health, social inclusion and employment potential (where appropriate) of carers.

3.17 **Consider how access to carers services can be improved.**
Carers reported that the lack of a single point of access, or named care coordinator for carers is a cause of frustration to some. Further work should be undertaken with agencies that support carers to consider how they can work together to 'mesh' services so it doesn't matter where people enter, they will get consistent and appropriate support.

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 FINANCIAL/RESOURCE 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**
None

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

6.3 **A Healthy Halton**
The health and wellbeing of carers is a priority in Halton, and the contribution they make to the health and social care sector is recognised.

6.4 **A Safer Halton**
None

6.5 **Halton's Urban Renewal**
None

7.0 RISK ANALYSIS

7.1 None identified at this time

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None identified at this time

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

9.1 None under the meaning of the Act.

HALTON BOROUGH COUNCIL

Health Policy & Performance Board

Scrutiny Review of Carer's Services

Report
February 2017

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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 type and quality of Carers Services provided in Halton and the associated pathways in place to support Carers' ability to access those Services.

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 March 2016. This report will be presented to Health PPB in March 2017. The report will also be presented to People Directorate Senior Management Team, Executive Board and boards or committees of stakeholders, as appropriate.

3.0 MEMBERSHIP OF THE TOPIC GROUP

3.1 An invitation to participate in the scrutiny group was made to all members of the Health PPB. The table below details which PPB members and officers participated in the review

3.2

Councillor Joan Lowe (Chair)	Paul McWade, Operational Director, People Directorate
Councillor Martha Lloyd-Jones	Emma Bragger Policy Officer, People Directorate
Councillor Pauline Sinnott	Mr Tom Baker (HealthWatch)
Councillor Stan Parker	Councillor Margaret Horabin
Councillor Shaun Osborne	

3.3 **The Chair would like to extend their thanks to all of the Carers, Officers and Organisations that took time to contribute to this review.**

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 the impact of caring, implications of the Care Act, best practice and commissioning.
- Monthly meetings of the scrutiny review topic group;
- Presentations by various key members of staff and providers ;
- Site visits, at which there was opportunity for service-user contribution;
- Meetings with carers in their own environments;
- The final draft of this report was circulated to participating staff to check for accuracy.

4.2 The above methods enabled Members to:

- Have an understanding of the impact of a caring role on the individual, and the contribution they make to supporting the health and social care system.
- Have an understanding of the services that are available to carers to support them in

their role.

- Have an understanding of the needs of carers, what types of support are effective and where there are potential gaps in provision.
- Have an understanding of the role that all agencies, including their associated responsibilities, (both statutory and voluntary/community sector) play in the provision of Carers Services.

4.3 Members considered, in making the recommendations contained in this report.

- National best and evidence based practice, and how it can be applied in Halton.
- Ways to continue to make improvements to services for carers 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 BACKGROUND

5.1 A carer is anyone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support. Young carers are children and young people who often take on practical and/or emotional caring responsibilities that would normally be expected of an adult.

5.2 Carers are the largest providers of care and support in each area of the UK. The economic value of the contribution they make is £119bn per year.

5.3 The economic cost of carers' health, if it breaks down, could be vast since the value of the support provided by the UK's six million carers has been valued at £57 billion.[i] Carers' ill-health itself will place a cost on the NHS

5.4 A report[ii] by The Princess Royal Trust for Carers reveals that 70% of older carers suffer a devastating impact on their health due to their caring role. Based on a survey of 639 carers aged 60-94, the report found that 65% of older carers have long term health problems or a disability themselves and seven out of ten (68.8%) say that being a carer has an adverse effect on their mental health. The causes of carers' poor physical and mental ill health are due to a lack of information, lack of support – either the right kind or the right amount, worry about finances and the general stresses and strains of caring full-time with everyday life and isolation.

5.5 While caregiving can be beneficial for carers in terms of their self-esteem, it can be difficult for working-age carers to combine paid work with caring duties and carers may choose to leave paid work, or reduce their work hours. This may compromise their future employability and lead to permanent withdrawal from the labour market. The extra costs of caring and fall in income many carers face may mean they cannot afford social activities anymore, leading to a risk of social isolation.

5.6 Isolation and loneliness is something that many people face as a result of their caring responsibilities. Research reveals that 8 out of 10 carers have felt lonely or isolated as a result of caring and over a third feel uncomfortable talking to friends about being a carer.

5.7 The Care Act, which came into force on 1 April 2015, gives carers rights on a par with the people they care for, which includes an entitlement to an assessment of their own needs.

5.8 This includes taking into consideration the carer's health and wellbeing, family relationships and their need to balance their home life with their education or work. If they are found to be eligible they are entitled to support funded by the local authority. In addition, all local authorities must provide advice and information and prevent carers' needs from getting worse.

5.9 The Care Act 2014 places a duty on local authorities to conduct a transition assessment for young carers, when it will be of 'significant benefit' to the person to do so. Significant benefit relates to the timing when the young person is ready to have an assessment and will get the most out of the process.

6.0 EVIDENCE CONSIDERED BY THE SCRUTINY TOPIC GROUP VIA MEETINGS AND PRESENTATIONS

Responsibilities of the Local Authority under the Care Act - *Commissioning Manager and Practice Manager Adult Social Care, Halton Borough Council*

6.1 The Halton Carer's Strategy was refreshed in 2016 to reflect the requirements under The Care Act and has been signed off by the council's Executive Board. The model of support for carers in Halton is based on the following principals:

- Prevention and early intervention
- Support to care
- Support in a crisis
- Recognition of the caring role

6.2 The officers outlined that the Care Act provides a shift in legal responsibility for local authorities, with carers now being recognised in the same way as the people who they care for, and with equal rights. Statutory Carers responsibility lies with the borough where the person who is being cared for resides. Halton Borough Council has made changes to the assessment process to reflect this.

6.3 The assessment considers;

- The impact of caring on the carer.
- The day-to-day life outcomes the carer wishes to achieve.
- If the carer is able or willing to carry on caring
- Whether they work or want to work
- Whether they want to study or do more socially.

6.4 When the assessment is complete, the local authority must decide whether the carer's needs are 'eligible' for support from the local authority, depending on the carer's situation. The Care Act puts in place a national eligibility threshold, setting one national level at which needs are great enough to qualify for funded services.

6.5 In terms of interventions for carers, support plans look at individual needs and what would help them maintain their caring role, considering what needs can be met through existing services, first of all. The Care Act promotes personalisation, which can be achieved through the use of personal budgets/direct payments. The officers reported that Halton has one of the highest rates of Direct Payments in the country. A banding system has been introduced based on the impact of caring role on the carer, which determines the value of the direct payment, up to £300. This is in keeping with the rest of the North West. There is an 'exceptional circumstance' panel, to consider requests for creative personalised support and support which may require a direct payment in excess of £300. It was noted by the Board that the Halton approach to personal budgets is supporting a change of culture, where the level of personal budget has to be linked to level of **need**, not just a token amount regardless of need.

6.6 Ninety Eight percent (98%) of carers who have been assessed go on to get a personal budget paid via a direct payment in Halton. There is an audit process in place to ensure that the payments are being used to support the carer. It was reported that the Direct Payments team in Halton is well established and works well to support the implementation of personal budgets to carers. If the person requests a personal assistant they are referred to Halton Disability Partnership to broker PA support. It was reported that Halton is becoming increasingly reliant on Halton Disability Partnership and the PA brokerage service as the demand for PAs grows. The Officers noted that training for PA/carers should remain a focus to encourage more PAs to enter the market and enable Halton Disability Partnership to meet the demands.

6.7 For those carers who are not assessed as eligible for a personal budget, the duty of care is still met by Halton Borough Council through signposting to a range of community provision. This is followed up 4 weeks after the initial signposting to see if the carer needs any additional support.

6.8 In Halton there is a Carers' Joint Strategic Needs Assessment (JSNA) which provides details of the Carers profile i.e. numbers, issues and challenges for carers in Halton, which is used to underpin future commissioning decisions. This, along with the Halton Market Position Statement, helps services and commissioners shape the market of support provision for carers.

Conclusion

6.9 The Board agreed that early intervention with carers was key to providing information and support that can help avoid carer breakdown and potential reliance on high cost services used in crisis. Linking carers' services to other prevention and early intervention work will stitch in carer support early on.

6.10 Responding to assessed carers needs though using social assets (ie voluntary/community sector), self-help though signposting to trusted information sources and universal and specialist services should be a priority where carers are not eligible for a personal budget. This should be balanced with the need for personalisation of support, with personalised budgets being a useful method in achieving this.

6.11 It should remain a priority to target groups of carers that are least engaged with support (ie male carers over 60). The need to continue efforts to engage with people currently hidden from carer services should be around an outreach approach to delivery of services in the community, rather than being building based, which may not appeal to certain cohorts of carers for a number of reasons. Working closely with colleagues and services in the Health sector (such as hospital discharge teams and primary care) will better enable carer support services to identify carers of people with health conditions at an earlier stage. Prioritising some groups of carers that find services hard to reach has been put into the Carers Centre service specification in order to address this issue.

6.12 Support for long term carers should be maximised through reassessment of needs at regular intervals, with potential scope for this within the follow up and review of the cared for person.

Halton Carers' Centre Provision - ***The Carers' Centre Manager, Deputy Manager and Member of the Carers' Centre Board***

6.13 The Board were provided with an overview of the Carers' Centre. Starting up in 2008 with a list of 500 carers, the Carers' Centre has now expanded to 5,500 carers on their caseload, 500 of which are young carers. The most recent census data indicated that 15,000 carers live in the borough, however it was noted that not all have support needs or wish to take up services.

6.14 The Centre is funded through a 50% match funding arrangement with Big Lottery funding, funding from Halton Borough Council, and also receives funding of £179k pa from NHS Halton CCG for staff and associated costs. Whilst there will always be a level of uncertainty associated with time limited funding streams, the Carers' Centre have responded to its own evaluation of its services, by bringing in a variety of additional funding streams, along with funds raised through events and activities.

6.15 A recent refurbishment of the centre in Runcorn Old Town, incorporating requirements identified through consultation with carers, now offers comfortable interview rooms, therapy rooms, IT suite and outdoor area.

6.16 Although the centre is in Runcorn, the centre also operates from a base in Peelhouse Family Centre on Peelhouse Lane in Widnes, which is open for carers to call into. Other satellite services are offered in Widnes, and these are promoted through partnership working and the Carers' Centre newsletter.

6.17 The staff team of six full-time and seven part-time staff, requires that the Centre team are extremely knowledgeable to be able to support carers of people with a number of conditions and needs. The team support people caring for people with a spectrum of needs including: learning disabilities; physical disabilities; mental health conditions and other cognitive impairments; sensory disability and substance dependency.

6.18 Referrals to the service come from partner organisations (ie other voluntary/community sector organisations and groups, health and social care services), outreach work at events and venues across the borough, GP practices and social media promotion. The Deputy Manager reiterated that outreach/partnership work being undertaken by the centre is fundamental and stressed that there is a need to move away from the notion of one access point, to engage different groups of carers.

6.19 Carers register with HCC at a rate of 80 per month and are benchmarked against a range of indicators relating to health, finance, work and social life at registration then checked again between 6-12 weeks. This initial assessment of the carer's needs is focused on a set approach, reflective of the statutory carers assessment undertaken by the local authority (ie what they are *able* to do) and what level of impact their caring role has on their day to day life. The questions asked draw out the specific needs of the carer which form the basis of a support plan used by the Carers' Centre. A six-week to twelve week review looks at their needs to see if the support put in place by the Carers' Centre is having a positive impact. It was reported that almost every carer experiences an improvement in at least one area. The Carers' Centre actively promotes statutory carer assessments from the local authority to carers, to see if they are eligible for funded care through social care.

6.20 The centre provides support to carers and people who are 'ex carers', through a range of interventions including: 1-2-1 assessment of the carers needs, 1-2-1 support from carers centre staff, peer support groups, day trips, activities, signposting to universal support services or specialist support organisations and delivery of holistic therapy sessions. Whilst people are supported at a distance that suits them, and the support provided changes and develops as required, all carers' needs are assessed annually in order to direct them to appropriate support as their needs change.

6.21 The centre strives to include carers in the development of new services and support available via the centre, and regularly undertakes feedback reviews to evaluate the services that they provide. Feedback is scrutinised to ensure that services continue to achieve the desired outcomes.

6.22 The Carers' Centre were able to demonstrate where they have responded to emerging needs through acting on feedback from carers. Examples include setting up a Male Carers Group, Former Carers Group (funded by a donation from HBC Community Development Fund) and Early Onset Dementia Carers Support Group. The centre has provided ADHD training, Personal Behaviour training in partnership with the Positive Behavioural Support team and a Family Dementia Carers Day.

The difference the centre has made…
The centre worked with The Flower and Plant Works in Church Street Runcorn to provide flower arranging courses for carers to have a break from their caring roles. One carer loved it so much that she asked for carer break funding to access a flower arranging course at Riverside College. The carer went on to open her own florist shop in Widnes.

The centre recruited and supported two volunteers who are also carers, who have since progressed to taking on paid job roles at Halton Carers Centre.

One young carer has stated that they no longer self -harm because they have now got support from Halton Carers' Centre.

The Former Carers Group has celebrated its 5 anniversary this year. They have 20 members who have restarted their lives following bereavement. This group has transformed the lives of the former carers reducing loneliness, depression and helping in the grieving process.

Conclusion

6.23 The Board were encouraged by the number of carers supported by the centre, variety of support available through the centre and the ability to respond to identified needs. The implementation of the START programme (dementia carer resilience building programme) and establishment of a younger dementia carers group were recent examples of this.

6.24 Access to services via the Carers' Centre should be as easy as possible, being mindful that there is a requirement to assess needs, but the centre's team have stated their willingness and flexibility to support a person through the registration process to ensure that they access everything that is appropriate.

6.25 The Board agreed with the Carers cCentre that there is continued need to look further at how to support those carers in transition (those 18 to 25 years old) and what needs to be done to make them aware of support available and engage them in support where required.

6.26 Since 2012 the Centre has been core funded through a 50% match funding arrangement with Big Lottery funding and funding from Halton Borough Council, this is to continue until 31st December 2017. It was reported by the Carers's Centre that by the end of 2017 centre will have saved HBC £649,864 in total due to successful matched funding applications to Big Lottery. The centre is currently looking to identify further funding post January 2018 for core costs, but is aware that if further external funding isn't forthcoming it may need to request financial assistance from HBC to continue providing services in Halton.

Role of hospital discharge teams in identifying carers of people who are leaving hospital – *Practice Manager, Halton Integrated Discharge Team*

6.27 The aim of the hospital discharge team is to facilitate hospital discharges in a safe and timely manner. This includes trying to reduce length of in-patient stay and to prevent re-admissions to hospital. The hospital discharge team's role is to assess adults who are being discharged from hospital, which may include people who are eligible for Intermediate Care Services (all age adults who may be eligible for support in accordance with the Care Act 2014).

6.28 The team also have a role in identifying carers as part of their work in establishing what the person's (who is leaving hospital) needs are upon discharge, and how they will be met by their carer and/or community services.

6.29 In the same way that the hospital discharge team work to support the transition from hospital back in to the community for the patient, the team look to ease the carer's experience as much as possible, however, carers' assessments are not generally done within the hospital team, the team refer onto the Initial Assessment Team and the Carers'Centre in order for these to be undertaken.

6.30 Whilst many of the carers the team are involved with have already had a carers assessment done previously, the Hospital Discharge Teams include carers in the patient's discharge assessment process in the hospital and they work closely with the Carers Centre and other agencies, departments and services. These include direct payments for the carer (this is a service we would commission, not a different agency), referring for a benefits check and welfare advice and respite services, with the aim of supporting carers as part of the team's involvement whilst the cared for relative/friend/family member is still in hospital, as well as after they are discharged. Community social care colleagues then follow up with the carer to ensure that they are accessing appropriate community based carer support, which is usually as part of a review process from Social Services for the Cared for, or as part of the Carers Assessment.

6.31 On occasion, the team are notified of discharges with little, or at short notice, however the duty worker will ensure that they action any requests for support or assessments in an urgent manner, and that the service and the carer receives the support which is required.

Conclusion

6.32 Coordination between hospital and community remains an issue for the Board. The Practice Manager reiterated that discharge team work with health and social care in the community, district nurses and end of life district nurse liaison, to share information to enable appropriate support ie equipment, packages of care, 24hr care placement, nutrition for the patient and support for carers, once the patient has left the hospital. The Practice Manager has been involved in work led by the Social Care Institute of Excellence regarding the transition from hospital to home. Social care

staff are assigned to wards and are able to involved in the planning of the patients hospital discharge. Currently, when someone has been discharged there is follow up phone call 24-48 hours after, by the Hospital Discharge Team, to check that the patients' community support is in place, but it also checks support needs are being met for the carer.

6.33 The Board identified a potential gap that may have implications on discharge from A&E, if carer assessment/support is not considered. The Hospital Discharge Team are rarely involved in discharges from A & E as patients are not classed as being 'admitted' to hospital. The Out of Hours Emergency duty team (24/7) is in place to support out of hours discharge, urgent or crisis situations instead – they shouldn't be routinely contacted. A & E record on their system if a carer is known and will try and make contact.

6.34 The Hospital Discharge Team often have to work a careful balance between the patient's wants/needs and the carer's requirements ie if someone wants to come out of hospital, but the carer may feel anxious or worried about their relative/family/member returning home, they are supported by social care staff with this transition. Discharge from hospital cannot be delayed by the team where a person has capacity and is requesting to go home, but they can explore services and resources to support the patient and the carer. Strong relationships with community professionals and access to suitable carer support provision is vital to enable successful hospital discharge to happen.

Health's role in supporting Carers – *Chair of NHS Halton Clinical Commissioning Group (CCG)*

6.35 The Chair of the CCG informed the Board there is a specific person at the Carers' Centre who is a liaison worker who works with all the GP practices in Halton, to foster the connection with GPs, raising awareness of carer services and encouraging referrals to the Carers cCntre.

6.36 GP practices had a system for sharing carer information with the Carers Centre, with the carer's permission. There were about 2000 people identified as carers in 2010, as current GP practice system of working with GPs started there was a regular influx of carer details from the GP practices into the Carers Centre, raising the number of known carers to over 5,500 over 2/3 years.

6.37 The number of known carers to the carers centre, as a proportion of the projected number of carers in Halton, is actually considered quite high. They currently have an active case load of in the region of 5,500, 495 of the carers are under 18. In 2015/16 GP scheme identified 142 people who were not previously registered. An additional 98 were also referred, but were already registered, but the re referral enabled a review of the support. Since April 2016, the average number of carers referred each month from GP practices is 19.

6.38 A gap had been identified around hospitals and identifying carers. The Carers' Centre has 5 areas with specific staff: Mental Health, Dementia, Primary Care, Hospital Liaison and Young Carers. The staff regularly attends clinical groups and patient groups so that they can build relationships to encourage more referrals from both

primary care and the hospitals. However, in the CCG's Chair's view the hospitals need more work to make referrals; referrals primarily come from the Carers' Centre worker being in situ or from carers info/posters in the hospitals, rather than hospital staff.

6.39 GP practices have Multi-Disciplinary Team (MDT) meetings where the Primary Care Carers' Centre staff member attends at 10 of the meetings across Halton. Within the MDT discussions they will identify new carers, or changes in the status of the carer. MDT meetings try to head off crisis, identify early interventions etc. There are 6 practices that currently do not have this Carers' Centre coverage in MDTs. The Carers' Centre Primary Care worker spends time in practice waiting rooms, especially when there are clinics on such as the flu jab clinic, to try and engage with carers. Carers are also notified of things like the flu jab through the carers newsletter – two way communication.

6.40 A weekly email is sent to practice managers, district nurses etc to remind them of the Carers' Centre support or relevant carers information, to build relationships.

6.41 The CCG Chair's view is that Halton is working hard to make connections between the Carers' Centre and the GP practices to increase referrals for carers support. The CCG are in regular contact with the Carers' Centre to see how improvements can be made. The CCG Chair is confident that Halton, in comparison to other areas, has got quite well established relationships and processes to support carers.

6.42 To put the contribution of unpaid carers to the health and social care economy into context, the CCG Chair quoted some research figures in relation to the cost to the nation. In some research, the value of unpaid care has been costed at £63bn, nationally. It was highlighted that many carers do not identify themselves as carers, particularly parent carers , and this can impact on the carers accessing support.

6.43 The Wellbeing Practice Model (Wellbeing Enterprises) is wrapped around each practice, and the feedback is positive and wellbeing scores are being increased through various initiatives. Within the first 18 months of the wellbeing enterprises offer, 75% of people accessing support were carers.

6.44 The Board referenced the importance of supporting ex carers ie help into employment, health and wellbeing support, as well as bereavement support. There is a risk of social isolation as a carer when their loved one has died. The Men's Shed was cited as a good example supporting male carers and ex carers.

6.45 The CCH Chair reported that GP practices do signpost carers to counselling and bereavement services, wellbeing enterprises etc for carers who re expressing concern about social isolation and bereavement. GPs are aware of mental health problem risks with carers, ie a higher chance of being depressed.

6.46 The Board asked the CCH Chair about what is happening with links with schools for younger carers. The CCG Chair confirmed that the CCG do not have any formal connections with schools, but school nurses and school pastoral care systems do identify young carers, which will link young carers into services.

6.47 In relation to data protection issues between the carer, cared for person, and GP, the GP should understand the relationship between the patient and carer, and get informed consent from the person for the carer to take part in the discussions. Mental Capacity issues need to be clarified. If the cared-for person has not got mental capacity the GP needs to understand who is acting on their behalf, legally and log it in the patient notes.

Conclusion

6.48 The Board commented on the considerable saving to the health and social care services by family members picking up caring roles. The gap between hospital and community can be difficult for carers to negotiate. The Board agreed that it is important that work is done with the Hospitals to work on that.

6.49 The Board accept that the Carers' Centre do not, and cannot, see every carer, the Wellbeing Enterprises within GP surgeries should continue to supplement the support that the Carers' Centre can offer. The Board agreed that the Health of the carer is important and should be recognised as such

6.50 The Board discussed that Members are well placed to support links with schools as many of them are Governors. The board did give examples of local Academies that did refer into carers services. The Board recognised that support for young carers is important to maintain their own mental health. The CCG give out Wellbeing Awards and The Health School got an award last year for what they do to care for the staff and children.

6.51 Whilst it is recognised that the Carers' Centre is very proactive, particularly with the GP practices, both the CCG Chair and the Board recognise that more energy at the hospital level would be beneficial. There is a need to raise the level of accountability for hospitals in identifying carers, and understanding what the hospital's offer to carers is, when they are in the hospital. There remain questions about what happens with carers, proactively, whilst someone is in hospital? Hospital discharge teams are only one part of the support.

6.52 Carers recognising themselves as carers is an issue, especially with younger carers. An engagement campaign may go some way to overcome this. The Board acknowledged that it is not possible to engage with all carers as there will always be a cohort who will not recognise themselves as carers, a cohort that doesn't want/need support etc.

7.0 EVIDENCE CONSIDERED BY THE SCRUTINY TOPIC GROUP PROVIDED BY CARERS

7.1 During July/August 2016 members of the Board met with two individual carers to gain an insight into the impact of a caring role on the carers' life and own health and wellbeing. The meetings were held at times and locations determined by the carer, within the community. The meetings were kept informal so the comfortable approach was able to get the most out of the opportunity to talk to people who had taken time out of their caring role, and were attended by a scrutiny group member and Policy Officer (note taker). There were no set questions, meetings took a conversational approach and were led by the experiences of the carer.

7.2 A summary of the meetings with carers can be found in *appendix 2.*

7.3 A number of common themes came out through conversation, including:

- Carers' grants, breaks and respite are a valuable support, providing a much needed break from routine.
- Use of carers grant/break funding is really useful to achieve personalised outcomes that can't be met through existing provision.
- Quality / availability of support for the cared for person is critical to the health and wellbeing of the carer. Where there are gaps in services or quality carers reported that this had a direct impact on their health and wellbeing in relation to stress and demands on their abilities as a carer.
- Whilst one person may have a more clearly defined caring role for the other, carers and the cared for person are often interdependent on each other. When carers themselves have health and wellbeing needs, this can impact on their ability to care for the other person, which may result in the cared for person caring for the carer to some extent.
- Agencies that support carers which have a sound understanding of the individual carers/cared for care arrangements, and how they work, are best placed to support carers when things change. Agencies that understand the individual carers specific role in supporting the cared for person are best placed to identify in a timely manner when things are going wrong, or changing, so to support the carer to make changes or get additional information, support etc.
- Being a carer for a family member is seen as a 'duty' by some, which can bring with it added pressures. One carer referred to their caring role for a family member as being "a thankless task". Carers of family members are working on 'motherly duty', or similar, and without guidance or support.
- Friendships and peer support are valuable for the carer, to share experiences and support each other, but outside of the care environment.
- It can be difficult for carers to sustain employment alongside their caring role.
- Carers gain strength, and feel supported, when they feel that their loved one's needs are being appropriately met.
- Courses and sources of information about conditions are useful for carers, helping them understand and equip themselves to support their loved one.
- Health and social care services need to be joined up so that carers do not slip through the net
- Easy access to carers' services is essential, without the need to repeat the carers/cared for history.

8.0 EVIDENCE CONSIDERED BY THE SCRUTINY TOPIC GROUP VIA SITE VISITS

8.1 In July 2016 members of the Board visited Halton Carers' Centre and met with staff and carers to gain an understanding of the range of provision provided by the centre, and the impact of taking on a caring role.

8.2 Below are some comments and themes that were picked up from the visit:

- Those who had been assessed reported that it was an effective process that led to them feeling supported.

- Carers should be made aware that they are eligible for a statutory carers assessment from the local authority, which is different from registering with the Carers' Centre.
- The Carers' Centre staff were praised for their knowledge and responsiveness by the carers who were spoken to on the visit.
- The needs of young carers and carers in transition from children and young people's services, to adult services, need to be considered further, with a younger carer reporting that she often has to "fit in" with support and services geared towards older carers.
- The carers reiterated the need for the Carers' Centre and the benefits that the services bring to carers.
- Finding carers who are 'hidden' is important so that they know what support is available, if they want it.

9.0 RECOMMENDATIONS TO HEALTH PPB

1	**There should be a continued focus on provision of information and support at the right time for the carer, to avoid carer breakdown and use of high cost services.** Prevention and early intervention services and organisations across health and social care should consider how they can proactively identify and engage with carers to be able to sign post them to/provide information that can support their caring role. Services should be able to demonstrate how they do this. Prevention and early intervention services are well placed to enable carers to have access to information and support at an early stage, which may help to mitigate progression of a crisis situation for the carer.
2	**Continued efforts to engage with people currently hidden from carer services.** Key stakeholders, including Social Care, NHS Halton CCG, GP practices, local acute trusts, Halton Public Health, the Halton Integrated Wellbeing Team and providers such as Wellbeing Enterprises should work collaboratively to: • Identify carers and promote available support to all parts of the community. • Develop innovative approaches to delivery of services in the community, in order to appeal to the diverse needs of carers in Halton. • Raise awareness, not only of information and service provision to support carers and professionals, but also *of what constitutes a carer*. • Work with partners in Children's and Adult's Services to embed the newly developed 'transition protocol', engaging with children at an earlier stage to plan for their transition into adult services, including carers support services where they are identified as being a 'young carer'.
3	**A renewed focus on relationships with health, in particular the Hospitals, to encourage identification and support of carers.** Whilst acknowledging that the Carers' Centre and GP Practices have well established and successful relationships in identifying and supporting carers, efforts need to be focused towards working with the local acute trusts.

	Carers are frequently identified through social care assessments, but less so for carers of people with health conditions. Health and Social Care Senior Management should consider carers, as a standing agenda item at existing meetings. This may include how to work with partners, including the acute trusts, to build awareness of the role of, impact on and needs of carers, promote what support is available locally and strengthen relationships between the hospitals and carer support services. Services and agencies that support carers should work with acute trusts to help them better understand how hospitals can identify and support carers whilst their loved one is in hospital, and throughout the discharge process.
4	**Assessment of long term carers needs at regular intervals.** Consider the scope within the annual review of cared for people to systematically offer an assessment to their carer, where previously it had been declined by the carer or they were previously not eligible.
5	**Involving carers in coproduced service development.** Examining and adopting different ways of engaging with carers in consultation and co-production of service developments. This may involve training and support for carers to take part in consultation and coproduction exercises.
6	**Ensure that within carer provision there are a range of different interventions to meet diverse and changing needs of carers.** Whilst there are no immediate plans to reduce the level of investment in carer services, Commissioners of carer support services and carer support organisations should consider how available resources are invested to be able to continue to deliver *different types of support* (ie 1:1, personal budget, carers breaks, peer support social groups). Services should also consider post caring support needs of carers ie after a bereavement. The variety of support not only needs to provide information and practical help for carers in their caring role, but should also consider wider factors including the mental health, social inclusion and employment potential (where appropriate) of carers.
7	**Consider how access to carers services can be improved.** Carers reported that the lack of a single point of access, or named care coordinator for carers is a cause of frustration to some. Further work should be undertaken with agencies that support carers to consider how they can work together to 'mesh' services so it doesn't matter where people enter, they will get consistent and appropriate support.

Appendix 1 Scrutiny Topic Brief

Topic Title: Carer Services

Officer Lead: Paul McWade – Operational Director, Commissioning & Complex Care: People & Economy Directorate

Planned Start Date: April 2016

Target PPB Meeting: March 2017

Topic Description and Scope:

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

Why this topic was chosen:
The Health Policy and Performance Board recognise and value the essential role that carers play in supporting some of the most vulnerable people in our community.

The 2011 census found that there were over 15,000 carers in the Borough who were providing unpaid help and support to their partners and relatives etc.

- Approximately 8,000 individuals provided unpaid care for 1 – 19 hours per week;
- Nearly 2,500 individuals in Halton provided unpaid care from 20 – 49 hours per week; and
- Over 4,500 individuals provided unpaid care for 50 or more hours per week

It should be noted that approximately 3,000 carers were aged 65 and over.

With the introduction of the Care Act 2014, Carers are now recognised in law in the same way as those they care for; this means they have the right to an assessment of their needs. As a consequence, the Act has resulted in an unprecedented focus on Carers and their own health and for the first time sets out a set of national criteria to establish whether the Carer is eligible for support. If this is the case they are entitled to a Carer Support Plan and a further review of their status after 6 to 9 weeks. The purpose of this review is to see whether the impact of their caring role is still significant.

It is felt that this Scrutiny topic will provide the Board with the opportunity to actively contribute to the review and development of a new service specification for the Halton Carers Centre and development of a Carer's Strategy, which have been identified as key developments in respect of Adult Social Care during 2016/17, as part of the Business Planning process, in addition to ensuring that the Local Authority is discharging its duty in respect of Carers as outlined in the Care Act 2014.

Key outputs and outcomes sought:

- An understanding of existing Carers Services available in Halton and associated pathways for Carers to be able to access them.
- An understanding of the role that all agencies, including their associated responsibilities, (both statutory and voluntary/community sector) play in the provision of Carers Services.
- Ensure services provided take into consideration national best and evidence based practice.
- Consider ways to continue to make improvements to Carers Services in Halton 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.
- Identification of the best methods for measuring the outcomes for Carers.
- Outcome of Scrutiny review to contribute to the development of the new service specification for Halton Carers Centre and the development of Halton's Carers Strategy.

Which of Halton's 5 strategic priorities this topic addresses and the key objectives and improvement targets it will be help to achieve:

A Healthy Halton – To improve the health and wellbeing of Halton people so they live longer, healthier and happier lives

- 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 Carer Services and how these Services can be accessed.

Preferred mode of operation:

- Meetings with/presentations from relevant officers from within the Council and partner agencies to examine current services.

- Visit to Halton Carers Centre/Other Carers Centre.
- Carer Interviews.
- Desk top research in relation to national best and evidence based practice.

Appendix 2 Notes from meeting with Carers

Notes of the meeting with Carer C.
Tuesday 19th July at 11 am

Those present: Carer C, Councillor Joan Lowe (JL), Councillor Shaun Osborne (SO), Emma Sutton-Thompson

Councillor Lowe began with introductions and an explanation about the Carers Scrutiny Review that is being undertaken by members of the Health Policy and Performance Board. Any recommendations regarding improvements for carers in Halton will be included within the final report and presented to the Health Policy and Performance Board and the Executive Committee for their approval.

At the beginning of the meeting, Carer C gave permission for information she provided to be included in the scrutiny report.

Carer C began by giving some background to her situation – "my son was 14 when he first became ill and wasn't able to finish school. He's 31 now. At that time, I didn't know where to go for help. The school suggested we contact the GP and he signposted us to Thorn Road Clinic which really helped him to understand things. He then went to the YPC in Chester for diagnosis and assessment and was assessed with schizophrenia which we were not expecting at all. My son has been so much better since he's been living in the community, he's been out of hospital now for 15 years, apart from a brief spell when his medication wasn't working so was changed. Now it is so much better and easier for me too. It used to be a 24 hour job for me. When my son was 18 they got him a flat, but he still needed lots of help, things like washing, shopping and cleaning. He was living on his own, with Outreach help. I was there a lot. My son couldn't focus on what he needed to do or the order in which to do them. I felt I had to teach him how to be independent. Over a long period of time, he made improvements with some set-backs. PSS helped with him getting a bus from his flat to my house, and they helped him in the flat. It took 12 years before he was able to do a shopping list himself and go shopping. I had no support as a carer."

JL – Asked how this could have been improved for Carer C. "Someone to go in 2 - 3 times per week would have given me a break, but I couldn't see how the staff would have the time. Now I don't have to do as much as I did. I only see him at weekends. He has a befriender in the week from MIND – they go out to play pool or to have a meal."

JL – Do you have any contact with the Carers Centre? – "Years ago I had contact with the Carers Centre, I was on the Carers Strategy Group and forums. I also had an illness myself

which took over for 5 years, but now I am on the right medication. If you look after someone on your own with a severe mental illness you'll end up with a mental illness yourself. Once my son phoned the crisis team and they told him to phone me! He acts upon the thoughts he gets (not voices). One day at his flat he was calling out loudly – I rang the outreach team as I knew he was very vulnerable, I was told it was not a 24 hour service. He wanted company, so I stayed within him on my own until he was ok. That was 6/7 years ago. One positive – I called the crisis team, two people came out and asked what help was needed. That was exactly what we needed to hear. My son has recently changed his drug and now doesn't have the thoughts, but he has put on six stone in weight. He's now on the Fresh Start programme which is run by the Council and he's lost 6 pounds. Now I only visit at the weekend, there's only the two of us in the family locally. Once a day we (my son and I) phone each other to check each other is ok. If there was a crisis now I would look for help. Earlier this year I had a crisis with myself, I have bi-polar disorder. My son looked after me, but one day he didn't feed me. He knew something wasn't right so he phoned the CPNs, our keyworkers and told them I was really poorly. . The keyworkers have the knowledge of how my son and I work together to look after each other.

JL – That's lovely that you support each other. You should be proud of the achievement you've both done.

SO – People don't realise the hard work it takes, you are a family member and a carer and it takes it toll.
"My son has made marvellous improvements and now he can help me. The best thing was a social worker years ago who sorted out his flat. He had to learn about remembering to take his keys and locking doors, etc. He now has appointees to sort out his finances, though advocates. He knows all about scams and how to deal with them. He says let the phone ring and it will stop. After my son was in the YPC in Chester, he then went to the Brooker Centre, after a year a nurse wanted to put him in an institution, but I said no. I wanted him to have care in the community. Sometimes it felt like a thankless task, although he is better than he was he is still very dependent on me. I help him with his mail and sorting through letters, but he's about 80% self-sufficient now.

SO – As a carer is there anything that would help you now? - Yes, having a break so that I can then help again. Sometimes I had no sleep as I was dealing with my son through the night, or worrying about him. Just having a rest, even an afternoon would have helped.

JL – in the position that you are in now, what do you think would help? – Having the befriender, the outreach worker and me helping. I just check he's ok and make sure he is on track.

JL – do you go out much yourself? – I have 3 friends who understand my situation and we go out shopping or for a meal to support each other. We are all single ladies. As carers we have received a grant, we went to London for 3 days and it was a lovely break. Some people say how could it be a break when you're with the person you're caring for, but I didn't have to do the washing up or shopping, so it was a lovely break. A very positive experience.

JL – do you have community groups that you can access? – I want to write a book, I did attend a writing group, but they weren't serious at writing, so I'm trying to do it freelance now. I like to read as well. I went to University in 2010 and did a course in leadership in Mental Health. Half-way through I had bi-polar for 2 weeks, but managed to get myself back

on track. When I was caring I was just using motherly instincts – I had no help or guidance on what I should be doing. I had to take calculated risks myself, for example, with my son crossing the road or making a cup of tea. I used to repeat things over and over again.

JL thanked Carer C for her time today and the valuable contribution that this will bring to the carers scrutiny review.

Notes from meeting Carer S

Present:

- Carer
- Service-user
- Cllr Margaret Horabin
- Cllr Joan Lowe
- Nicola Hallmark – Principal Policy Officer (minute-taking)

Date: Wednesday 20th July 2016 – 1pm to 2pm
Venue: Coffee shop in Widnes. The carer and service-user are co-habiting partners living in Widnes. They met almost 17 years ago and at the time the carer said she had very little understanding of her partner's condition. The service user has schizophrenia and is currently stable on fortnightly injections.

The carer spoke freely and openly of her journey and experience of caring with some further prompt from Cllr's Lowe and Horabin.

She began to unfold her story in relation to her current business interest. She said that this has given both her and her partner a focus. The carer expressed that her business had run for nearly 10 years and followed an assessment for carer's funding where the assessor had asked her what she'd like to do. Over a period of two years the carer used her carer's fund allocation to undertake two courses then was able to set up her business. Her partner helps out with the business and she said that this is great therapy for him. The carer said that the way they had used the fund to achieve this goal was, "absolutely fantastic, the best thing that had happened in a long time."

The carer and her partner have two dogs and she uses their needs to motivate her partner's. "He has to get up and do walks in a morning." She stated that the business provides additional structure for him. They have some regular clients but it can also be patchy dependant on the time of year.

In addition to the business the carer currently works one day a week (24 hours shift) for a care agency. She used to do two but was unable to sustain this because of her caring responsibilities.

Services have diminished over a period and while the service user had provision of care during the carer's paid working day this is now ended. The carer told us that he had had a Support Worker for a time. This was for around 1 to 2 hours when she was at work on the Monday. They would go for a coffee and a chat and it was a good outlet for him and she knew he was safe during this time. The Support Worker was then pulled and he was changed over to a Mental Health Social Worker. There was no change for her at that time as she was

secure in the knowledge he was still supported. After a time however this was pulled and her understanding was that this service is only open to in-patients for a period following discharge. The carer is left concerned that there is no cover for her partner during her working hours. The carer suggested that this provision was vital and gave her partner a chance to off-load from a different perspective.

The carer and her partner have friends whom they can both chat to but don't feel this is the best channel for unburdening in relation to issues encountered as a result of the condition being managed. Removal of provision has taken away a single point of contact for them both in respect of contact with services. The carer expressed that her only source now is the Crisis Team – and this inevitably is when they've reached crisis.

The carer said that in the past year a new post has been put in place which helps (Carer's Development Worker) with carer needs but for herself it's more about managing her partner's needs. She said that she doesn't need to off-load herself so doesn't tend to access services herself.
At the start of her caring journey the carer engaged successfully with the Carer's Centre and was signposted to a course. This offered her insight into schizophrenia and the pathways for getting help. The carer admits knowing very little at the time and as a result of attending the course was better equipped to support her partner. During one of his hospitalisations she was able to access advocacy services and said she wouldn't have known about this were it not for the course. She has not taken up any of the complimentary therapies for carers as feels she's not got time because of her caring responsibilities. More recently she hasn't seen any other training that she feels would be useful.

The carer stated that she had reached a bit of a crisis point herself and visited her GP. She is now on anti-depressants to "help deal with the stress of the situation." She described that she had become unable to sleep at night and got anxious and in a rage. She said that she doesn't feel like that now but "doesn't want to take the chance of coming off" her medication for fear that she will return to this state.

Some discussion took place over whether the Carer's Centre was now closed. Confirmation was given that the Carer's Centre in Runcorn was now fully open after refurbishment. The carer was urged to re-engage with the service. She said that she thought it was fantastic for new carers but "not much use" for established carers.

The carer spoke of an issue in work, prior to her anti-depressant medication, where she'd got angry. She did contact the Carer's Centre on that occasion and they supported her by helping with a response letter. She said she "felt relieved there was something there when needed."
The carer reiterated her concern that there's a lack of support for her and her partner prior to reaching crisis point. She feels that the health service and social care provision are not fully tied together and this leave them wanting for a point of contact. At times the carer has been in touch with services and asked for previously known workers. That way she knew they had knowledge of her partner's case.

She said that the idea of services previously (Support Work/SW) was to support her partner to support himself. She's acutely aware however that he's "never going to be able to function properly," and in that way there needs to be more support for ongoing need rather than rehabilitation. He is under psychiatric services for his medication but has received no social care support for the past 5-6 months. This has not made much difference to her at present,

as he is stable on current meds, but she said that “it feels wrong that there’s no support.” It does add pressure to some extent however and the carer said that when she’s not spoken to him all day she has to make contact to check on him. She tries her best to track his “frame of mind” in order to monitor change. She feels that she has to “go to work in the morning and just hope everything is alright.” She will make suggestions as to activity during her working day but she’s not aware of whether he takes them up. She manages the rest of his week more closely to “keep him moving and motivated.”

The carer spoke of the strain of caring responsibilities on their relationship. She expressed difficulty with aspects of his behaviour resulting from his condition. She said that she’s “not just a carer but part of a couple and this is a lot to get your head around as I need to emotionally cut-off. When nasty things come out you have to think ‘it’s not meant for me’. I have to box it off. When you’re with your partner they’re everything to you. We do get on well and I’m with him 24/7 until Monday when I go to work.”

When asked about how she winds down she said she has a drink on a Tues and a Fri – as she doesn’t drink before work. She has a garage which is her ‘chill out space’ where she sits with friends. She also likes to watch horror movies and her partner tends to go to bed and leave her to it.

She was asked what support she would like and she said that a single point of contact is vital so they don’t have to go through his history all over again.
The carer feels she is strong and would ask for help if needed but doesn’t tend to bother with smaller groups or networks as neither has the time or sees the benefit. The couple were going to join the gym but never got round to it. They are aware that there are some services that they could but don’t access.

A carer’s assessment has been undertaken and the carer continues to take up the carer’s break money. This is invaluable to the couple who take two breaks a year in a log cabin in the Lakes with their two dogs. She did say that the amount has reduced and this adds pressure as it used to pay for the petrol also or a meal but now they have to save.

The couple receive working tax credits because of the carer’s low income. The service user also receives Disability Living Allowance. The carer owns her own house and expressed that she feels ‘lucky’ to be in this position.

The carer said that she has considered supporting others she knows but then has to draw herself back as knows “it’s too much” to take on.

The Councillors agreed they had the information they needed for the scrutiny review and that the carer’s comments would feed-in to their overall recommendations.

Cllr Lowe explained the scrutiny process to the carer along with the reason why this topic has been chosen for review. She explained that the review will be a public document and asked the carer whether she wanted to be named. She expressed that she would prefer to remain anonymous.

The carer and the service user were thanked for their contribution.

Notes from visit to the Carers’ Centre

Health PPB: Carers Scrutiny Review
Carers Centre Visit (Runcorn) 26th July 2016

Present:
Cllr. Pauline Sinnott
Tom Baker (Healthwatch representative)
Natalie Johnson, HBC Policy Officer (notes)

Cllr. Sinnott and Natalie were welcomed to the centre by Carl Harris (Manager) who confirmed that he and his colleague would be attending a future meeting of the topic group and would be able to share the results of a recent survey with carers. Today, he had arranged for a group of carers/cared for people to be available for a general discussion.

The meeting began at 1:00pm with Cllr. Sinnott introducing herself to the group of carers/cared for people and thanking them for attending the meeting. She explained that the role of the Health PPB is to scrutinise local services. Cllr. Sinnott has a particular interest in the centre being one of the ward councillors for the area and also because she was a carer herself until recently. It was clarified that the purpose of today was not to scrutinise those attending the meeting but to find out about their experiences, views etc.

Cllr. Sinnott explained the aims of the scrutiny topic and the subject areas to be considered as outlined in the information pack for councillors.

There were introductions around the room:
L and his son (carers), L's wife is on the 'Forget me not' ward, "Lucia from the centre is doing a brilliant job supporting the family"
P (cared for) and his daughter S (young adult carer)
M (cares for his wife) and his daughter B (young carer)
J (carer) and his wife (cared for)
B who cares for her husband who has Alzheimer's
P who cares for her mum and brother and also runs a support group and works at the centre as well
S who cares for her husband who has dementia

Cllr. Sinnott suggested the group discuss the recent change in the law brought about by the Care Act in terms of **carer's assessments** – has everyone had a statutory assessment from the Council (it was clarified that this is different to registering with the centre)?

- S and B said they had not had one;
- P explained that you have to request one, they're not automatic like they used to be;
- Other members of the group reported that they had been assessed, usually through the cared for person's Social Worker;
- Those who had been assessed reported that it was an effective process that led to them feeling supported;
- Cllr. Sinnott suggested that this is an issue that could be raised with staff at the centre and they will be able to advise how to go about getting an assessment. These assessments are important as they recognise the rights and needs of the carer as well as the person they care for.

- All carers upon registration with the centre and during review are ask if they want to be referred to HBC for a carer's assessment. It is also included as an article in the carers centre newsletter from time to time informing carers of their right to an assessment as well as in our information pack that all carers receive upon registration.

Cllr. Sinnott asked the group for feedback on **sources of information** and **how easy people found it to access the centre**:

- People reported that without Lucia they wouldn't know about anything (support etc.)
- Everyone feels listened to at the centre, staff will help in any way they can, nothing is ever a problem, you don't get 'fobbed off', it doesn't matter how minor or major your issue is staff will always put the effort in to help you and they help with any issues and they are quick in the help and support they provide;
- It was reported that schools refer young carers to the centre and there are posters in GP surgeries etc. and often when Social Services visit the cared for person, they refer the carer to the centre;
- Carers think it is their 'job' to care (i.e. they don't recognise that they are a 'carer') so don't realise that help and support is available;
- Social Workers and GPs are better at referring to the centre but there isn't consistency in the information available;
- J and his wife reported a poor experience on her discharge from hospital (no support, GP unhelpful);
- Mixed experiences from different GP practices – a GP at New Town, Widnes is very supportive of the carer role and ensures support is being accessed, at Beechwood (Widnes) there are messages flashing up about the centre, however, at Hallwood (Runcorn) GPs don't refer to the centre although leaflets were available;
- It should be fed back to the CCG that some practices are not promoting carer's services/support (individual experience can depend on the interest/expertise of the particular GP).

Tom Baker arrived 1:25pm, Cllr. Sinnott introduced Tom to the group and re-capped on discussions that had already taken place.

There was some discussion around **eligibility for accessing funded services through HBC**:

- Three categories – not sure if categorising is appropriate;
- Cllr. Sinnott read the information on eligibility within the topic group information pack – someone is likely to meet the criteria if there is a significant impact on their wellbeing as a result of their caring role.

Cllr. Sinnott asked the groups where the **gaps** are in terms of services/support for carers:

- S felt that there is nothing for young adult carers (i.e. aged 18-25) and she has to fit in with groups aimed at young people (teenage carers) or older people, which doesn't fit with her own needs/interests. It has been suggested that S set something up but she feels that she needs the support and therefore not able to provide the support to others. S sees things taking place in other areas;
- It was agreed that in some cases there isn't the right kind of specific support and if you haven't got the resources etc. to set something up then you are not supported but services should fit with you not the other way round;

- There was some discussion around the stigma that is attached to being a young carer – B and S are involved in work making use of the Internet to try and tackle this issue and make support for young carers more appealing (there was a suggestion around young carers linking in with older age groups to support with technology);
- There was a general feeling in the group that it should be a national commitment that young people shouldn't have to take on an unpaid caring role although the group applauded S and B for what they do, which they feel is 'normal' / 'natural'. It was noted that some young people can cope but others might not be able to and there should be support out there for them and the Government should not put that responsibility on young people. It was noted that these are important issues but we can only make things better at a local level.

Cllr. Sinnott asked the group about their experience of **respite** (e.g. carer's breaks):

- Sometimes other family members have to step in to provide care (e.g. 'my mum won't have anyone else coming in'), which presents a barrier for the carer;
- S reported that her husband doesn't recognise his own illness so he won't go into respite, he thinks he can manage and if it's suggested that S needs a break he says 'we will go then', the only respite S has is a coffee morning or a meeting like today but she can't leave her husband for an entire day;
- There is a sense of responsibility – 'my mum brought me up so now I'll be there for her' – but it does take its toll and you need a break to 're-charge' and enable you to continue caring;
- One person mentioned day centres that used to pick people up but they are now closed;
- J reported feeling like he had to be strong for his wife and he was bottling things up but one day he asked to leave the house for a while and he just screamed to let everything out, he needed that 'release';
- It was felt that sufficient funding should be there. L's wanted to mention the 'Disabled People Against Cuts' (DPAC) group – they have a website and Facebook page, they lobby Government.

Cllr. Sinnott asked the group if there was **anything else** they wanted to mention:

- 'Don't let this place (the centre) go!'
- Need to find the 'hidden' carers who aren't receiving support;
- 'How will we know the outcome of this?' Cllr. Sinnott assured the group that the centre would be sent a copy of the final topic group report (overall it is looking at wider remit, not just the centre), although it is a public document as well;
- P mentioned that she is attending the Carers Strategy Group (led by Paul McWade) and they are looking for a wider group to get involved (currently just mental health and learning disability carers). It was noted that the group should perhaps come to the centre like today's meeting as it can be daunting for carers to attend council meetings.

Cllr. Sinnott thanked the group for their attendance today and confirmed that the findings from today's discussions and the other elements of the topic group would be fed back to the Health PPB in the final report in order for them to decide what actions take place – thank you for having your voice heard and feeding back your views!

[i] Carers UK (2002) Without us…? Calculating the value of carers' support, Carers UK
[ii] "Always on Call, Always Concerned

REPORT TO: Health Policy & Performance Board

DATE: 7th February 2017

REPORTING OFFICER: Strategic Director, People

PORTFOLIO: Health & Wellbeing

SUBJECT: Safeguarding Update

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To update the Board and highlight key issues with respect to Safeguarding and the work of Halton's Adult Safeguarding Board (HSAB).

2.0 **RECOMMENDATION: That:**

The report be noted

3.0 **SUPPORTING INFORMATION**

3.1 Following discussions at the HSAB Development Session, concerns were raised as to whether the current membership of HSAB was too large and therefore impacting on the effectiveness of the Board and how it operates. There was agreement obtained to restructure HSAB from September 2016 onwards and to recruit a Board Officer to support the Board. It also agreed to the establishment of a Partnership Forum and a Health sub group in order to support the role of the Board and to take safeguarding in the Borough forward.

3.2 Self-neglect is a complex area of work, arising as it does from a large range of causal factors. The Care Act 2014 recognises self-neglect as a potential safeguarding matter among those who are either in receipt of, or in need of care and support, and when their health and wellbeing or that of others is seriously compromised.

3.3 In order to address and co-ordinate this area of work this HSAB have agreed a policy, procedure and good practice guidance which proposes intervention at a stage when self-neglect and/or hoarding have given rise to significant concerns that an individual (and/or others) may be at risk of serious harm. It sets out clearly that a collaborative and multi-disciplinary approach to those at high risk is the most effective way to achieve creative and proportionate interventions that respect the individual's right to self-determination. It has also agreed the establishment of a self-neglect panel to draw

together a range of agencies and services with whom the individual is or may have previously been involved with in order to provide an opportunity for multi-agency working of cases.

3.4 Nothing is more worrying or distressing than when a loved one or friend goes missing or doesn't return home when expected. For people living with or caring for someone with Dementia, this may be quite common.

3.5 The Herbert Protocol is a national scheme adopted by Cheshire Police and other police services across the country. It encourages carers, families, friends or neighbours, to hold information about the person with Dementia that can help the police find them if they do go missing. Cheshire Police are intending to work with local care home providers to introduce it into the Borough.

3.6 Halton Borough Council took part in a Peer Review into safeguarding for two days during January 2017. A Peer Review is intended to help Councils by providing a constructive and supportive process with the central aims of helping Council's and their partners to assess their current achievements and identify areas for improvement. The initial feedback was positive noting the commitment of the Council and partners to safeguarding. We are awaiting the final written feedback

3.7 The Law Commission undertook a review of the Deprivation of Liberty Safeguards (DoLS) system and asked for responses to a consultation paper. In brief they concluded that There is a compelling case for replacing the DoLS through legislation. The system is currently unsustainable and DoLS has failed to deliver improved outcomes for those lacking capacity and their families. Any new scheme must reduce the administrative burden and costs of DoLS. A more streamlined and flexible scheme will be introduced with the responsibility for establishing a deprivation of liberty shifted to the commissioner not the provider. The commissioner will in many cases be able to rely on existing assessments of capacity and best interests. The publication of their final report and draft bill was due to be published in December; however, it is now expected in March 2017.

3.8 Operation Hornsman was a recent European wide operation targeting modern slavery. In total, more than 170 people were spoken to in Halton and Warrington. Although there were no victims locally the operation did flag up that there is a question regarding the potential need for longer term health and support services, should any victims of trafficking or modern slavery be discovered. Many people interviewed appeared to be speaking from a script, and some were working 10 hours plus a day. There are now plans

to work with housing officers to make sure people are safe and well, looking at health and safety and Housing Act Regulations. During the operation, it was found many properties were private, small rentals with landlords associated with the actual car washes that their tenants worked in.

4.0 POLICY IMPLICATIONS

4.1 None identified

5.0 FINANCIAL IMPLICATIONS

5.1 None identified

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

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

None identified

6.5 Halton's Urban Renewal

None identified

7.0 RISK ANALYSIS

7.1 Failure to consider and address the Statutory duty of the Local Authority could expose individuals to abuse and the Council as the Statutory Body 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**

None under the meaning of the Act

REPORT TO: Health Policy and Performance Board

DATE: 7th February 2017

REPORTING OFFICER: Strategic Director, People

PORTFOLIO: Health & Wellbeing

SUBJECT: Implementation of Community Multi-Disciplinary Teams (MDT)

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To provide inform the Board on the development and implementation plan of the Community Multi-Disciplinary Team (MDT) model for all adults over the age of 18.

2.0 **RECOMMENDATION: That:**

i) The report be noted

3.0 **SUPPORTING INFORMATION**

3.1 There is an evidence base to suggest that a Multidisciplinary teams approach is a cost effective way of delivering improved health and social care outcomes; increased participation and compliance with treatment; reduced length of stay and bed days in hospital; increased numbers of patients discharged home; reduced admission to residential and nursing care and acute hospitals, and improved patient/service user and carer satisfaction.

3.2 A number of legislative and policy developments have contributed to the development of the community multi-disciplinary approach in Halton, which is now being implemented; further illustrating the commitment to integrated health and social care in the borough.

3.3 A dedicated Steering Group with membership from Adult Social Care, Bridgewater Community NHS Trust, Halton NHS Clinical Commissioning Group and IT services from NHS and the HBC, have developed a model for Multi-Disciplinary Team working, to provide better communications and coordination of care across health and social care and improving outcomes for people with complex needs.

The Community MDT Model

3.4 Please see Appendix 1 – MDT Model

The model for Community MDTs in Halton consists of staff from several different professional backgrounds, including GPs, Social Workers, Community Care Workers District Nurses, Social Care in Practice (SCiP) workers, Community Matrons, Continuing Health Care Nurses, and Wellbeing Officers, who are able to respond to people who require the help of more than one kind of professional.

3.5 Community MDTs are aligned to 4 localities (Widnes North, Widnes South, Runcorn East and Runcorn West), with each locality having a hub of GP practices within the locality. Adult Social Care Complex Care Teams (Widnes and Runcorn), Community Matrons and District Nursing resources have been allocated to each locality based on the GP registered populations in each area. The Community MDT process is a key enabler to ensure there is focus on case identification, early intervention, and management of people with complex needs and/or frequent users of services. This encompasses, face to face working, MDT meetings, working together across professions in the assessment process (i.e. joint home visits), joint care planning, closer joint working between district nurses and social workers on complex cases, including working closely with GPs. Referrals can be taken daily and directed to the relevant professionals in the MDT.

Anticipated outcomes of the Community MDT approach

3.6 The MDT approach was introduced to help the management of people with Complex Needs and intends to:-

- Improve the health and well-being of people with complex needs and those who are high intensity users of health and social care services;
- Increase the awareness and utilisation of a range of tools and processes associated with anticipatory care planning and support – reducing the need for, and cost of emergency and unplanned treatment, care and support;
- Support people, their significant others and all providers of health and social care to effectively utilise the full range of health and social care provision in the borough; and
- Reduce the number of non-elective admissions and A&E attendances of an identified population through the use of individualised programmes of care and support.
- This approach to integrated working is supporting the Every Contact Counts approach, a wider vision to service delivery and delivering seamless support.

Implementing the MDT Approach

3.7 Prior to implementing the approach, a number of regular cross agency meetings have taken place to plan the transition, develop the model and address any real or perceived barriers to this way of working.

3.8 The MDT Model has been implemented by :

- Working with identified shared caseloads of clients within GP populations.
- Developing a joint care plan, which offers a holistic assessment and a streamlined approach and avoid duplication.
- Having access to case files and electronic case records, where there are appropriate governance arrangements. This provides more comprehensive information on people using service which will helps to support their care needs and offer speedier assessments and better outcomes.
- The setting up of a named care co-ordinator pilot within the SCiP team, with a view to expanding the potential for named care coordinators to be drawn from any of the professionals within the community MDT.
- Named workers from within Adult Social Care have been identified to work alongside named district Nurses and Community Matrons in the community MDT model, where relationships are being further strengthened between professions.
- The research shows that developing a common 'culture' is at least as important as processes as described. This means taking time out to get staff to address issues such as professional identities, boundaries and accountabilities is essential, this will be enhanced by regular joint team meetings. We are planning a series of launch events involving district nurses, community matrons and social care staff, preparing staff for the improved joint working practices. with full implementation of the model in April 2017. The launch events will run alongside the development of the joint care plan.

Development of a Joint Care Plan

3.9 There are 2 main policy drivers for the implementation of the Joint Care Plan, which identify the positive outcomes for adults related to integrated care planning:

3.10 ***'Safe, compassionate care for frail older people using an integrated care pathway' (NHS England. Guide for Commissioners)***

- Personalised care planning, shared across all organisations

3.11 ***Older people with social care needs and multiple long-term conditions NICE guidelines [NG22]***

- Develop care plans in collaboration with GPs and representatives from other agencies that will be providing support to the person in the care planning process.
- Seamless referrals between practitioners, including the appropriate sharing of information

3.12 Work was undertaken by the MDT Steering Group to identify appropriate health and social care fields to be included in the joint care plan. The proposed health and social care Joint Care Plan has been approved by the Older People's Pathway Group and will be implemented in early 2017.

3.13 A formal launch date and work with the staff teams will ensure that there is consistency in use between health and social care. The launch will be scheduled for January 2017, to avoid launching during winter/Christmas pressures.

3.14 The care plan now includes a contingency plan to ensure that any interruption to normal care is mitigated.

Named Care Coordinator

3.15 The community MDT approach is moving towards people having a named coordinator. This is currently being piloted by SCiP (started Nov 2016), with a view to either a District Nurse, SCiP worker or other members of the community MDT taking on the role of named care coordinator.

3.16 The specification for the named care coordinator pilot began in November 2016, with the following functions in mind:

*A first point of contact.

*A lead role in the assessment process

*Liaises and works with all health and social care services, including those provided by the voluntary and community sector

*Ensures referrals are made and are actioned appropriately

Next Steps

Initial Assessment Team (IAT), Occupational Therapy, Mental Health and

3.17 IAT and Occupational Therapy - This is a small front ended team dealing with initial assessments, signposting and short term pieces of work. They refer any ongoing case work or complex work into the complex care teams (Runcorn and Widnes) and within this occupational therapy service provide initial and long term assessments from 'cradle to grave'. This process will remain with the introduction of the community MDT approach.

3.18 Mental Health – Mental Health are already working in an MDT model under the Care Programme Approach (CPA). Mental Health teams already work with agencies within the Community MDT model, and will

continue to use the established referral pathways that support joint working.

3.19 These Teams will remain as they are at present but will be subject to future consideration and planning in line with the model.

IT Solutions

3.20 The technical programme to allow GP's to access Carefirst from their own Health Computers will be via VDi (a virtual desktop view of Carefirst). The connection between Health Computers and the Council's IT is in place, and is in the process of being activated. Once this is activated, the entire Health network has the potential to access Carefirst. HBC IT has contacted Health IT and is waiting for a response to progress this.

3.21 The Council's It services have sponsored the N3 connection request, which is now on order and will be connected in early February 2017. Work is ongoing in activating the N3 connection that is required for Social Care Staff to access EMIS Web.

3.22 In addition to the above, ICT Services are looking into the potential to develop a single "View" of the client, which brings together data from Carefirst and EMIS into a single system that all Health professionals can access (via the Council-Health network link). EMIS and OLM are currently looking at usability options.

Shared Case Loads between MDT professionals

3.23 There are locality based caseloads within the 4 areas (Widnes North, Widnes South, Runcorn East and Runcorn West), where the professionals within the community MDT are working with a shared cohort of people.

4.0 POLICY IMPLICATIONS

4.1 This work work reflects the requirements of the Care Act and the integration of Health and Social Care through the NHS Halton CCG strategy for General Practice Services, Halton Health and Wellbeing Strategy and the Halton Better Care Fund plan.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 This work will be undertaken within existing resources. There could be a financial implication with one off Capital cost related to the IT infrastructure to support community MDT practice. Dedicated resource to project manage the MDT approach will be explored to enable constant and focused development.

This will be reported on through the usual routes as cost is identified.

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

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

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

6.3 **A Healthy Halton**
Integrated health and social care offers better outcomes for service users and patients. Unplanned, and possibly unnecessary, hospital admissions may continue at the current level if this integration of social care into MDTs and continued integration between health and social care stakeholders does not take place.

6.4 **A Safer Halton**
None

6.5 **Halton's Urban Renewal**
None

7.0 **RISK ANALYSIS**

7.1 None identified at this time

8.0 **EQUALITY AND DIVERSITY ISSUES**

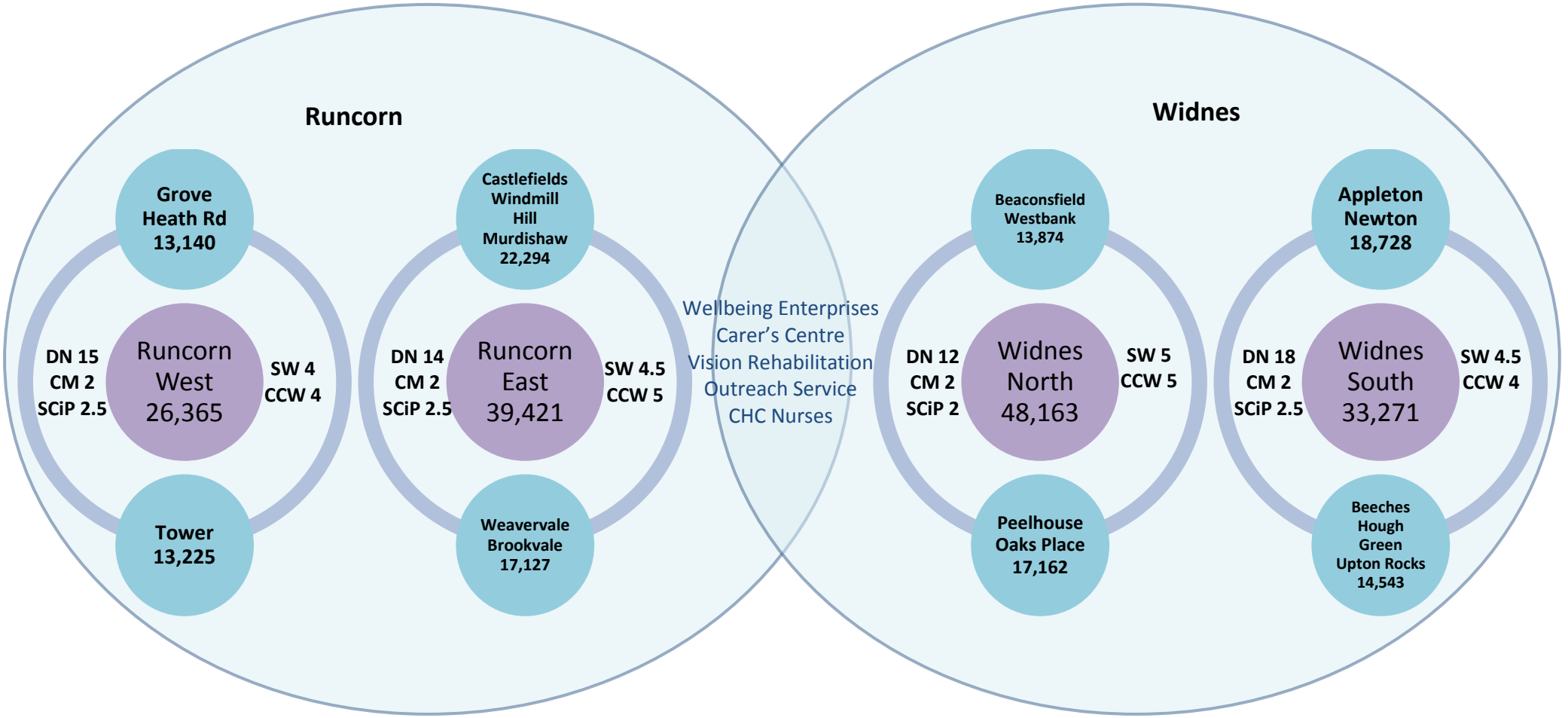
8.1 None identified at this time

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

None.

Appendix One

MULTI-DISCIPLINARY INTEGRATED TEAM MODEL



DN – District Nurse
CM – Community Matron
SCiP – Social Work in Practice
SW – Social Worker
CCW – Community Care Worker

REPORT TO:	Health Policy & Performance Board
DATE:	7th February 2017
REPORTING OFFICER:	Strategic Director – People
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Health Policy and Performance Board Work Programme 2017/18 – Scrutiny Topic
WARD(S)	Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 This report is the first step in identifying a scrutiny topic for the Health Policy & Performance Board (PPB) to examine during 2017/18.

2.0 **RECOMMENDATION: That the Board:**

i) Put forward and debate its initial suggestions for a Topic to be included in the Board's 2017/18 work programme;

ii) Agree the Scrutiny Topic to be examined during 2016/17 with a view to an associated topic brief being developed and agreed at the next meeting of the Board.

3.0 **SUPPORTING INFORMATION**

3.1 Whilst the Board ultimately determines its own Topics, suggestions for Topics to be considered may also come from a variety of other sources in addition to Members of the Board themselves. This may include members of the Council's Executive, other non-Executive Members, officers, the public, partner and other organisations, performance data and inspections.

3.2 Prior to determining the Board's preferred Topic, the PPB may wish to take soundings from relevant Executive Board portfolio holders, the Health & Well Being Board and other key partners.

3.3 In previous year's scrutiny topics have included :-

Year	**Topic**
2016/17	• Carers
2015/16	• Discharge from Hospital
2014/15	• Care at Home Provision in Halton • Cancer Services (Joint Scrutiny)
2013/14	• Mental Health

2012/13	• Falls Prevention • Vascular Services (Joint Scrutiny)
2011/12	• Homelessness • Dignity

3.4 A meeting has taken place with members of the Board to discuss the priorities for 2017 as part of the Adult Social Care Business Planning process. Members may feel they would want to select a topic during 2017/18 that supports one of priorities identified during this process.

Suggestions that were put forward during that meeting included:-

- Supported living for people with a Learning Disability;
- Partnerships/Co-production; and
- The work of the Health Improvement Team, e.g. successes, what could be done differently, etc.

4.0 POLICY IMPLICATIONS

4.1 The outcome from the Scrutiny Topic may result in the need to review associated policies.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 The outcome from the Scrutiny Topic may result in recommendations which have financial or other implications and these will be considered as necessary.

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**
Any topic identified will support the Council's strategic priority of Improving Health.

6.4 **A Safer Halton**
None identified.

6.5 **Environment and Regeneration in Halton**
None identified.

7.0 RISK ANALYSIS

7.1 No risks associated with this report have been identified.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 An Equality Impact Assessment is not required for this report.

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

9.1 None identified.

Appendix 1

OVERVIEW AND SCRUTINY WORK PROGRAMME

Topic Selection Checklist

This checklist leads the user through a reasoning process to identify a) why a topic should be explored and b) whether it makes sense to examine it through the overview and scrutiny process. More "yeses" indicate a stronger case for selecting the Topic.

#	CRITERION	Yes/No
Why? Evidence for why a topic should be explored and included in the work programme		
1	Is the Topic **directly aligned with and have significant implications for at least 1 of Halton's 5 strategic priorities & related objectives/PIs, and/or a key central government priority?**	
2	Does the Topic **address an identified need** or issue?	
3	Is there a **high level of public interest or concern about the Topic** e.g. apparent from consultation, complaints or the local press	
4	Has the Topic been **identified through performance monitoring** e.g. PIs indicating an area of poor performance with scope for improvement?	
5	Has the Topic been **raised as an issue requiring further examination through a review, inspection or assessment, or by the auditor?**	
6	Is the Topic area likely to have a **major impact on resources or be significantly affected by financial or other resource problems** e.g. a pattern of major overspending or persisting staffing difficulties that could undermine performance?	
7	Has some **recent development or change** created a need to look at the Topic e.g. new government guidance/legislation, or new research findings?	
8	Would there be **significant risks** to the organisation and the community **as a result of not examining this topic**?	
Whether? Reasons affecting whether it makes sense to examine an identified topic		
9	**Scope for impact** - Is the Topic something the Council can actually influence, directly or via its partners? Can we make a difference?	
10	**Outcomes –** Are there clear improvement outcomes (not specific answers) in mind from examining the Topic and are they likely to be achievable?	
11	**Cost: benefit** - are the benefits of working on the Topic likely to outweigh the costs, making investment of time & effort worthwhile?	
12	**Are PPBs the best way to add value** in this Topic area? Can they make a distinctive contribution?	
13	Does the organisation have the **capacity** to progress this Topic? (e.g. is it related to other review or work peaks that would place an unacceptable load on a particular officer or team?)	
14	Can PPBs contribute meaningfully given the **time** available?	

REPORT TO:	Health Policy and Performance Board
DATE:	7th February 2017
REPORTING OFFICER:	Strategic Director, People
PORTFOLIO:	Health & Wellbeing
SUBJECT:	Cheshire and Merseyside Sustainability and Transformation Plan
WARDS:	Borough Wide

1.0 PURPOSE OF THE REPORT

The purpose of this report is to share the Cheshire and Merseyside Sustainability and Transformation Plan (STP) with the Health Policy and Performance Board.

2.0 RECOMMENDATION:

The Health Policy and Performance Board is asked to:

i) Note the contents of the Cheshire & Merseyside Sustainability & Transformation Plan (STP);

ii) Note the commitment to continued local engagement and the requirement to comply with statutory requirements for public involvement, and to seek the views of the Health Policy and Performance Board about the next phase of local engagement.

3.0 SUPPORTING INFORMATION

3.1 Background

The NHS Five Year Forward View, published in October 2014, set out strategic intentions to ensure the NHS remains clinically and financially sustainable. The Forward View highlighted three key areas:

- The health and wellbeing of the population;
- The quality of care that is provided; and
- NHS finance and efficiency of services.

Subsequently, the 2015/16 NHS planning Guidance set out the steps for local health systems to deliver the Five Year Forward View, backed up by a new Sustainability and Transformation Fund intended to support financial balance and to enable new investment in key priorities. As part of the planning process, health and care systems were asked to develop Sustainability and Transformation Plans, to cover the period from 2016/17 to 2020/21.

A total of 44 areas (or 'footprints') were identified across England to work together as health and care systems to develop Sustainability and Transformation Plans (STPs) that set out how these gaps can be addressed. STPs represent a change in the way that the NHS in England plans its services; with a stronger emphasis on collaboration to respond to the challenges facing local services and a focus on place-based planning for whole systems of health and care.

While STPs are primarily being led by the NHS, developing credible plans will require the NHS to work in close partnership with social care, public health and other local government services, as well as third sector organisations and local people.

The Cheshire and Merseyside Sustainability and Transformation Plan is the second largest STP in England. It covers a population of 2.5 million, has 12 CCGs, 20 providers and 9 local authorities.

The Cheshire and Merseyside STP was submitted to NHS England on 21st October 2016. This was drafted as a requirement of the NHS England Planning Framework and follows on from a first submission in June 2016. NHS England required time to review the October submission and set a publication date for the Cheshire and Merseyside STP for 16th November 2016.

The STP is drafted as a technical document responding to the requirements of NHS England. A public summary and frequently asked questions document have been produced to support public understanding of the rationale and the content of the plan. The STP document refers to a number of accompanying appendices which have also been published and can be accessed alongside the plan on all local NHS websites.

3.2 STP Priorities

The STP sets out four common priorities for Cheshire and Merseyside:

1. **Support for people to live better quality lives by actively promoting health and wellbeing.** The plan sets out priorities to address the factors that have a negative impact on population health and that are increasing pressure on services.
2. **The NHS working together with partners in local government and the voluntary sector to develop joined up care**, with more care accessible outside of hospitals to give people the support they really need when and where they need it.
3. **Designing hospital services to meet modern clinical standards and reducing variation in quality;** to establish consistency and improvement in clinical standards for hospital care across Cheshire and Merseyside.

4. **Becoming more efficient by reducing costs, maximising value and using the latest technology;** reducing unnecessary costs in managerial and administrative areas, maximising the value of clinical support services and adopting innovative new ways of working, including sharing electronic information across all parts of the health and care system.

3.3 Local Delivery Systems

The Cheshire and Merseyside STP is designed to address the challenges of the region in terms of population health and wellbeing, quality of care and financial sustainability. The majority of delivery will be through the plans developed by the three local delivery systems (LDS): North Mersey; the (Mid Mersey) Alliance; and unified Cheshire & Wirral.

All three local delivery systems will deliver the same four key priorities set out in the Cheshire and Merseyside plan. However, each local plan will tailor the way these priorities are delivered to reflect the particular needs of their population and the local health and care system.

The three Local Delivery Systems are at different stages of development. For some areas, collaborative plans to improve health outcomes and to address the future sustainability of the health and care system have been in development for some time. For other areas, partners may have been collaborating for a shorter time and their local plans largely represent ideas still to be shaped into firm proposals.

3.4 The Alliance Local Delivery System (LDS)

The Alliance Local Delivery System (LDS) is made up of 4 Clinical Commissioning Groups (NHS Halton, Knowlsey, St Helens and Warrington CCGs) and 5 NHS providers (5 Boroughs Partnership NHS Foundation Trust, Bridgewater Community NHS Foundation Trust, St Helens & Knowsley Teaching Hospitals NHS Trust, Warrington and Halton Hospitals NHS Foundation Trust and Southport & Ormskirk Hospitals NHS Trust). The Alliance LDS is also engaging with the local authorities covering the boroughs of Halton, Knowsley, St Helens and Warrington.

The Alliance LDS builds upon the work already being done at a local level, the proposals submitted by the Alliance LDS include options and models of transformation for the local health system that aim to address a funding shortfall of £202 million, whilst at the same time improving health, wellbeing and outcomes by:

- Prevent the demand from materialising **(Prevention at scale)**
- Provide more (cost) effective ways of responding to the demand **(Out of Hospital Care)**

- Find more productive/efficient ways of delivering acute hospital care **(Reducing Variation & Improving Quality, Clinical Support Service Collaboration)**
- Making our overhead and running costs as efficient as possible **(Back Office Collaboration and Working Together more effectively)**

The proposals set out in the Alliance LDS were submitted to NHS England, and form part of the Cheshire and Merseyside STP. Following formal publication of the Cheshire and Merseyside STP, we are now further developing these proposals into outline plans and will commence wide scale programme of engagement and communication during 2017.

4.0 POLICY IMPLICATIONS

Since the Health and Social Care 2012 Parliament, through the Secretary of State for Health, sets a Mandate for the NHS to deliver. The delivery of this Mandate is overseen by NHS England and taken forward by Clinical Commissioning Groups. The production of the Sustainability and Transformation Plans across England has been mandated by NHS England, NHS Improvement and the other arms-length bodies and represents the response of providers and commissioners in the NHS to the financial settlement for the NHS agreed by Parliament within which they are required to deliver NHS Constitution and other standards.

5.0 OTHER IMPLICATIONS

It is recognised that there is significant public interest in STPs and the process by which proposals will be developed and agreed.

The view of NHS England is that there should be a public conversation to gain views on the proposals contained in the STP and its constituent parts in the form of the LDS plans.

It should be noted that the STP is a planning footprint and not a statutory entity. Consequently, with regard to accountability, individual NHS organisations will remain responsible for ensuring their legal duties to involve are met during the design, delivery and implementation process of specific proposals. This includes ensuring that any reconfiguration proposals which represent a potential significant variation in service are subject to public and local authority overview and scrutiny and formal public consultation.

A full engagement plan is being developed for the next phase of public and stakeholder engagement for the STP, with NHS and local authority representatives involved in shaping an overarching plan for Cheshire and Merseyside, which also reflects the different approaches that may be taken by each LDS. The Health Policy and Performance Board is

asked to give a view on any additional engagement approaches on the contents of the STP in this context.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children and Young People in Halton

NHS provided services for children and young people are included in the scope of the STP and the LDS delivery plans.

6.2 Employment, Learning and Skills in Halton

None as a result of this report.

6.3 A Healthy Halton

The *One Halton* approach has been incorporated into the Alliance LDS submission as part of the STP and features prominently in the demand management and prevention at scale work stream.

6.4 A Safer Halton

None as a result of this report.

6.5 Halton's Urban Renewal

None as a result of this report.

7.0 RISK ANALYSIS

The STP Programme Team and the LDS teams are developing an assurance system to identify and mitigate the risks of this programme.

8.0 EQUALITY AND DIVERSITY ISSUES

In sharing the STP with the public and seeking further engagement the NHS is:

- Giving due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

- Giving regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

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

Cheshire and Merseyside Sustainability and Transformation Plan (STP)

Cheshire and Merseyside STP Public Summary

Frequently Asked Questions

Cheshire & Merseyside
Sustainability and Transformation Plan

People and Services Fit for the Future

2

The Challenge for the NHS

As a nation we are fortunate to have a National Health Service that is free at the point of care, delivering world class services.

However, we also know that the NHS is facing some big challenges and there are clear signs that it needs to adapt and change if it is to be fit for the future.

While on a day-to-day basis most areas are running well, we are seeing pressures in areas such as hospital care, A&E, mental health and GP services. Some of this is being experienced in longer waiting times and variable quality of care.

There are several reasons why the NHS is under pressure:

- People are living longer, but not always healthier, lives;
- Care is not always joined up for patients, especially for the frail elderly and those with complex needs. As a result, too many people do not get the right care in their homes or community, which creates an over-reliance on hospital services;
- We need to do more to support children, young people and adults effectively with their mental health challenges;
- At the same time, there is enormous pressure on health and social care budgets.

There is also a growing financial challenge. The NHS will continue to receive a small year on year increase over the next five years, but this is not keeping pace with increasing costs and increasing demand for services. If we do nothing, the NHS faces a £30 billion funding gap by 2021. For Cheshire & Merseyside our share of this funding gap is £908m.

We know that these issues require us to think more radically about how best to address the problems we face together otherwise we will fail to support the needs of our communities into the future.

In 2014, NHS England published a document entitled ***The Five Year Forward View (FYFV)***, which identified three priorities for the NHS to focus on in order to improve services and the health of our country:

1. **health and wellbeing** – supporting people to stay well
2. **quality of care** – providing good services consistently wherever you live
3. **NHS finances** – maximising efficiency and reducing duplication in services.

3

FIVE YEAR
ORWARD VIEW

Cheshire & Merseyside Sustainability and Transformation Plan

4

Cheshire & Merseyside
in Partnership

2.5 million people

30 *NHS* organisations

9 local authorities

Although the NHS is a national public service it is made up of hundreds of organisations, including hospitals, community services, clinical commissioning groups and specialist services. In addition, public health and social care are the responsibility of local authorities who work in collaboration with the NHS. Community and voluntary organisations also provide a great deal of support to complete this picture. It's clear that the scale of the challenge is too big to be resolved by organisations making changes in isolation.

For this reason NHS England has established 44 Sustainability and Transformation (STP) 'footprints' across the country, bringing together NHS organisations, local authorities and other partners to work together to deliver the priorities from the NHS Five year Forward View, by developing new ideas and proposals to improve health, improve quality and to ensure that the NHS remains financially sound. This is being backed up by additional investment over the next five years, above existing NHS budgets, to address these challenges.

NHS organisations and local authorities across Cheshire & Merseyside are working together to develop ideas and proposals to share with the public about how we can address our challenges and come up with the right solutions. These ideas have come together in the Cheshire and Merseyside Sustainability and Transformation Plan (STP).

Cheshire and Merseyside is a diverse region; with urban areas that have higher levels of poor health and a greater concentration of hospital services, alongside towns and rural areas that have different challenges, including physical access to services.

"The role of the Sustainability and Transformation Plan (STP) for Cheshire and Merseyside is to co-ordinate our efforts, ensuring we promote the best ideas and expertise to provide for the needs of the whole region now and into the future."

Louise Shepherd
Lead for the Cheshire and Merseyside STP and Chief Executive of Alder Hey Children's NHS Foundation Trust

6

Our Priorities

NHS organisations and local authorities have been working together for the last few months, looking at examples of good practice and improvements that have delivered good results elsewhere.

Our core purpose is to ensure that the people of Merseyside and Cheshire continue to have access to safe, good quality and sustainable services, which also means making the best use of the funding we will receive over the next five years.

Ideas and proposals have come together in the Cheshire and Merseyside Sustainability and Transformation Plan (STP), which has four main priorities:

1. **Support for people to live better quality lives by actively promoting what we know will have a positive effect on health and wellbeing.** The way we live now is having a negative impact on our health and putting pressure on services. Alcohol, smoking, poor diet and inactivity are increasing demands on the NHS. We have to change this.

2. **The NHS working together with partners in local government and the voluntary sector to develop joined up care,** with more of that care offered outside of hospitals to give people the support they really need when and where they need it.

3. **Designing hospital services to meet modern clinical standards and reducing variation in quality;** people should be confident that they will receive similarly high standards of hospital care regardless of where they live.

4. **Becoming more efficient by reducing costs, maximising value and using the latest technology**; reducing unnecessary costs in managerial and administrative areas, maximising the value of our clinical support services and adopting innovative new ways of working, including sharing electronic information across all parts of the health and care system.

Improving Health and Wellbeing

We want to see significant improvements in the health and wellbeing of people living in Cheshire and Merseyside. We want people to be better informed and empowered to make positive lifestyle choices and we want to do more to prevent illness. If we can support people to stay well for longer we will be able to improve quality of life and reduce reliance on the NHS.

The plan identifies three Cheshire and Merseyside-wide projects, that will support reductions in alcohol abuse, blood pressure and antimicrobial resistance.

There is a strong health and business case for investing in schemes to prevent people becoming ill. This is the most effective way to make the NHS sustainable in the longer term

Eileen O'Meara
Director of Public Health, Halton

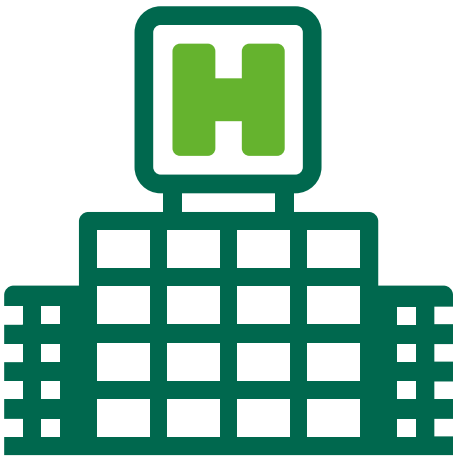
For example, tackling high blood pressure is about encouraging more people to have checks, not only in traditional ways such as through their GPs, but also in everyday places in communities, including pharmacies. If we increase awareness and checks we can intervene to support the thousands of people who have undiagnosed high blood pressure, which often has no symptoms, and avoid deaths and instances of stroke and heart disease.

Not only will these three schemes improve health, they will also reduce reliance on the NHS.

Better Care Outside of Hospital

One of the most far-reaching areas of change we could make is to establish integrated services for better care in our communities. In practice, this is about different parts of the NHS and social care services working together seamlessly with a better focus on people's needs.

For example, in our communities GPs will work in integrated teams with hospital specialists, district nurses, mental health workers and social workers to improve care for people with long-term conditions such as diabetes, elderly people who are frail or children and adults with very specific needs. If we do this effectively we will keep more people well, improve quality of life and have fewer people needing to be admitted to hospital.



"Offering good services closer to home will improve care for the most vulnerable in our communities and reduce admissions to hospital. This is good for patients and for the NHS."

Jerry Hawker
Accountable Officer, NHS Eastern Cheshire Clinical Commissioning Group

Improving Hospital Services

Across Cheshire and Merseyside we will undertake a review of clinical services across all our hospitals to identify where there are variations in quality and to look at how we can establish consistently high clinical standards. Our plans for hospital services will lead to greater collaboration and sharing of expertise and resources. The work to review variation and standards is at a very early stage and will take some further time to deliver impact.

In reviewing hospital services, we will be open about the issues we face that may lead to proposals to change how and where some hospital services are delivered.

For example, there is evidence that for some specialist areas, such as stroke services, it is better to concentrate care in fewer centres as we know that this will improve outcomes for patients.

We also have a shortage of doctors and nurses in some specialties, such as urgent and emergency care, which are making it difficult to provide good quality services in every hospital.

We will establish consistently high clinical standards in all Cheshire and Merseyside hospitals, so people can trust that services will be good regardless of their postcode.

Dr Simon Constable
Medical Director,
Warrington and Halton Hospitals NHS Foundation Trust

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Better, More Efficient Care

We will also look for new opportunities to reduce costs and duplication, whilst at the same time improving care and access to services.

Reducing costs is a big driver for looking at our administrative and clinical support services, but there are also opportunities in clinical support services to improve standards and access in areas such as radiology, pharmacy and pathology. For example, hospitals each invest in expensive equipment such as scanners. As demand continues to increase there are opportunities to better share these resources across hospitals so that resources are being used optimally before we consider investing in new equipment.

When it comes to administrative support, our principle is to share resources across organisations, where this makes sense, in areas such as finance, human resources and IT, to achieve maximum efficiency.

The four main priorities set out in the Cheshire and Merseyside STP are supported by eight clinical programmes looking to improve the way we deliver:

- **Neuroscience**
- **Cardiovascular disease**
- **Learning disabilities**
- **Urgent Care**
- **Cancer**
- **Mental Health**
- **Women's and Children's**
- **Primary care (GP services)**

"We want every penny of NHS funding to be used effectively; there are opportunities to re-shape management and administrative support to reduce costs and maximise investment in patient-facing services."

Tracy Bullock
Chief Executive,
Mid-Cheshire Hospitals NHS Foundation Trust

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Local Delivery Systems across Cheshire and Merseyside

For some of our ideas it clearly makes sense to deliver them across the whole region. However, due to the diversity of Cheshire & Merseyside, we are also working in three smaller partnerships called Local Delivery Systems (LDS) – North Mersey; the Alliance and Cheshire & Wirral. All three local delivery systems will deliver the same four key priorities set out in the Cheshire and Merseyside plan. However, each local plan may tailor the way these priorities are delivered to reflect the particular needs of each area and the local health and care system.

All three local delivery systems will deliver the same four key priorities set out in the Cheshire and Merseyside plan. Each of the Local Delivery Systems are at a different stage in their thinking. For example, plans to transform services have been in development for some time through programmes such as Healthy Liverpool or Caring Together in Eastern Cheshire. For the other areas where partners have been collaborating for a shorter time, ideas are at an earlier stage. This means that there will be opportunities at a very early stage for people to give their views and to get involved in shaping proposals.

Number	Organisation
01	The Walton Centre NHS Foundation Trust
02	Southport and Ormskirk Hospitals Trust
03	Alder Hey Children's NHS Foundation Trust
04	Liverpool Heart and Chest Hospital NHS Foundation Trust
05	The Royal Liverpool & Broadgreen University Hospitals NHS Trust
06	Bridgewater Community Healthcare NHS Foundation Trust
07	Aintree University Hospitals NHS Foundation Trust
08	Liverpool Community Health NHS Trust
09	Clatterbridge Cancer Centre NHS Foundation Trust
10	Wirral Community NHS Foundation Trust
11	Wirral University Teaching Hospital NHS Foundation Trust

Number	Organisation
12	Liverpool Women's Hospital NHS Foundation Trust
13	Mersey Care NHS Foundation Trust
14	North West Ambulance Service NHS Trust
15	Warrington and Halton NHS Foundation Trust
16	East Cheshire NHS Trust
17	Cheshire and Wirral Partnership NHS Foundation Trust
18	Countess of Chester NHS Foundation Trust
19	5-Boroughs Partnership NHS Foundation Trust
20	Mid-Cheshire Hospital NHS Foundation Trust
21	St Helens and Knowsley Hospitals Trust

NHS Trusts


02
Southport
08
07
01
St Helens
05
03
13
15
06
11
10
12
04
21
Warrington
19
Runcorn
09
14
16
Macclesfield
CHESHIRE
17
Chester
18
20
Crewe
GREATER MANCHESTER
WEST MIDLANDS
Cheshire & Merseyside Sustainability and Transformation Plan

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Overview of Local Delivery System Plans

The Alliance: Warrington, Halton, St Helens and Knowsley

The work of the Alliance is at a very early stage of developing ideas to ensure local health services are sustainable and fit for the future.

The plans build upon ideas and developments already happening at local level, with local people. For example, in Warrington, GPs are already working together in 'clusters' to provide more services at GP practice level and in Halton, Wellbeing Practices have been in place for some time and are helping people to become healthier.

As ideas develop into plans we will be asking local people, staff and others for their feedback. Any proposals to change services will be consulted on at a local level, but this won't be until we have worked plans up further in 2017.

"The ideas and proposals detailed in the Alliance plan, are just that; 'ideas' that build upon developments already happening at local level. Whilst existing plans go some way to meet the challenges, we really do need to do more by working together to achieve better health and making sure that people receive the best possible care in the right place at the right time."

Simon Banks
Accountable Officer, NHS Halton CCG

Cheshire and Wirral LDS

Cheshire and Wirral LDS are also in the early stages of developing ideas to transform health services across this footprint. They have identified priorities for making their health care system sustainable now and in the future and have created collaborative, digital initiatives like the Cheshire and Wirral Care Records.

Cheshire and Wirral will continue to engage with local communities and consult on any major service changes, if they happen, later in 2017.

Cheshire and Wirral LDS are developing ideas to transform health services, building upon existing programmes including Caring Together, Healthy Wirral, The West Cheshire Way and Connecting Care. We have clear priorities for a health care system that is sustainable now and into the future and we will continue to engage with local communities about the best way forward.

Jonathan Develing
Senior Responsible Officer for the Cheshire and Wirral LDS

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North Mersey LDS

The North Mersey LDS serves the populations of Liverpool, Sefton, and Knowsley. North Mersey will build on programmes like Shaping Sefton and Healthy Liverpool, which was set up in 2013 in response to the city's Mayoral Health Commission, and recommended some significant changes to the way local health services should be delivered, to address poor health and relieve pressure on services.

North Mersey is one of the most complex health systems in the country, with nine NHS providers of services, including two adult acute hospitals and a range of other trusts.

The main intention, set out in the North Mersey plan, is to reduce unnecessary hospital care and shift the balance towards a pro-active wellness system rather than a system which just treats illness. This shift to better care outside of hospital will enable hospital services to be improved and redesigned to meet the future needs of patients.

North Mersey LDS has a three year head start and is already working collaboratively to embed changes in services, both in communities and in hospital. The area is also a national exemplar for digital innovation in health, with ambitious schemes to establish shared electronic health records and to use assistive technology to help people manage their health conditions.

"We have developed a strong partnership across our system so we can truly act as one to address the challenges we face in tackling poor health and inequalities; maintaining good services both in and outside of hospital and protecting the excellent specialist services on our patch which serve the whole of Cheshire and Merseyside."

Katherine Sheerin
Chief Officer,
NHS Liverpool CCG

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What's Next?

To be successful STPs must be developed with, and based upon the needs of local patients, carers and communities, and health and social care professionals must be effectively engaged with those plans.

In preparing the Cheshire and Merseyside Plan local partner organisations have so far involved senior doctors and system leaders in drawing up ideas, and many more will be involved in developing the plans to take forward the four priorities for action.

The publication of the Cheshire and Merseyside STP on 16th November 2016 marks the start of further engagement on a way forward for local health and social care services.

Over the next weeks and months we will be talking to lots of people to ensure there is a good level of awareness and understanding about the need for change and to listen to ideas or concerns about any aspect of the plan as it currently stands.

Every partner organisation is committed to actively involving patients, carers, staff and local people in shaping future plans and ensuring they have their say on how services will look in the future. Any proposal to substantially change any service will be subject to thorough and detailed engagement and consultation with those people potentially affected by any suggested change.

We will only take forward proposals that are supported by strong clinical evidence and where we can demonstrate a positive impact in terms of quality, safety and sustainability.

The full STP document can be viewed on each of the following CCG websites:

www.liverpoolccg.nhs.uk
– North Mersey

www.wirralccg.nhs.uk
– Cheshire and Wirral

www.warringtonccg.nhs.uk
– The Alliance

Follow us on NHS social media channels and look out for information about opportunities to find out more and get involved on our websites.

For any queries or comments please get in touch by emailing **mlcsu.cmstp@nhs.net**

Cheshire & Merseyside Sustainability and Transformation Plan

Cheshire & Merseyside
Sustainability and Transformation Plan
15 Nov 2016 issue version 4.4

2,571,170
people

32%
Live in most deprived areas

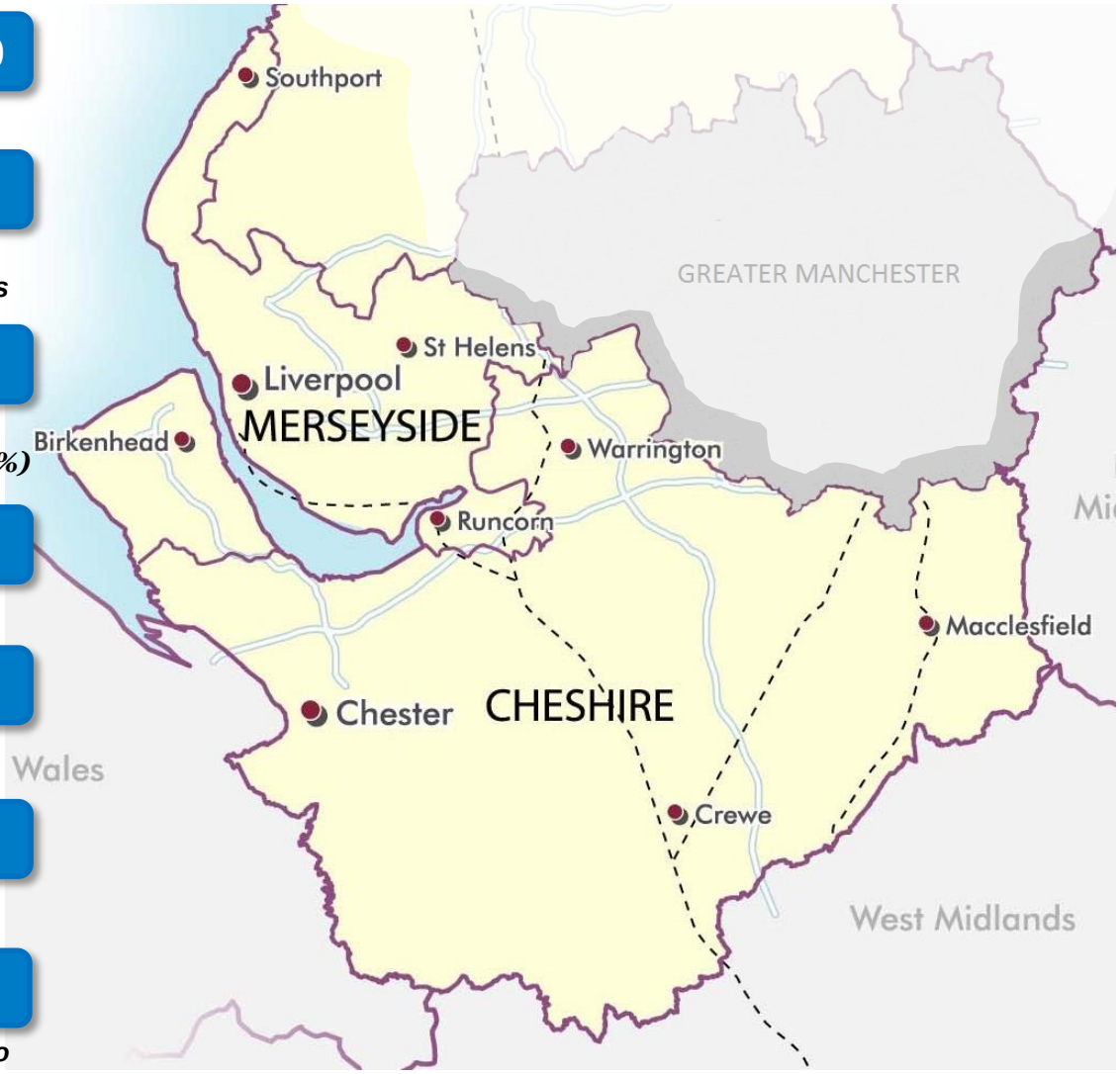
8.3%
Aged 75+ (UK ave. = 7.8%)

12
CCGs

20
Providers

2nd
Largest STP

2
Proposed Devo footprints



Key information
Name of footprint and no: Cheshire & Merseyside; No. 8
Region: North
Nominated lead of the footprint including organisation/function: Louise Shepherd, Chief Executive, Alder Hey NHS FT
Contact details (email and phone): louise.shepherd@alderhey.nhs.uk – 0151 252 5412
Organisations within footprints:
CCGs – Knowsley, South Sefton, Southport and Formby, Eastern Cheshire, Wirral, Liverpool, Halton, St Helens, South Cheshire, Vale Royal, West Cheshire, Warrington
LAs: Knowsley, Sefton, Liverpool, Halton, St Helens, Cheshire East, Cheshire West and Chester, Warrington, Wirral
Providers: Liverpool Heart and Chest Hospital NHS Foundation Trust, Alder Hey Children's NHS Foundation Trust, Royal Liverpool NHS Foundation Trust, Countess of Chester NHS Foundation Trust, St Helens and Knowsley Hospitals Trust, Walton Centre for Neurology and Neurosurgery, Bridgewater Community Healthcare NHS Foundation Trust, Wirral University Teaching Hospital NHS Foundation Trust, Mersey Care NHS Foundation Trust, East Cheshire NHS Trust, Cheshire and Wirral Partnership NHS Foundation Trust, Wirral Community NHS Foundation Trust, Liverpool Women's Hospital NHS Foundation Trust, Warrington and Halton NHS Foundation Trust, 5-Boroughs Partnership NHS Foundation Trust, Mid-Cheshire Hospital NHS Foundation Trust, North West Ambulance Trust, Aintree University Hospitals NHS Foundation Trust, Clatterbridge Cancer Centre NHS Foundation Trust, Southport and Ormskirk Hospitals Trust, Liverpool Community Trust

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Foreword

Partners across Cheshire and Merseyside have been working together over the last 4 months to develop further the blueprint we set out in June to accelerate the implementation of the Five Year Forward View (5YFV) for our Communities. We have come together to address head on the challenges we articulated then: that people are living longer, but not always healthier, lives; that care is not always joined up for patients in their local community, especially for the frail elderly and those with complex needs; that there is, as a result, an over-reliance on acute hospital services that often does not provide the best setting for patients; that there is a need to support children, young people and adults more effectively with their mental health challenges. At the same time, there is enormous pressure on health and social care budgets.

We are clear that these issues require us to think much more radically about how best to address the problems we face together, otherwise we will fail to support the needs of our Communities into the future. This document summarises the plans developed to-date to address these challenges across all our different communities in Cheshire and Merseyside and fall into 4 common themes:

- support for people to live better quality lives by actively promoting the things we know have a really positive effect on health and wellbeing;
- working together with partners in local government and the voluntary sector to develop more joined up models of care, outside of traditional acute hospitals, to give people the support they really need in the most appropriate setting;
- designing an acute care system for our communities that meets current modern standards and reduces variation in quality;
- making ourselves more efficient by joining up non front-line functions and using the latest technology to support people in their own homes;

Much of this work is already underway at local level but there is also still much to do. The role of the Sustainability and Transformation Plan (STP) for Cheshire and Merseyside (C&M) is to co-ordinate our efforts, ensuring we promote the best ideas and expertise to provide for the needs of the whole Region in the future.

Executive Summary

Our submission in June identified the key challenges faced by the Cheshire and Merseyside (C&M) STP, including:

- ***high rates of diseases associated with ageing, including dementia and cancers;***
- ***high rates of respiratory disease;***
- ***early years and adult obesity;***
- ***high hospital admissions for alcohol;***
- ***poor mental health and wellbeing; and***
- ***high rates of teenage conceptions.***

Furthermore our analysis confirmed that across the region there are significant service and financial challenges, either at individual organisational level or across whole economies. Health and social care services have grown and developed over time in fragmented, uncoordinated ways that do not meet the changing needs of our Communities. At the same time, there are significant pressures on health and social care budgets. Both these issues mean that we will fail to meet the future needs of our population and provide the standard of care they deserve without a radical change in current delivery. Continuing with current models of care provision will result in a gap in our finances of £908m by 2021 across the Region if we do nothing. This challenge has narrowed from the £999m in our June submission, reflecting the fact that some cost reduction plans are already being delivered in 2016/17, which is year 1 of the 5 year plan, and the remaining gap now reflects the four year period 2017/18 – 2020/21.

We are clear on the ambition we have for the patients, staff and population of the C&M STP

Our core purpose is to create sustainable, quality services for the population of C&M. This is effectively our ambitious blueprint to accelerate the implementation of the Five Year Forward View (5YFV) across C&M.

Sustainable means delivering services within the amount of finance made available to C&M for the provision of health and social care.

Quality means services that are safe, and deliver excellent clinical outcomes and patient experience.

We have devised a portfolio of 20 programmes, each with clear objectives, scope and emerging governance structures – some are further ahead than others in developing their detailed plans.

The LDS programmes are the delivery vehicles that deliver the principles, guidance and clinical models developed across the other programmes. To effectively deliver the strategy it is important that this is well understood to avoid duplication of effort.

This STP provides a platform for the key themes and direction that we are taking in order to deliver our goals. It draws on much of the work that is already underway across the three LDSs, and aims to deliver additional scale economies, learning and collaboration through the focus on a one C&M approach to those activities where additional scale can bring benefits.

Maximising opportunities

If it can be done at STP level we assume that is where the greatest benefit can be achieved – but we are acutely aware that many initiatives require a more local flavour so they will be designed and delivered locally.

All too often really good strategies are developed with clear benefits that aren't ultimately achieved due to poor implementation. The start of successful implementation starts with a clear, detailed plan which is monitored through its various stages.

The key themes we are pursuing

Investment in improving the resilience of services delivered outside of hospital settings (primary care, social care, community care, mental health) is essential for us to transform our system and move towards both lower cost and higher quality care delivery.

By improving the support for self care, better and more proactive care in the community and addressing the wider determinants of health at a CM scale, we can better address peoples need for care and the associated demand on acute services.

There remains a need for C&M to undertake an STP wide review of clinical services, to reduce variation and determine future options for hospital configuration. Through taking a pan-C&M approach we can reduce unwarranted variation and improve quality.

A first step will be to identify how acute care is performing under its current configuration. This will enable effective and well informed decisions to be made and will help to identify areas of focus and opportunity.

Our vision for collaborative productivity is to deliver cost effective, efficient and commercially sustainable Back Office operations.

Delivery happens at LDS level, and in the organisations that make up the LDS so it is important that the LDS's have a clear set of plans to effect implementation of the STP programmes, as well as delivering on their own portfolio of change and transformation.

What stage are we at now?

The Cheshire and Merseyside Sustainability Programme (STP) is still at a developmental stage. We are in the design phase of a programme that will help to create healthier NHS services across Cheshire and Merseyside for future generations.

We know that these changes can't happen overnight and that they shouldn't. Some NHS care models haven't changed much in over fifty years and it is unrealistic to expect them all to be suitable for a growing, aging, online population with changing expectations and needs.

1 - Our starting point

Our previous submission in June demonstrated a sound understanding of our issues, and a clear strategy for going forward

Our submission in June identified the key challenges faced by the Cheshire and Merseyside STP, including:

- *high rates of diseases associated with ageing, including dementia and cancers;*
- *high rates of respiratory disease;*
- *early years and adult obesity;*
- *high hospital admissions for alcohol;*
- *poor mental health and wellbeing; and*
- *high rates of teenage conceptions.*

Furthermore our analysis confirmed that across the region there are significant financial challenges, either at individual organisational level or across whole economies. *The 'do nothing' affordability challenge faced by the Cheshire & Merseyside health economy is forecast to be* ***£908m.*** This challenge has narrowed from the £999m in our June submission, to £908m driven by the gap now reflecting the fact that some cost reduction plans are already being delivered in 2016/17, which is year 1 of the 5 year plan, and the remaining gap now reflects the four year period 2017/18 – 2020/21.

Clearly C&M isn't going to sit back and 'do nothing'. In addition to the work already underway within our three Local Delivery Systems (LDS) we identified the strategic STP priorities that would make our health and care system sustainable in the near medium and long term:

1. **Improve the health of the C&M population** (previously referred to as 'Demand Management' and 'Prevention at Scale') by:
   - *Promoting physical and mental well being*
   - *Improving the provision of physical and mental care in the community (i.e.outside of hospital)*
2. **Improve the quality of care in hospital settings** (previously referred to as 'Reducing variation & improving quality in support of hospital reconfiguration') by:
   - *Reducing the variation of care across C&M;*
   - *Delivering the right level of care in the most appropriate setting*
   - *Enhancing delivery of mental health care*
3. **Optimise direct patient care** (previously referred to as Productive back office and clinical support services collaboration) by
   - *Reducing the cost of administration*
   - *Creating more efficient clinical support services*

After the existing LDS plans were modelled we forecast a surplus of £49m by 2021. However, these plans required further analysis and challenge to convert them from sound ideas into robust plans.

Our work since June has been focussed on the development of these 'sound ideas' into 'robust plans'.

We have created a portfolio structure that brings together twenty distinct, but interrelated programmes of work. Each of these programmes has developed clear objectives, is in the process of agreeing its governance model and are developing their plans for delivery. Each is at a different stage of maturity and this STP submission reflects this.

Our strategic STP programmes aim to provide guidance and clear principles about how we will tackle four key issues across the STP footprint:

1. Improving the health of the C&M population
2. Improving the quality of care in hospital settings
3. Optimise direct patient
   a) Reduced administration costs
   b) Effective clinical support services

These programmes are supported by eight clinical programmes looking to improve the way we deliver:

4. Neuroscience;
5. Cardiovascular disease (CVD)
6. Learning disabilities
7. Urgent Care
8. Cancer
9. Mental Health
10. Women's & Children's
11. GPs and primary care

There are five programmes that support and enable the above programmes:

12. Changing how we work together to deliver this transformation.
13. Finance
14. Workforce
15. Estates and facilities
16. Technology, including Digital
17. Communications and Engagement

Delivery of these programmes is at LDS level, each of which has a programme of work delivering improvements locally:

18. North Mersey
19. The Alliance
20. Cheshire and Wirral

The overarching purpose of these programmes is to deliver on our purpose of creating sustainable, quality services for our population.

2 - Our Cheshire & Merseyside strategy

We are clear on the ambition we have for the patients, staff and population of the C&M STP

Our core purpose is to create **sustainable, quality services for the population of C&M**. This is effectively our ambitious blueprint to accelerate the implementation of the 5YFV across C&M.

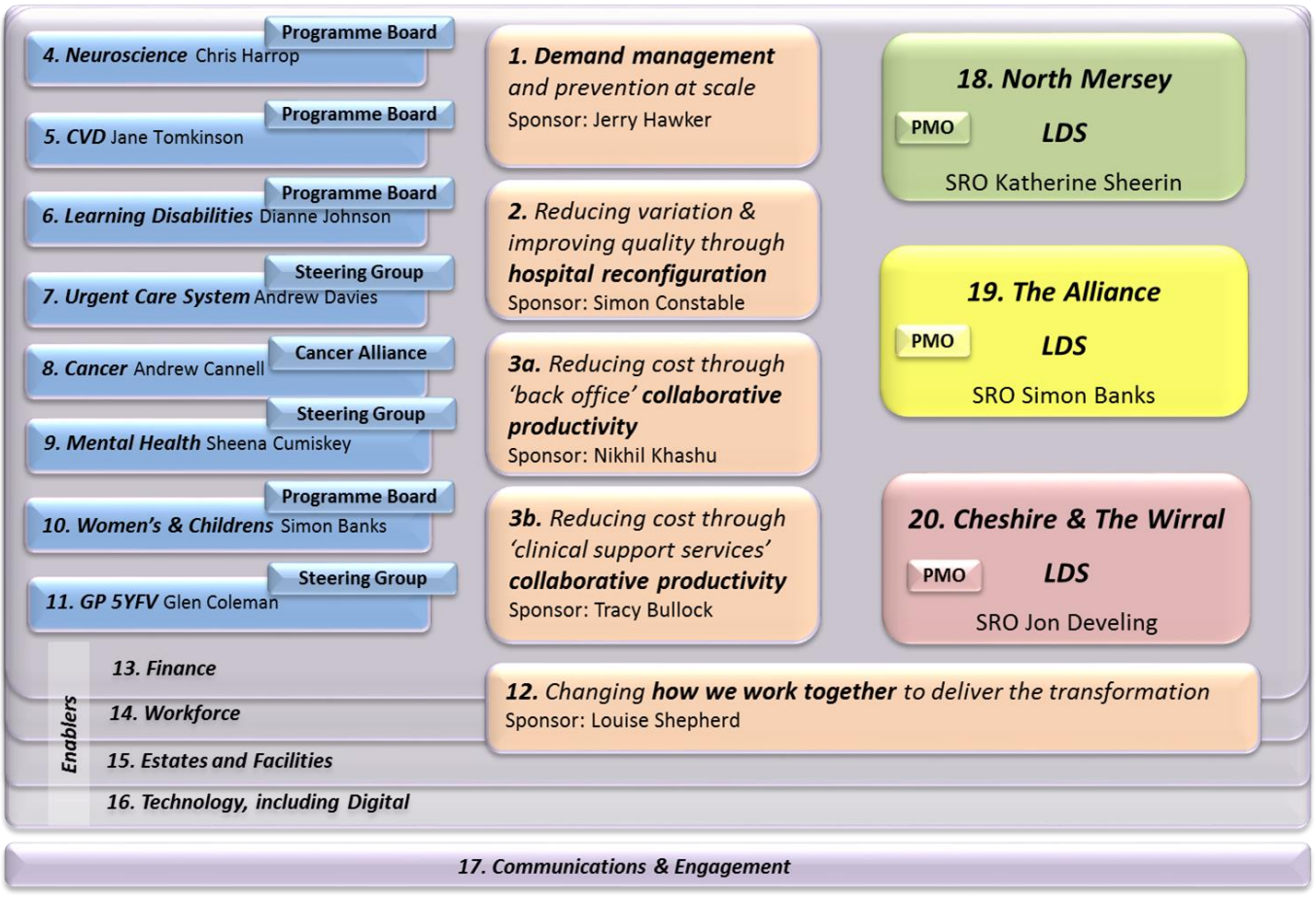
Sustainable means delivering services within the amount of finance made available to C&M for the provision of health and social care.

Quality means services that are safe, and deliver excellent clinical outcomes and patient experience.

Doing the right things

The 20 programmes that form our delivery portfolio have been chosen as a direct consequence of the issues faced by C&M, and with a clear end goal in mind. These were noted in Section 1 and are regularly communicated by way of the graphic below:

Each programme is at a different point of maturity, and this is reflected in the later sections of this plan. As with any portfolio this is not unusual and there is no reason to get them all to the same place. However, there is an overarching process that each programme will go through and that the PMO will use to help assess progress.



2 - Our Cheshire & Merseyside strategy

Clarity on responsibility

The LDS programmes are the delivery vehicles that deliver the principles, guidance and clinical models developed across the other programmes. To effectively deliver the strategy it is important that this is well understood to avoid duplication of effort.

This STP provides a platform for the key themes and direction that we are taking in order to deliver our goals. It draws on much of the work that is already underway across the three LDSs, and aims to deliver additional scale economies, learning and collaboration through the focus on a one C&M approach to those activities where additional scale can bring benefits.

There are no budgets or quality standards held at STP level. Changes will directly impact organisations at level 1, with level 2 LDS plans providing oversight of progress, and, over time, a consolidated view of performance measures.

We have been really clear on the role of people at STP level, ensuring we are not duplicating effort.

Level 1 STP has a focus on:

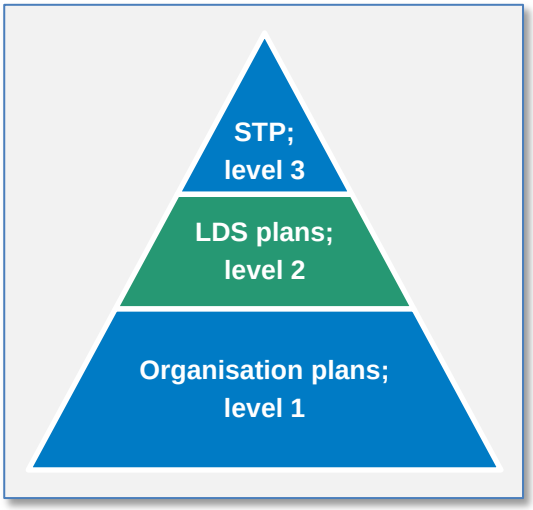
- **Economies of Scale** – what can be done at STP to create additional economies
- **X-LDS learning** – how can each LDS learn from each other
- **National benchmarking** – how is the STP doing compared to national benchmarks
- **STP wide system design** – design once, deliver locally – e.g. ACO/ACS framework
- **Governance** – agreeing and managing an STP wide approach
- **Assurance** – provision of assurance to STP lead, and ultimately NHSE
- **Performance** – responsibility for meeting and reporting against STP wide control totals
- **Communications and engagement** – consistent delivery of overarching key messages

Level 2 LDSs also have a clear role to play:

- **Locality strategy** – how this works in the LDS
- **Detailed delivery plans** - development and delivery of LDS plan
- **Monitor progress** – regular monitoring of plan
- **Reporting to STP** – progress reporting to STP
- **Financial control** – managing impact on finances

across LDS.

At Level 1 the responsibility is well known around meeting financial and quality standards. Currently it is only at Level 1 that a budget can be impacted. Level 1 organisations also have a clear responsibility to manage communications within their organisation and to their Boards/Governors.



Maximising opportunities

Our approach to delivering improvements is that opportunities will be designed and delivered at the highest level of our triangle.

If it can be done at STP level we assume that is where the greatest benefit can be achieved – but we are acutely aware that many initiatives require a more local flavour so they will be designed and delivered locally.

The emergence of an STP plan doesn't reduce the focus on organisational delivery at level 1 or their need for financial balance.

2 - Our Cheshire & Merseyside strategy

All too often really good strategies are developed with clear benefits that aren't ultimately achieved due to poor implementation. The start of successful implementation starts with a clear, detailed plan which is monitored through its various stages.

Managing a portfolio of 20 programmes is a significant undertaking and the dependencies between them need to be effectively managed.

Managing dependencies across the portfolio

With twenty programmes of work there are many interdependencies that need to be carefully managed, such as:

- Effective management of demand on our healthcare system will influence the future configuration of where and how services are delivered;
- Future hospital service configurations will be driven by clear clinical strategies that place patients at the heart of any redesign;
- Very few changes can be made without the implicit inclusion of the Workforce, Estates and IM&T programmes

Section 6 will look in more detail at how the STP will deliver the transformation required.

STP Interventions

This STP does not capture everything that we are doing as a health and care economy. Instead it focuses on the priority areas of focus that we believe will have the greatest impact on health, quality and finance.

Our challenges

Demand for health and care services is increasing	**Cheshire and Merseyside face different challenges as a consequence of its geography and demographics. There is therefore unacceptable variation in the quality of care and outcomes across C&M**	**The C&M system is fragmented resulting in duplication and confusion**	**The cost of delivering health and care services is increasing**

Our priorities and areas of focus

Improve the health of the C&M population,		**Improve the quality of care in hospital settings**		**Optimise direct patient care**	
1a. improving the provision of physical and mental care in the community (i.e.outside of hospital) • Agree framework to deliver via ACOs • Managing demand across boundaries • Joint commissioning and delivery models • Community risk stratification • GP Federations, Primary Care at scale	***1b. Promoting physical and mental well being*** • Addressing primary prevention & the wider determinants of health • Pan C&M Alcohol Strategy • Pan C&M High BP Strategy	***2a. Reducing the variation of care across C&M*** • Common standards, policies and guidelines across organisations at C&M level • Standardised care across pathways	***2b. Delivering the right level of care in the most appropriate setting; and enhancing delivery of mental health care*** • Common standards, policies and guidelines across organisations at C&M level • SOPs and high level service blueprints for specialist services	**3a. *Reducing the cost of administration*** • Optimised workforce, reduced agency usage • Consolidated Procurement functions – an integrated Supply Chain Mgmt. function	**3b. *creating more efficient clinical support services*** • Consolidated clinical support services

The impact of our plans

• Reduction in A&E attends and non-elective admissions • Reduced elective referrals • Reduced emergency bed days, and length of stay • Reduced re-admissions • Early identification and intervention • Delivery of care in alternative settings • Increased use of capitation-based and outcomes-based payments	• Improved clinical outcomes and reduction in variation • Improved performance against clinical indicators	• x-organisation productivity and efficiency savings • Reduced duplication • Reduction in temporary staff dependency

Governance and Leadership - Changing how we work together to deliver the transformation

Programme Delivery Structure

Communications and Engagement

Enablers – IM&T; Estates; Workforce

2.1 - Improve the health of the C&M population

Introduction

We previously referred to this programme as 'Demand Management' and 'Prevention at Scale'.

Investment in improving the resilience of services delivered outside of hospital settings (primary care, social care, community care, mental health) is essential for us to transform our system and move towards both lower cost and higher quality care delivery.

By improving the support for self care, better and more proactive care in the community and addressing the wider determinants of health at a CM scale, we can better address peoples need for care and the associated demand on acute services.

What are the objectives

- To maximise the benefits that C&M can gain from the improvement to its population's health.
- To provide the guidance and principles upon which the work around demand management and prevention will be delivered at LDS level.

Why is this programme important?

The current challenges makes integration and consolidation across organisational boundaries a necessity. The NHS five year strategy sets out the ambition for this and local government leaders are keen to take a leading role in the integration agenda. Leading health economies are moving in this direction and they are delivering real reductions in hospital admissions; better population health through prevention; and 10-20% cost savings.

Integrated care is what service users want to have, what providers want to be able to deliver and what commissioners want to pay for. It allows social and health care to work together in a joined up way that improves the outcomes for individuals and the experience for service users and professionals.

Another important feature of the population health PIDs that have been developed is that as well as supporting the development of benefits over the next 5 years directly (from reduced hospital admissions / attendances etc), they will also play a crucial role in supporting the sustainability of the current STP. For example, by not addressing the real behavioural problems that excessive drinking can run the risk of creating future problems and dilute the positive impact that the current set of interventions are expected to have.

What is the scope of the work

Improving the provision of integrated primary and community, health and social care (i.e. Out of Hospital)

1. A substantial range of schemes & interventions which can be broadly categorised as Prevention, CCG Business efficiencies (QIPP) and new Out of Hospital initiatives.
2. Promoting physical and mental well being to reduce the need for people to access care.
3. Developing an STP wide methodology and structure for tackling unwarranted variation in demand for care services and enabling effective delivery of the first two objectives.

What is the structure of the programme?

1. Three STP prevention schemes will be delivered at LDS Level::
   - Alcohol Harm Reduction
   - High Blood Pressure
   - Antimicrobial resistance
2. Three high impact areas help manage demand, delivered at LDS level:
   - Referral management
   - Medicines management
   - CHC
3. Development of integrated primary and community, health and social care
4. Create a framework for the development and implementation for Accountable Care approaches (name of the chosen vehicle may be different but they are nationally known as ACOs)

The first phase of the programme has focussed on helping each LDS develop their plans and to verify the opportunity. This will now be taken forward at LDS level leaving the work at STP to focus on creating a framework to support development of ACOs and supporting the accelerated implementation (delivery) of high impact demand management initiatives (e.g. Right Care).

How will the change be lead?

Sponsor:	Jerry Hawker
Members:	Eileen O'Meara (CHAMPS WG DPH Lead) Alliance – Leigh Thompson/Colin Scales Cheshire & Wirral – Tracy Parker-Priest North Mersey – Tony Woods Local Gov't – TBD Andrew Davies, Urgent Care CCT

2.1 - Improve the health of the C&M population

Current Position

Management of demand

There is a strong symmetry across all three LDS plans and a further opportunity to share best practice and reduce inter-LDS variation. NHS England's referral management audit (template) suggests significant variation across three of the LDSs with respect to implementation of the eight high impact changes.

The high impact change areas being adopted across the LDSs include:

- Medicines management (**£66.6m**)
- Referral management – implementation of eight demand management high impact changes for elective care (**£61.5m**)
- Implementation of Right Care (**£42.5m**)
- Continuing healthcare (**£16m**)

(indicative values)

These are predominantly flagged as business as usual efficiencies within CCG plans.

Prevention

Three population based prevention projects have been developed to support reductions in Alcohol abuse / harm, blood pressure and antimicrobial resistance (AMR).

The first two have identified benefits including reduced hospital admissions & "whole system impact" where appropriate (e.g. prevention of alcohol related violence). AMR will produce more long term impact.

All are key to the longer term sustainability of the STP i.e. doing nothing runs the risk of increasing our challenge post 2021.

The blood pressure team have identified a number of benefit scenarios associated with the level of increases in diagnosis rates. The table below shows the low end estimated net benefits i.e. based on a 5% increase BP diagnosis being achieved – these could be as high as £9.1m if the higher rates are achieved of 15%.

Delivery plans for these projects are noted overleaf

Prevention	Alcohol	Blood Pressure	Total benefit (2021)
Gross benefit	£13.65m	£9.5m	**£23.15m**
STP investment required	£2.45m	£2.5m	**£4.95m**
Net benefit at LDS level • C&W • Alliance • NM	 £4.7m £3m £3.5m	 £2.8m £2m £2.2m	 **£7.5m** **£5m** **£5.7m**
Total STP net benefit (2021)	**£11.2m**	**£7m**	**£18.2m**

2.1 - Improve the health of the C&M population – alcohol prevention and High Blood Pressure Plans

Alcohol Prevention Project	Milestones
STP demand reduction (alcohol) steering group	• Establish a system wide leadership approach through the establishment of a CM cross-sector working group(s), networks and collaborations • Detailed business case worked up • Develop and continue to risk register • Develop and implement a stakeholder engagement and communications • Establish a data/outcomes working group
Enhanced support for high impact drinkers	• Develop multi-agency approaches to support change resistant drinkers' • Ensure the provision of best practice multidisciplinary alcohol care teams in all acute hospitals • Review pathways and commission outreach teams
Large scale delivery of targeted Brief Advice	• Facilitate local agreements with GPs, pharmacy and midwifery to screen patients with staff offering brief advice and referring to local specialist services as required. • Ensure screening and advice for Making Ever Contact Count includes evidence based alcohol IBA, and brief interventions such as high BP, smoking cessation, diet and physical activity.

Effective population level actions	• Ensure all Emergency Departments across Cheshire and Merseyside collect and share enhanced assault data to the optimum standards.
	• Ensure North West Ambulance Services record call outs related to alcohol and share this data with relevant local partners
	• Ensure local partners collaborate to ensure efficient use of data and considerations of improvements, including:
	  • Targeting interventions to prevent violence and reduce alcohol-related harm
	  • Targeting police enforcement in hotspot areas
	  • Use of intelligence in the license review process and targeting alcohol licencing enforcement

High Blood Pressure Project	Milestones
STP demand reduction (BP) steering group	• Detailed business case write up • Risk register write up • Stakeholder engagement and communication plan developed
System Leadership approach	• System leadership approach is ensured in the delivery of the C&M strategy • Systematic triangulation and review of cross-sector patient safety measures is embedded into strategy dashboard
Population approach to prevention	• Develop healthy local policy
BP awareness raising campaigns	• Link with community pharmacies, community partners and voluntary sector partners and inform patients and communities of key messages
Making Every Contact Count at scale	• Roll out MECC across primary and secondary healthcare settings, community pharmacies and with non-clinical community partners
Blood pressure equipment	• Increase availability of BP machines and Ambulatory Blood Pressure Monitoring to meet local need
Primary care education and training programme	• Develop education and training programme that utilises Sector Led Improvement principles
Medicines Optimisation	• Increase uptake of Medicine Use Reviews and New Medicines Services on antihypertensive medicines

2.1 - Improve the health of the C&M population – antimicrobial resistance

Project	Milestones
Ensure every Trust, Community Trust [including non-medical prescribers] and CCG has an AMR action plan	• Obtain assurances that every trust has an AMR action plan • Obtain assurances that every trust has an Antimicrobial Stewardship Committee

Implement back up prescribing for the treatment of upper respiratory tract infections	• Implement Back Up Prescribing via Practitioner-Centred Approach or Patient-Centred Approach
	• Audit post implementation:
	  • Establish whether implementation in Accident and Emergency Departments, Walk-In Centres, Out Of Hours and with Non-Medical Practitioners is required. Consistency can be achieved by harmonising access to GP records.
	  • Prior to implementation, establish whether Healthwatch should be involved.

Engagement	• Pharmacy:
	  • Ensure consistent messages are given by all prescribers and all pharmacists.
	  • Ensure pharmacies support the AMR strategy as appropriate
	• Care Homes:
	  • Establish whether the Care Home Hygiene Award Scheme needs scaling up

Ensure AMR awareness, stewardship and training is delivered to all prescribers, non-medical prescribers and health care workers	• Target all prescribers (medical, non-medical, pharmacists) and consider including AMR in yearly mandatory training • Ensure that training addresses and meets the PHE Antimicrobial prescribing and stewardship competencies
Support public facing media campaigns to aid and inform about Antimicrobial Resistance	• Local authorities and CCGs engage with any national or international AMR campaigns and plan local activities to promote the initiative
Implementation of AMR and Stewardship education at the primary and secondary level	• Utilise the free ‘e-Bug’ resource produced by PHE in all schools to encourage a generational change in the attitude to the use of antibiotics
Identify a dedicated Community Microbiologist function to support AMR Stewardship	• Ensure protected sessions are available and establish whether these can be enhanced to a more proactive and accessible clinical advisor service for GPs and other antibiotic prescribers in the community
Identify an Antimicrobial Stewardship Lead GP	• Establish how this resource can be identified and secured, assuming that the role doesn’t exist already
Ensure that every secondary care trust is implementing PHE Start Smart – Then Focus toolkit	• Obtain assurances that every trust has implemented the tool kit, including a ward-focused antimicrobial team
Ensure that every GP Practice is implementing TARGET (Treat Antibiotics Responsibly, Guidance, Education, Tools) (best practice recommendations)	• Obtain assurances that every GP Practice has implemented the tool kit
Ensure every Trust and CCG has an Antimicrobial Pharmacist and ensure that they are provided with sufficient protected time to fulfil this role	• Obtain assurances that every trust has a dedicated Antimicrobial Pharmacist
Ascertain assurances that community antimicrobial formularies are confluent with secondary care antimicrobial formularies and obtain assurances that community antimicrobial formularies are used by primary care prescribers	• Primary and secondary care formularies should dovetail • Obtain assurances that Community Antimicrobial Formularies exist and include information regarding Antimicrobial Resistance

2.1 - Improve the health of the C&M population

Development of ACOs

ACO's are one option for supporting the development of a standardised care model for non-acute care across the C&M Footprint that includes Primary, Community, Mental Health & Social Care with a view to driving & managing demand and pursuing population health management. We might want to look at this as a way of enhancing care for medically unwell and frail patients in particular, by integrating organisational arrangements, sharing clinical and financial risk across the system

Ambition - There is significant variation in the progress made on developing ACOs across the STP; most are at an elementary stage. St Helens has made the most progress having commissioned advisors to consider the options for an accountable care management system. Further work is required in most localities to fully define the vision and outcomes.

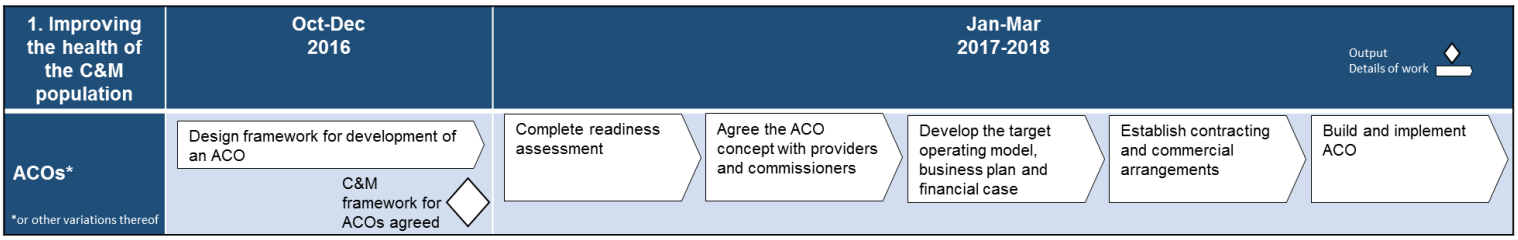
Care Model - Greater focus could be paid on ensuring primary care is at the centre of care models and ACOs are built on GP registered lists. Additionally, processes to engage primary care need to be determined. In parts of the system there is some ambition to build the ACOs around multispecialty community providers. The connection between ACOs and already established/proposed care models in some areas needs to be clearer e.g. the Caring Together programme in Eastern Cheshire.

Delivery Model - There is significant variation in the form of ACOs being proposed and developed across the STP. For instance, in some areas an 'accountable care management system' is being developed whilst in others a 'partnership' is envisioned. In almost all areas there is no defined operating model agreed and no delivery plans in place for implementation.

Capabilities - Learning should be shared as much as possible by those areas who are leading in the development of their ACOs. The process to understand the capabilities required for the successful implementation of an ACO is in place in some areas. Further work is required on the approach to sharing accountability amongst partners include risk and gain sharing.

There needs to be a real focus on the development of an STP wide framework to help design the right ACO model for each locality.

Each locality is at a different state of maturity – the potential plan below is an indicative view of the process and timeline that a more mature locality might aspire to.



Plans

There are a number of next steps to follow on from the work:

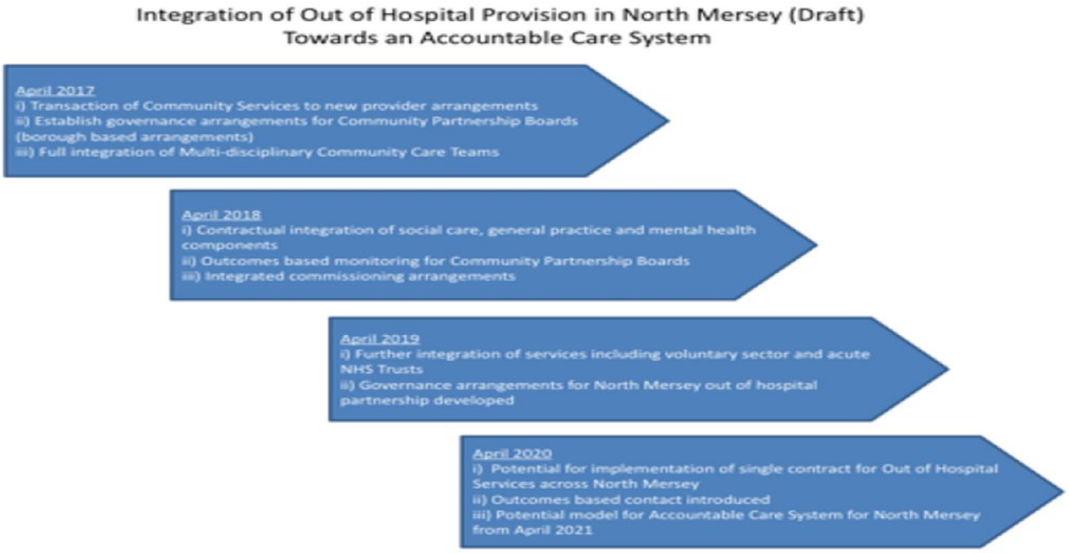
- Need to agree the relevant priorities of the projects and the associated investments.
- There is an immediate need to agree how benchmarking intelligence will be provided and utilised by end November.
- Each LDS should review existing plans against business intelligence to strengthen activity and financial modelling and assure schemes against benchmarked evidence to ensure that plans are targeted appropriately, by end November.
- The STP should identify a way to support each LDSP to stress test its business efficiencies (QIPP) schemes due to the significant financial variation, by end November.
- Develop a framework document to provide structured support to fast track potential exemplar ACOs and provide STP wide guidance and principles.

Much of this is to be delivered as part of the LDS plans, and features in their delivery plans, highlights of which are overleaf.

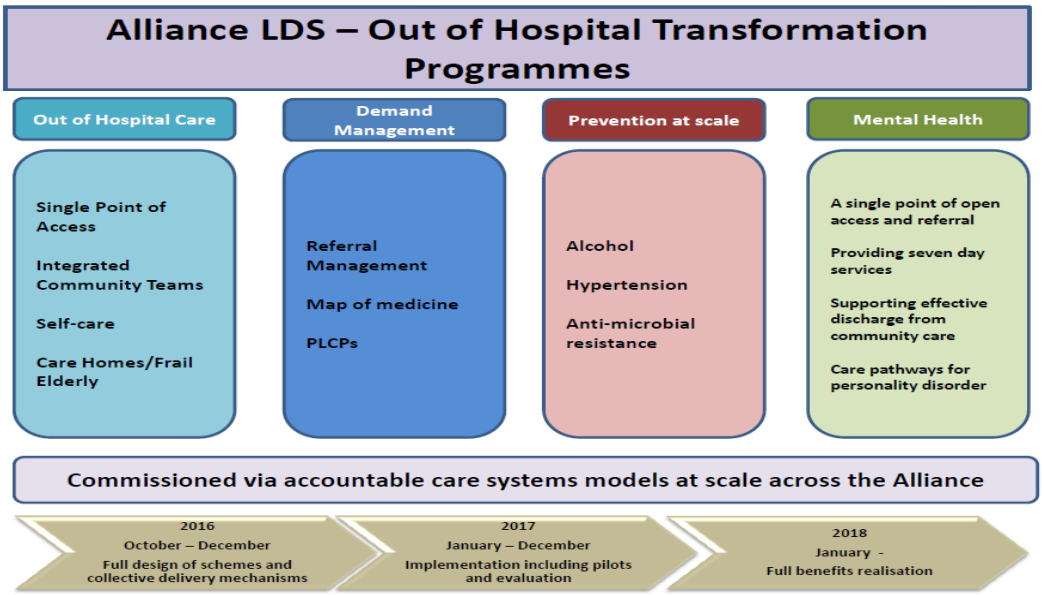
2.1 - Improve the health of the C&M population

Each LDS has plans that will tackle demand, enhance prevention, bring care closer to home and radically improve out of hospital care, the highlights of which are shown below. Full details are in each LDS plan that is within the supporting documents. By providing coordination, guidance, standards and clear principles, LDS's will learn from each other and C&M will achieve greater economies of scale.

North Mersey



The Alliance



Cheshire & Wirral

The core C&W ambitions by 2020/21 are:

- Implement Cheshire and Merseyside Wide Prevention strategies in Hypertension, Alcohol, and AMR.
- Implement Cheshire and Wirral wide prevention strategies for Respiratory conditions and Diabetes.
- Implement Cheshire and Merseyside Wide Neurology, Cancer and Mental Health Programmes.
- Implement a Gain Share agreement with NHSE for specialised commissioning
- Embed integrated community teams by 2017/18 that include General Practice, Social Care and Community Services that will manage demand effectively throughout Cheshire and Wirral.
- Implement high impact demand management initiatives identified by NHSE through our current and ongoing QIPP Programme.
- Implement measures to reduce CHC expenditure by £8m
- Encourage and deliver better management of primary care prescribing (through self-care, over the counter status, repeat prescriptions)
- Continue to implement and optimise the benefit of sharing clinical information through the Cheshire (and Wirral) Care Record.
- Establish an approach to deliver Accountable Care Organisations across Cheshire and Wirral.

2.2 - Improve the quality of care in hospital settings - overview

Introduction

We previously referred to this programme as 'Reducing variation and improving quality to support hospital reconfiguration'.

There remains a need for C&M to undertake an STP wide review of clinical services, to reduce variation and determine future options for hospital configuration. Through taking a pan-C&M approach we can reduce unwarranted variation and improve quality.

A first step will be to identify how acute care is performing under its current configuration. This will enable effective and well informed decisions to be made and will help to identify areas of focus and opportunity. There is a strong need for a service line-by-service line review of the current acute care model, in order to generate the evidence and data required to inform an explicit decision to be taken on the locations of acute provision based through analysis of future patient flows.

What are the objectives

- To maximise the quality of care delivered in hospital settings.
- To provide the guidance and principles upon which work around hospital services will be delivered at LDS level.

Why is this programme important?

There is a wide variation of the quality of care across C&M – this is not acceptable and our population should expect the same quality service and outcomes wherever they live in C&M.
Hospital care is expensive – we should only be treating people in hospital when it is evidenced that their outcomes will be better by treating them there.
Improving care is at the forefront of our STP ambitions, and delivering effective, safe and efficient care in hospital settings is a core principle.

What is the scope of the work

There are two STP Level projects:

1. Technical solutions for the C&M system:
   - Critical decisions developed by specialist and technical expertise which exists already in the clinical networks or Vanguards for new models of care (e.g. Urgent and Emergency Care and Women's and Children's Health)
   - Agree the best clinical models across C&M and their detailed specification, which will include access issues, consideration of co-dependencies and the un-intended consequences. This will be underpinned by the very best evidence base and specialist expertise.
   - Pilot to then be expanded through all the specialities.
2. Reducing variation in outcomes
   - Clinical effectiveness is at the heart of the programme to reduce variation in clinical practice and outcomes across C&M.
   - Existing programmes of work such as Advancing Quality (AQ) and Getting it Right First Time (GIRFT) will be strengthened, standardised and harmonised.
   - Intra-hospital as well as inter-hospital variation will be considered
   - Workforce issues through people as well as processes will be standardised or harmonised at STP level to manage system as well as cultural issues through the assistance of Health Education England, the North West Leadership Academy and the Advancing Quality Alliance (AQuA).
   - An overarching principle will be achieving even modest improvements at scale over the whole C&M and reducing the variation that exists.

How will the change be lead?

Sponsor:	Simon Constable
Members:	Alliance - Ann Marr Cheshire & Wirral - David Allison N Mersey - Steve Warburton/Fiona Lemmens Local Gov't - **TBD** Andrew Davies, Urgent Care CCT Simon Banks, Women & Children's CCT

2.2 - Improve the quality of care in hospital settings – delivery plans

To date, this thinking has largely been driven at the LDS level with little consideration of hospital reconfiguration across the C&M-wide footprint.

However, we believe there is benefit and the financial imperative to undertake this thinking at C&M level to deliver a consistent clinical service across the STP footprint.

We recognise that the current acute configuration within this footprint is unsustainable. This is perhaps most evident in Cheshire. The number of tertiary providers in Merseyside presents an atypical challenge and opportunity as well.

Given the importance and sensitivity of this area, our first task is to instigate a service by service review of the acute care model.

This will be a single programme of work that will run in parallel to the emerging LDS-led reviews and work undertaken by the NW Specialised Commissioning team.

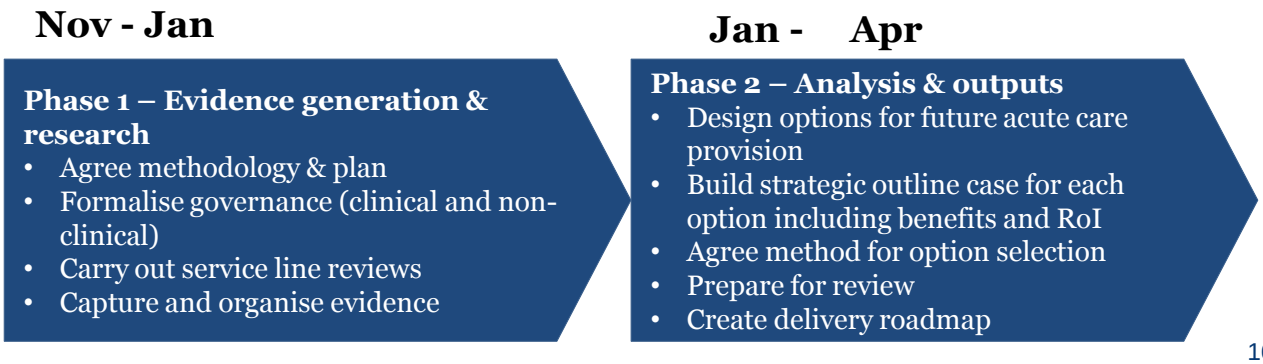
Our view is that the definition and specification of the local District General Hospital will be sustainably supported through a network of specialist provider services, making a virtue of Merseyside's strong cohort of tertiary centres. This big idea is underpinned by health and social care integrated at the core.

The review will be undertaken rapidly with an outcome on the direction of acute provision being available for the next stage of consultation by March 2017 (subject to further discussion and agreement).

Work is underway with AQuA to identify from an international and national evidence base the areas in which reduced variation would give the maximum potential in addressing the quadruple aims of the 5YFV across the whole of C&M. The output of this work is expected in late 2016. In addition one of the early scoping pieces of work across the STP through the local delivery systems is to identify where there are already plans implemented or in train to reduce variation and/or implement hospital reconfiguration, to ensure that outputs and outcomes are known, understood and assessed and adopted at pace and scale utilizing a range of clinical, managerial, patient and other change agents and supporting systems that are already in place.

The engagement strategy for this workstream is critical to its success in delivering against the quadruple aims of the 5YFV. The approach, with the appropriate level of programme management support and resource to oversee the progress of engagement, is to utilize existing networks of clinicians across primary and secondary care, other staff across the health and care system, and patients and carers to create a dialogue in the design of the priority work programmes (utilizing the intelligence identified above as an input) and identify, at a range of levels, change agents who have experience and are motivated to influence at a range of levels. So in addition to the necessary scoping of areas of focus for this workstream both in terms of existing improvement work in the STP area, and national/ international evidence base, we will undertake a piece of scoping around the existing engagement fora in order to enable face to face discussion about areas of focus. We see the STP Clinical Congress as a key engagement mechanism for clinical engagement along with existing networks of clinicians, particularly at and within LDS level. We will also, in conjunction with the STP workstream area around ways of working, explore the possibility of digital collaborative platforms to maximize engagement.

This review will focus on how acute provision will synergistically work within the construct of a demand management system (and potential ACO-driven environment), as well as embracing new technology such as tele-tracking to create individual control centres capable of having visibility across multiple providers who exist in a networked way. The review will consist of 2 phases of work as shown below:



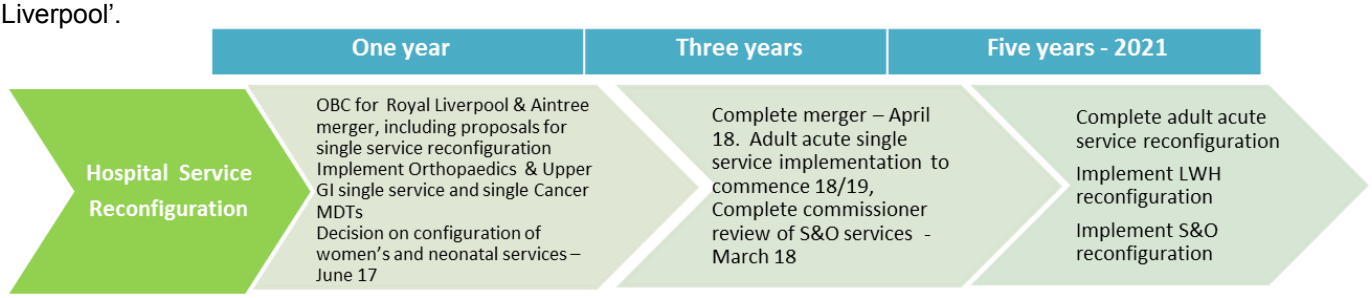
2.2 - Improve the quality of care in hospital settings – LDS plans

Whilst there is clear benefit in developing this thinking at STP level there remains a great deal of similar work across the three LDSs, supported by work in the cross cutting clinical programmes that will also inform potential solutions.

The highlights from the LDS plans shown below are designed to drive out variation, improve standardised levels of care and configure hospital services in a way that best provides efficient quality care.

North Mersey

A more granular plan is included in the NM LDS plan. built from well established plans described in 'Healthy Liverpool'.



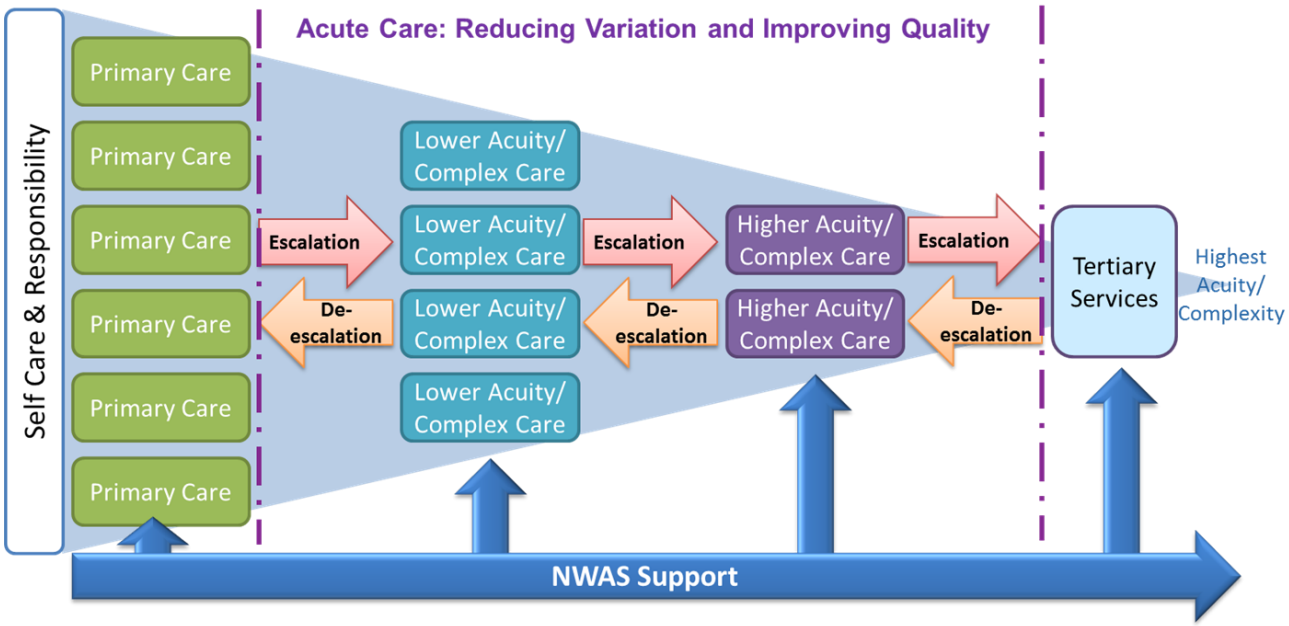
Review of Services at Southport & Ormskirk NHS Trust

NHS Southport & Formby CCG will lead a review of the services provided by Southport and Ormskirk NHS Trust, the outcome of which is to ensure long term clinical and financial sustainability and to meet the particular needs of this population. The review process will be conducted by a multi-stakeholder partnership that will develop a case for change which will inform plans for the future of these services.

- Process, Governance and Stakeholder Mapping (Jan-March 2017)
- Case for Change (April-June 2017)
- Pre-consultation engagement (July-September 2017)

The Alliance

The Alliance has developed a vision for hospital reconfiguration, and started to develop a range of options. A plan for the assessment and design of these services will be completed by December.



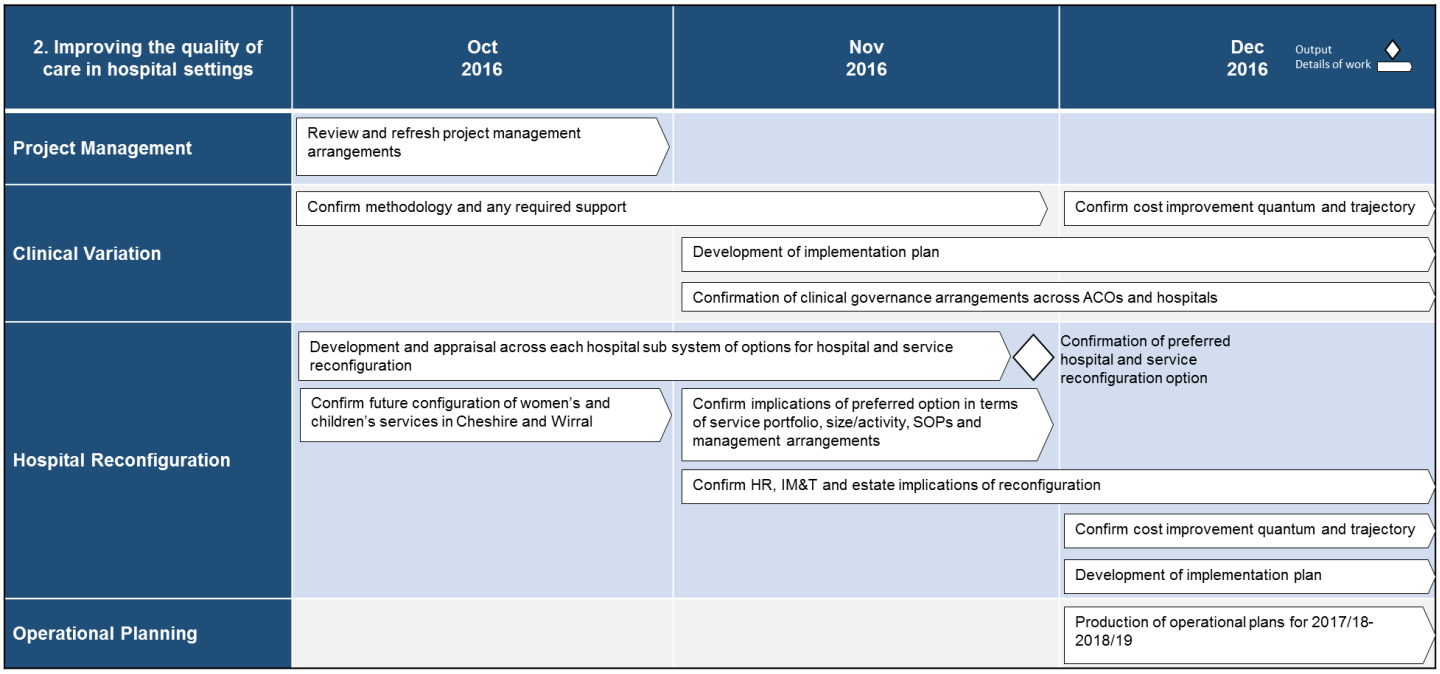
2.2 - Improve the quality of care in hospital settings – LDS plans

Whilst there is clear benefit in developing this thinking at STP level there remains a great deal of similar work across the three LDSs, supported by work in the cross cutting clinical programmes that will also inform potential solutions.

The highlights from the LDS plans shown below are designed to drive out variation, improve standardised levels of care and configure hospital services in a way that best provides efficient quality care.

Cheshire and Wirral

C&W have a short term plan to rapidly address variation and reconfigure hospital services across Cheshire and Wirral



Hospital Services in Eastern Cheshire

The Caring Together programme is a well-established transformation programme within Eastern Cheshire. The programme aims to improve the health and wellbeing of the local people by implementing enhanced integrated community care supported by clinically and financially sustainable hospital services.

Extensive modelling work has been completed and indicates that transforming just one segment or service of the local health and social care economy will not be sufficient to address the challenges the economy is now facing. Instead a system-wide solution is needed. The Caring Together Programme Board met with system regulators (NHS England and NHS Improvement) on 17 October 2016 and agreed to complete financial modelling on two care model options.

The two options are based on clinical and financial sustainability of hospital services at East Cheshire Trust, taking into account clinical dependencies and the impact these options have on the development of enhanced proactive community care for the local population.

Options for the future of high risk general surgery are currently under review and The CCG is working with East Cheshire Trust to assess compliance of the *Healthier Together* standards from April 2017.

The modelling of Options 1 and 2 including capital requirements and potential impacts of tariff plus payments/MFF will be completed by the end of 2016 with the findings being presented to the Caring Together Programme Board and NHSI/NHSE for a final decision in early 2017.

2.3a - Optimise direct patient care – reduce the cost of administration

Introduction

We previously referred to this programme as 'Back Office'.

While performance improvements within organisations remain important, we are making a move to longer term transformation and strategic planning across the health and care economy.

Our vision for collaborative productivity is to deliver cost effective, efficient and commercially sustainable Back Office operations. The ambition is to collaborate at STP level, but to build to this capability in phases, recognising the organisational and operational challenges of working together at scale and across a complex footprint.

What are the objectives

- Reduced spend in the Back Office will enable additional spend and effort to be directed towards front line services.
- Cost reduction in Back Office is a key driver of change, but the programme must also deliver increased customer services and better user experience, reducing the time and effort clinical staff spend interacting with non-patient-facing services.
- Existing good practice in the STP will be shared and form the minimum benchmark for improvement, and national examples of best practice should form the basis of the approach to collaboration where appropriate to the local system.
- Improve links and engagement with stakeholders to ensure that reconfigured services meet both corporate and clinical need.
- Identify the required changes to ways of working and to organisational culture to enable delivery of collaboration.
- Create an engaging and rewarding place to work, operating flexibly across structures and ensuring staff are able to build a broad framework of skills and experience
- Ensure that Back Office operations are sufficiently flexible to meet changing needs of the organisations in the footprint

Why is this programme important?

The Carter Review made clear that we can no longer rely on traditional efficiencies and cost improvement programmes within single organisations.

Instead, we are working more collaboratively to realise the productivity and service improvement opportunities which lie beyond organisational boundaries. This is how real efficiencies are identified and how greater economies of scale can be delivered.

Values - Where appropriate, Back Office services will be maintained within the NHS to provide wider economic benefit to communities in Cheshire & Merseyside region.

What is the scope of the work

For all Back Office services, the ambition is to collaborate at STP level, but to build to this capability in phases, recognising the organisational and operational challenges of working together at scale and across a complex footprint.
The projects that will delivered are to be prioritised on the basis of deliverability, scale of benefit and time to transform.

Projects can be described in two ways:

- Transactional savings leveraging economies of scale and best in class approaches and models across the patch
- Procurement at category level, then built up to a cluster approach at LDS and then STP level

How will the change be lead?

Sponsor:	Nikhil Khashu
Members:	Alliance – Andrea Chadwick, WHH Cheshire & Wirral – Tony Chambers North Mersey – Aidan Kehoe Local Gov't - **TBD**

2.3a - Optimise direct patient care – reduce the cost of administration

Delivery

The 'Plan on a Page below is a summary of the more detailed plans that are included in the Appendices.

There is a clear opportunity to create some early wins in this programme, though there are risks and challenges - he key challenge being the capability and capacity to deliver within the timescales.

The main enablers for the Back Office programme will be:

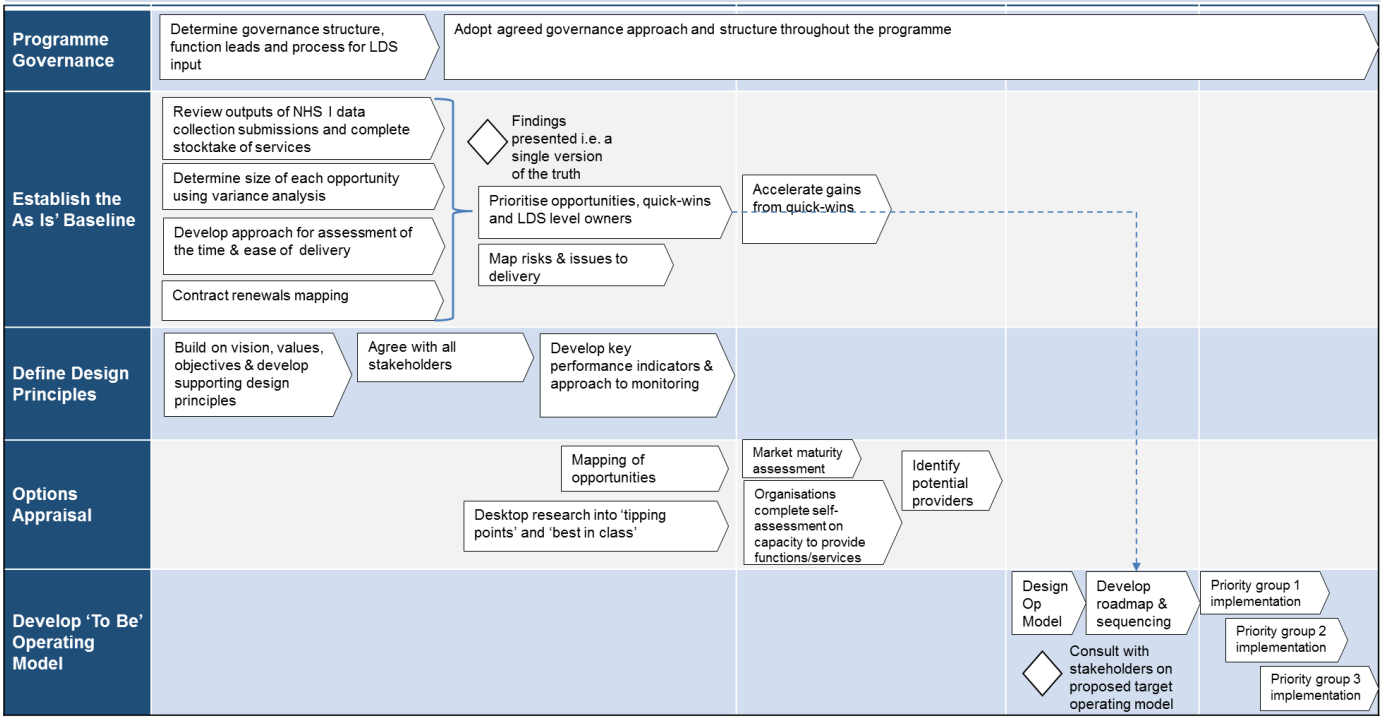
- Breaking down department or Trust silos and ensure open communication and sharing of data.
- Sharing lessons learnt and good practice swiftly and openly
- Investment in required technology and systems.
- Balanced focus across business as usual and future state development – being future focussed according to the needs of our stakeholders.

Proposed Governance Arrangements

- The existing Back Office Steering Group is to become the Back Office Programme Board
- Back Office SRO is a member of the Steering Group representing the 3 LDSs, with a remit to challenge, drive and support the LDSs in the delivery of the programme and where appropriate, escalate issues or opportunities to STP Membership Group for consideration
- LDS Back Office leads / SROs will be part of the Programme Board
- Governance at the level of the LDS leads for the functional areas will be determined as part of the next phase of work.

Immediate next steps

- Determine governance for the Back Office programme considering the structure, leads for identified function areas and process for LDS input
- Collate and analyse the organisation submissions for the NHS Improvement corporate and administrative data collection exercise
- Complete stocktake of services delivered at an organisational level
- Present findings from both of the above and gain agreement from all stakeholders on the current 'as-is' state



2.3b - Optimise direct patient care – efficient clinical support services

Introduction

We previously referred to this programme as 'Middle Office, or Clinical Support Services'.

The vision is to deliver cost effective, efficient and commercially sustainable Clinical Support Services which can be transformed to deliver improved services to front line services across the STP footprint.

What are the objectives

- Reducing variations in practice / services across the STP footprint area and develop a set of standards which every service can comply with irrespective of *how* they are delivered (e.g. either via a "network" arrangement or a single managed service).
- Reduced spend by delivering increased efficiencies generated by Clinical Support Services operating differently across the C&M footprint, enabling additional spend and effort to be directed towards front line services.
- Cost reduction in Clinical Support Service areas is a key driver of change, but the programme must also deliver increased customer services and better user experience, reducing the time and effort clinical staff spend interacting with non-patient-facing services
- Existing good practice in the STP will be shared and form the minimum benchmark for improvement, and national examples of best practice should form the basis of the approach to collaboration where appropriate to the local system
- Reduction of on call rotas through better / increased use of digital enablers

Why is this programme important?

The Carter Review, and indeed Lord Carter's review of pathology services some 15 years ago, demonstrated that there is still a significant potential saving if these services are consolidated on a regional basis.

Therefore, there are a range of future collaborative models which we are considering across the different support services in C&M, ranging from, for instance, setting up a single wholly owned subsidiary organisation for manufacturing and dispensing medicines, to outsourcing dialysis services to a satellite dialysis provider.

What is the scope of the work

- Radiology
- Pharmacy
- Pathology

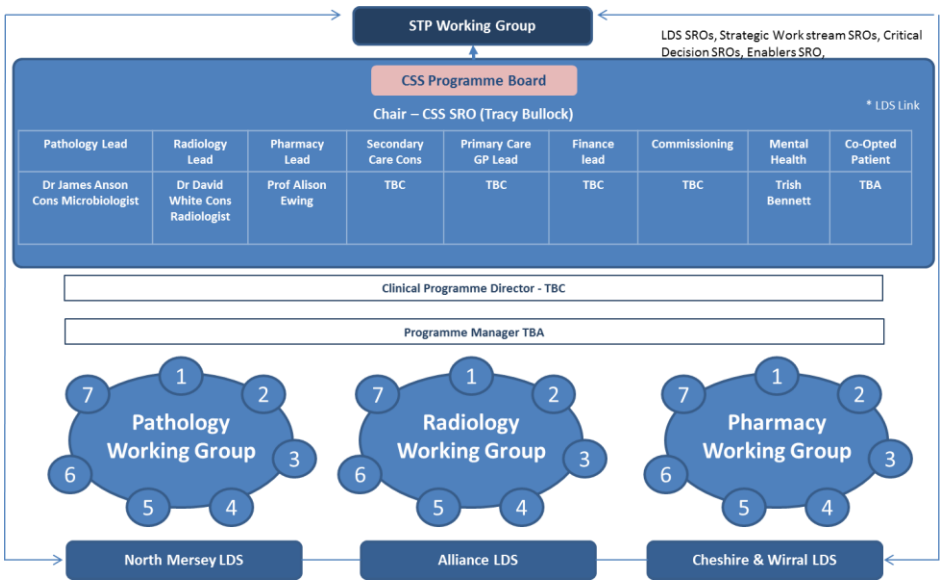
The ambition is to collaborate at STP level wherever possible and to build to this capability in phases, recognising the organisational and operational challenges of working together at scale and across a complex footprint

How will the change be lead?

Sponsor:	Tracey Bullock	
Members:	Pharmacy:	Karen Thomas, Prof. Alison Ewing
	Pathology:	Dr James Anson
	Radiology:	Dr Dave White

2.3b Optimise direct patient care – efficient clinical support services

Proposed Governance Arrangements



Delivery

The principle is collaboration across the entire STP but recognising that this will be a journey starting with programme based collaboration at STP level in the first 18 months of the programme, building to full STP collaboration where appropriate between 18 and 36 months or even longer in some cases.

The 'Plans on a Page, below and overleaf, are summaries of the more detailed plans that are included in the Appendices.

3b. Optimise direct patient care: Clinical support services- Radiology	Phase 1 Oct-Mar 2016-2018	Phase 2 Apr-Sep 2018-2019
Collaborative reporting arrangements	Develop project scope and review 'as is' model Identify how working practices might need to be changed to promote a change in reporting arrangements Agree new design principles Identify and evaluate options for future delivery arrangements Develop new operating model and a business case Determine investment costs required to ensure IT systems are compliant across the footprint	Consult on the proposed business case proposal Examine governance and HR requirements to support proposed new model of care
Flexible reporting arrangements – home reporting	Identify how working practices might need to be changed to promote a change in reporting arrangements Agree new design principles Identify the options for future delivery arrangements Identify any infrastructure/IT costs to support/facilitate home care reporting arrangements Carry out gap analysis of how future reporting arrangements compare to current and identify potential investment costs	Increased use of honorary contracts Examine governance and HR/legal issues in support of changing practices Introduce trials of home reporting arrangements and carry out evaluation of results Expansion of home reporting across the C&M footprint
Flexible reporting arrangements- establishing 'hub and spoke' units	Consideration and development of new operating model including establishment of a central management team charged with managing requests for work/balancing demand with capacity in system Explore flexibility/use of honorary contracts to support flexible working arrangement across Trusts	Examine implications of introducing honorary contracts to allow flexible working arrangement across Trusts Establish central reporting hubs to allow group involvement in speciality reporting Consolidation and expansion of radiographer role extension
Greater collaboration around procurement	Carry out audit of equipment which is regularly purchased by type, manufacturer and value Identify when larger items are due for replacement and synchronise purchasing schedule Standardise range of equipment lines Establish a single managed service via a lead Trust/supplies team to lead the negotiations with potential suppliers about the range of items required and agree potential discounts	Commence the procurement of standard range of interventional radiology equipment Central procurement of contrast media Central procurement of imaging technology

Output Details of work

2.3b Optimise direct patient care – efficient clinical support services

Delivery, cont.

3b. Optimise direct patient care: Clinical support services- Pathology	Phase 1 Oct-Mar 2016-2018	Phase 2 Apr-Sep 2018-2019 Output Details of work
LDS consolidation and partial centralisation (phase 1)	Alliance merger consolidate further with Warrington North Mersey LDS to complete consolidation by merger of Regional Genetic Service into LCL and examine the potential merger/centralisation of Alder Hey pathology service into LCL Cheshire and Wirral- to review collaborative models feasible between the current collaboration and CoCH & Wirral. Identify options for further consolidation/centralisation of services Identify current unsustainable services and opportunities across C&W/C&M for short term sustainability Identify IT and support system investments required vs financial/sustainability benefits Develop business cases	Develop Project Implementation Boards to implement agreed business cases
STP wide/C&M single managed service	Commence scoping of potential future strategic direction of services including development of baseline position (costs, staffing, service and performance issues) Look at demand and capacity and site options to accommodate any further centralisation options Undertake workshops and engagement sessions with key stakeholders to define a well understood and agreed set of design principles that could govern future change with specific focus on the use of increased collaborative working arrangements. Define which processes are suitable for delivery through a more consolidated function versus those that should be retained within local hospitals / LDS level	Review potential governance models that could best support an STP single managed service Review governance arrangements that could support the operation of the above solution and clarify performance of services required Review and discuss potential vision and models with stakeholders to seek buy-in and support Consider how this supports the acute service reconfiguration model which evolves from the STP work Undertake an options appraisal of the best solution and identify the relevant costs and benefits associated with this for the C&M footprint area Examine the potential for novation of contracts over time

3b. Optimise direct patient care: Clinical support services- Pharmacy	Phase 1 Oct-Mar 2016-2018	Phase 2 Apr-Sep 2018-2019 Output Details of work
Medicines information	Develop project scope Identify and evaluate options CEO/STP sign off	Implement new operating model and establish and transfer services
Aseptic service	Develop project scope and clarify investment/support costs Establish 'as is' position- audit what is currently provided at each site and identify those areas that could be centralised and what would need to remain under local direction Agree vision ('to be' operating model) and establish design principles	Establish a communication plan Evaluate estate's capacity/capability to meet potential transfer of services Develop business case to support service proposal Develop stakeholder engagement plan and engage key stakeholders Finalise options Develop implementation plan Commence roll out of proposed service moves
Clinical Pharmacy Templates	Develop project scope and clarify investment/support costs Establish 'as is' position- Assess what is currently done and how pharmacists/technicians currently spend their time delivering these functions Identify what a good pharmacy service looks like Establish patient:pharmacist contact criteria eg when a patient would see a pharmacist, how long consultation should take (average) Establish criteria which would support a medicines review for a technician	Design templates for pharmacists and technicians and agree new standards of working Undertake a gap analysis- compare proposed solution with the 'as is' situation and develop a case for change Develop a shared medicines management training programme via e-learning package Staff side engagement and consultation Establish potential opportunity for improvement across the STP footprint from moving to the new operating model Set KPIs to inform performance management and to adhere to standards
Forging links with the community Pharmacy	Develop project scope and clarify investment/support costs Establish vision of the proposed future state Undertake assessment of current pharmacy dispensing arrangements across every Trust in the C&M footprint and how they are funded Explore legal implications of the proposed operating model Evaluate potential options/commercial vehicles to support the proposed venture/operating model	Develop service specification and obtain professional advice Develop tender arrangements to secure preferred partner Develop appropriate legal documentation to support the proposed commercial partnership arrangement Determine new governance arrangements Set up new commercial vehicle(s) with proposed community pharmacy partner
Formulary management and application	Review current plans/proposals being developed in C&W in short term for proposals to cover the five existing Trusts in the area Undertake assessment of staffing costs Agree, if applicable, a wider vision and target operating model prior to regional centres being established Consider proposed governance arrangements to support proposed model	Consult with stakeholders on proposed single sit solution and how this will work Implement single formulary arrangement with the advent of the Regional Medicine Optimisation Committee coming on line for the North West area

2.4 - Mental Health

Introduction

Mental disorder is responsible for the largest proportion of the disease burden in the UK (22.8%), which is larger than cardiovascular disease (16.2%) or cancer (15.9%). One in four adults experience at least one diagnosable mental health problem in any given year. *Mental health problems represent the largest single cost of disability in the UK. The cost to the economy is estimated at £105 billion a year – roughly the cost of the entire NHS.* In England, if you have a serious mental illness, you are twice as likely to die before the age of 75 years. On average, you will die 15-20 years earlier than other people.

People with long term illnesses suffer more complications when they also develop mental health problems, increasing the cost of care by an average of 45%. For example, £1.8billion additional costs in diabetes care are attributed to poor mental health.

Two thirds of people with mental health needs are seen in primary care. Local GP registers indicate that 9 out of the 12 CCGs in Cheshire and Merseyside have a higher number of adults with depression than the England average. The number of people on Cheshire and Merseyside GP registers with severe mental illness is also higher than the England average and over 50% of Cheshire and Merseyside CCGs have been flagged for having a high prevalence rate of dementia.

Additional funding to support the transformation of mental health services will include centrally-held transformation funding and allocations via CCGs. It is assumed that an appropriate share of national monies will be made available and that this investment will rise to at least £57.9m in Cheshire and Merseyside by 2020/21. Evidence provided within the Centre for Mental Health Economic Report indicates that significant savings across the health and care system will outweigh the investment needed to deliver services.

What are the objectives

- Additional psychological therapies so that at least 19% of people with anxiety and depression access treatment, with the majority of the increase from the baseline of 15% to be integrated with primary care;
- More high-quality mental health services for children and young people, so that at least 32% of children with a diagnosable condition are able to access evidence-based services by April 2019, including all areas being part of CYP IAPT by 2018;
- Expand capacity so that more than 53% of people experiencing a first episode of psychosis begin treatment with a NICE-recommended package of care within two weeks of referral.
- Increase access to individual placement support for people with severe mental illness in secondary care services by 25% by April 2019 against 2017/18 baseline;
- Commission community eating disorder teams so that 95% of children and young people receive treatment within four weeks of referral for routine case; and one week for urgent cases;
- Reduce suicide rates by 10% against the 2016/17 baseline.
- Ensure delivery of the mental health access and quality standards including 24/7 access to community crisis resolution teams and home treatment teams and mental health liaison services in acute hospitals.
- Increase baseline spend on mental health to deliver the Mental Health Investment Standard.
- Maintain a dementia diagnosis rate of at least two thirds of estimated local prevalence, and have due regard to the forthcoming NHS implementation guidance on dementia focusing on post-diagnostic care and support.
- Eliminate out of area placements for non-specialist acute care by 2020/21.

A C&M Mental Health Programme Board will be established to oversee nine workstreams to facilitate delivery of these key objectives. The Board will identify workstream owners and confirm timescales for delivery of all workstreams.

How will the change be lead

Sponsor:	Sheena Cumiskey
Members:	Alliance – Simon Barber C&W – Sheena Cumiskey North Mersey – Neil Smith / Joe Rafferty

2.4 - Mental Health

Delivery

Three priorities have been identified for early implementation:

- Eliminate out-of area-placements
- Develop integrated clinical pathways for those with a personality disorder
- Enhance Psychiatric Liaison provision across the footprint and establish Medically Unexplained Symptoms (MUS) service

The nine projects below have been developed to deliver the objectives. Detailed plans for each workstream are currently being prepared.

A Mental Health plan on a page is included overleaf to provide the headline phases of work.

Project	Impact	'Workstream'
Children & Young People's (CYP) MH	Increased number of CYP receiving community treatment; reduced use of inpatient beds; improved outcomes for children with conduct disorder leading to savings in the public sector, mainly the NHS, education & criminal justice	• Community access • 24/7 crisis & liaison • School age screening & education
Perinatal MH (PMH)	Improved identification of perinatal depression & anxiety; improved health outcomes; reduction in adverse impact on the child (which account for >70% of total long-term costs to society);	• Build PMH capacity & capability • Improve screening programmes & access to psychological therapy
Adult MH: Common MH Problems	Relieve pressure on General Practice , reduce A&E attends & short stay admissions. Target most costly 5% of patients with medically unexplained symptoms (MUS)	• Increase access to psychological therapies • Develop Medically Unexplained Symptoms Service
Adult MH: Community, Acute & Crisis Care	Reduced bed days, lower rates of relapse, reduced admissions and lengths of stay Reduced use of MH services and improved outcomes	• Early Intervention in Psychosis • 24/7 Crisis Resolution & HTT • All-age MH Liaison in acute • Increase GP screening & access • Scale up IPS employment services • Improve psychological therapies
Secure Care Pathway	Prevent avoidable admissions & support 'step-down' and ongoing recovery	• Improve pathways in & out of secure care
Health & Justice	Fewer GP consultations, hospital admissions & inpatient MH treatment	• Expand access to liaison & diversion services
Suicide Prevention	Main benefits relate to non-public sector costs relating to the individual and the family	• Suicide Prevention
Sustaining Transformation	Prevent avoidable admissions, reduce length of stay, improve community access and eliminate out-of-area placements	• Care pathways • Workforce MH
Dementia Care	Increase dementia diagnosis rates & create dementia-friendly health & care settings	• Implement commitments from PM's Challenge on Dementia 2020

2.4 - Mental Health – plan on a page

9. Mental Health		2016-2017	2017-2018	2018-2019	2019-2020	2020-2021
Enablers	Output / Details of work	Establish Transformation Board				
		Identify BI capacity & capability to complete baseline assessments & provide ongoing support / delivery of schemes				
		Confirmation of funding as per 5 YFV for MH				
Children & Young People's (CYP) Mental Health	Community access	Design	Implementation	Post-implementation phase. PDSA		
	24/7 crisis & liaison	Baseline assessment & design	Implementation	Post-implementation phase. PDSA		
	Screening of school children & provision of parenting programmes	TBC				
	Develop school based mental health curriculum (social & emotional learning)	TBC				
Perinatal Mental Health	Build PMH capacity & capability and improve screening programmes & access to psychological therapy	Recruitment	Full implementation	Post-implementation phase. PDSA		
Adult Mental Health: Common MH problems	Increase access to psychological therapies	Baseline assessment & design	Implementation	Post-implementation phase. PDSA		
	Develop a specialist Medically Unexplained Symptoms (MUS) service	Baseline assessment & design	Implementation	Post-implementation phase. PDSA		
	Provide collaborative care for long-term conditions & co-morbid MH		Baseline assessment & design	Implementation	Post-implementation phase. PDSA	
	Early Intervention in Psychosis	Implementation	Post-implementation phase. PDSA			
	24/7 Crisis Resolution & HTT	Baseline assessment & design	Implementation	Post-implementation phase. PDSA		
	Deliver all-age mental health liaison teams in acute hospitals	Baseline assessment & design	Implementation	Post-implementation phase. PDSA		
	Armed forces community MH		Baseline assessment, design & implementation	Post-implementation phase. PDSA		
	Increase GP screening & access		TBC			
	Scale up IPS employment services		TBC			
	Improve access to psychological therapies	Baseline assessment & design	Implementation	Post-implementation phase. PDSA		
	Supported housing step-down facility		TBC			
	Improve pathways in & out of secure care		TBC			
	Expand access to liaison and diversion services		TBC			
	Suicide Prevention	Design	Implementation	Post-implementation phase. PDSA		
	Care pathways (multi-phased)	Baseline assessment & design	Implementation	Post-implementation phase. PDSA		
			Baseline assessment & design	Implementation	Post-implementation phase. PDSA	
	Workforce MH		TBC			
	Implement the 18 commitments outlined in the Prime Ministers Challenge on Dementia 2020	Baseline assessment & design	Implementation	Post-implementation phase. PDSA		

3 - Embedding the change locally

Please see separately attached LDS plans in full

LDS Plans

The previous section has described the programmes of work at the STP level, together with the LDS's contribution to them. Delivery happens at LDS level, and in the organisations that make up the LDS so it is important that the LDS's have a clear set of plans to effect implementation of the STP programmes, as well as delivering on their own portfolio of change and transformation.

The strategic programmes that will drive transformation across C&M are not new or particular to C&M. They are issues that health economies have tackled over many years but so often failed to deliver on.

However, there is now an compelling need to deliver on these ideas that have been developing. This is reflected in the plans of the three LDSs. All three have already put in place programmes to help improve out of hospital care, to reduce the demand on our acute hospitals and to persuade people that they need to take responsibility for their own health.

Acute hospitals in each LDS have started work on aligning and sharing services, including clinical service lines, and in North Mersey, merger discussions are at an advanced stage. There is also a, mixed, history of back office collaboration and working together on city and county wide issues.

Over the following pages we have summarised the key programmes being developed in each LDS, together with their delivery plans.

The graphics below illustrate the overall alignment of LDS plans with the STP's strategic programmes:

1. Demand Management,
2. Variation and Hospital Reconfiguration,
3. a) Back Office, b) Clinical Support Services, and
4. Mental Health

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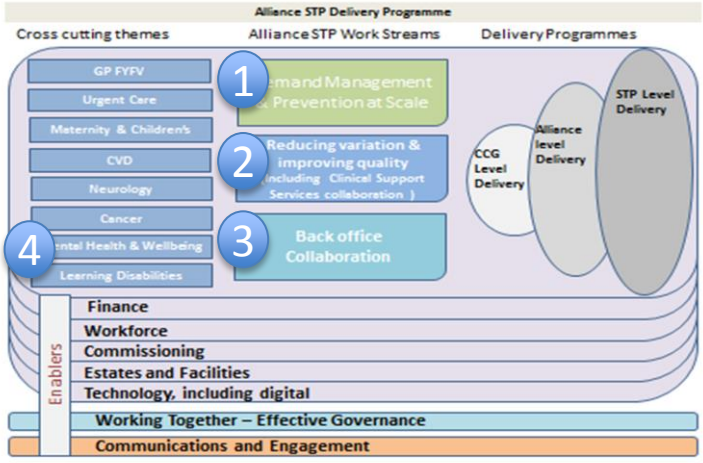
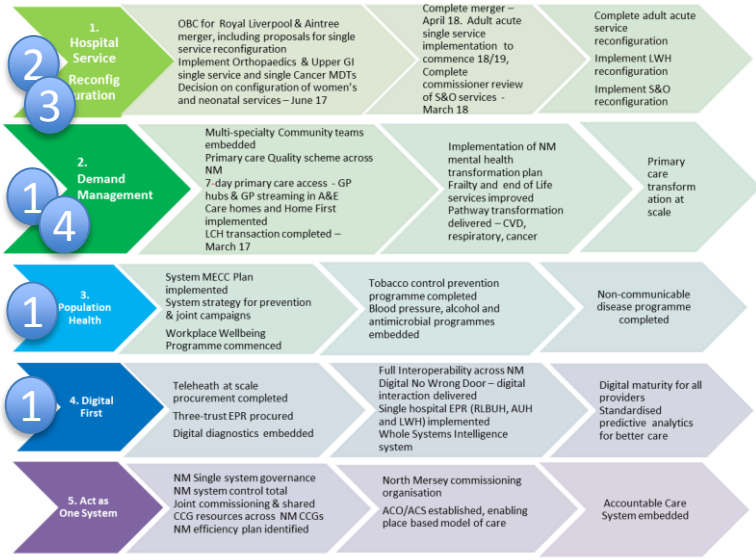
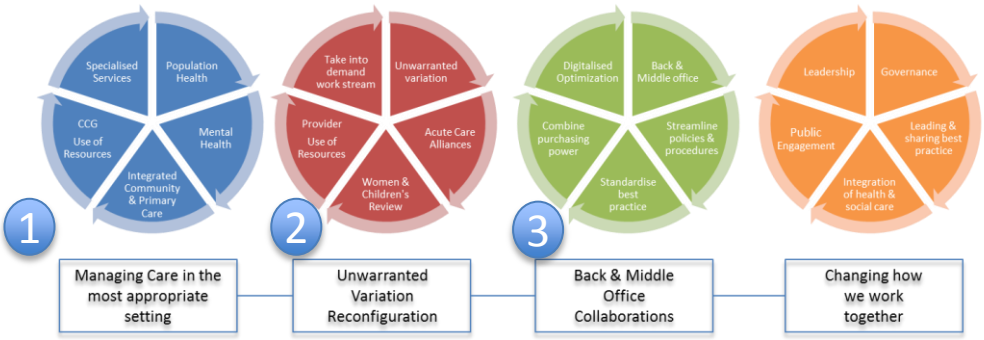






3.1 - Alliance approach and plans

The Alliance LDS has aligned its transformational work streams and delivery structure to mirror that of the C&M STP to ensure that delivery will be at the most appropriate level – organisational, LDS level or STP footprint.

Since the June submission the Alliance has gained a greater understanding of the potential service models that will transform services and achieve long term financial sustainability.

This plan represents options and models of transformation for the local health system that have been developed by the member organisations and are still subject to wider engagement and where necessary formal consultation with stakeholders.

Alliance LDS – Transformation Plan on a page

Transformation Programmes	Schemes (subject to consultation)	Benefits	Net Saving	Year (full benefits delivered)
Prevention at Scale	Alcohol Blood Pressure AMR	Improved population health Less MRSA	£3.5m	2019/20
Out of Hospital Care /Demand Management (Inc. Mental Health)	• Referral Management • Single Point of Access • Integrated Community Teams (Virtual Ward, Intermediate Care, Discharge to Assess, Rapid Assessment) • Self-care – Tele-health, Telemedicine, Meds Management • Care Homes/Frail Elderly • Mental Health	Contain predicted growth in; • A&E Attendances • NEL Admissions • OP Appointments • Elective & Day case procedures	£52.5m	2018/19
Acute Care - Reducing Variation and Improving Quality (Inc. Clinical Support Services & Estates)	Single Acute Service Models • Urgent Care • Elective Care • Maternity and Children's Clinical Support Service Collaboration • Pathology • Radiology • Pharmacy Estates	• Improved outcomes • Reduced LoS • Reduced premium/agency costs • Improved efficiency (Carter metrics) • Achieve access targets	£30.1m	2020/21
Back office Collaboration	Payroll Transactional HR Procurement Financial services	• Reduce overhead costs • Reduce variation and duplication	£15.5m	2020/21

The Alliance is still developing its programme of work and the detailed plans that explain how delivery will be effected.

In addition to the core programmes shown above the Alliance is working closely with the Clinical programmes and have clear objectives with regard Urgent Care, Women's and Children's, Elective Care and Clinical Support Services

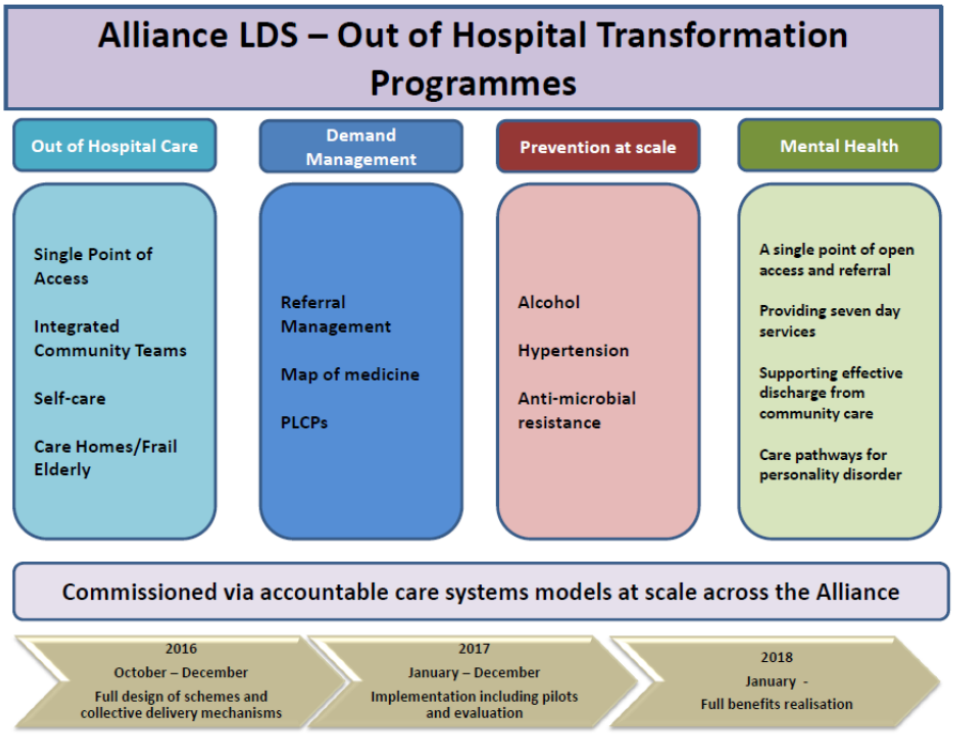
Over the page are the models and frameworks they have developed for developing improved out of hospital care and also improving the quality of acute care.

3.1 - Alliance approach and plans

Improve the health of the C&M population by:

- *Promoting physical and mental well being*
- *Improving the provision of physical and mental care in the community (i.e.outside of hospital)*

Out of hospital care is a key component of the future vision for services across the Alliance. The individual CCGs have already started to develop plans and the challenge now is for the commissioners to come together and work collaboratively to scale up the ambition and impact of these plans to impact on the overall sustainability of the LDS. This is a complex programme of work that has 4 core elements as shown below:

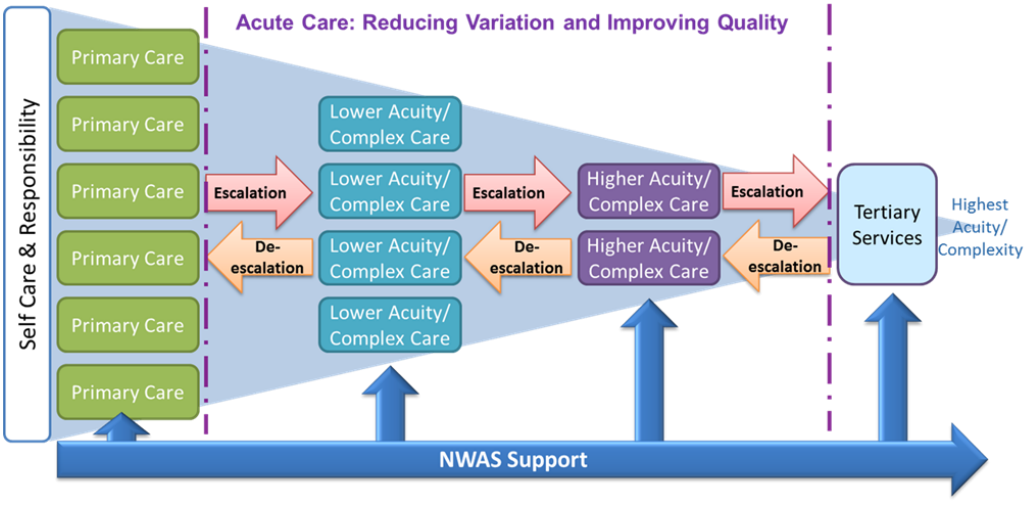


Improve the quality of care in hospital settings by:

- *Reducing the variation of care across C&M;*
- *Delivering the right level of care in the most appropriate setting*
- *Enhancing delivery of mental health care*

The Acute Providers will work together to develop a new model of working, including:

- More streaming of patients depending on their acuity and complexity
- The highest acuity care can be delivered on fewer sites with the appropriate facilities
- Site specialisation to suit that patient cohort with the appropriate resources and facilities
- NWAS streaming patients to the site/service appropriate to their need



3.1 - The Alliance plans - Demand management

Projects	Change Delivered	Outcomes
Quality Referral Management	Single quality referral management system across the Alliance LDS managing demand using Map of Medicine and generic pathways agreed between the acute hospital sites. Utilisation of Map of Medicine and greater scrutiny of PLCP.	Impacts Acute Outpatient Activity and Acute Elective and Day Cases Activity For Acute Outpatient: 20% activity reduction (equiv. 150,000), and £22.5m gross saving in FY202/21 For Acute Elective and Day cases: 4% activity reduction (equiv. 7,000) and £7m gross saving in FY2020/21 1-2 year timeframe for benefits delivery
Single point of access	Single clinical governance regime and infrastructure which enables access to the appropriate level of support in a variety of settings for patients and professionals in instances of unscheduled care	Impacts Acute Elective and Day Cases Activity and Acute Non Elective Activity For Acute Elective and Day Cases: 5% activity reduction (equiv. 5,000), and £5m gross saving in FY202/21 For Non Elective: 6% activity reduction (equiv. 5,000) and £7.5m gross saving in FY2020/21 2-3 year timeframe for benefits delivery
Integrated community management teams (virtual ward)	Integrated services involving social care which not only involves the work of professional teams but also integrated information systems and the sharing of patient and client information; this also supports discharge by linking into SPA - including domiciliary care and care homes.	Impacts Acute A&E Activity and Acute Non Elective Activity For Acute A&E: 4% activity reduction (equiv. 15,000), £1.8m gross saving in FY2020/21 For Acute Non Elective: 5% activity reduction (equiv. 5,000), £7.5m gross saving in FY2020/21 2-3 year timeframe for benefits delivery
Medicines Management Optimisation	Reduction in primary care medicines management spend	£4m gross saving in FY2020/21 0-1 year timeframe for benefits delivery
Telehealth and telecare	Identifying individuals to support better self care to provide them with IT equipment in their own home to monitor their conditions to reduce emergency admissions	For Acute A&E: 4% activity reduction (equiv. 15,000) and £1.8m gross saving in FY2020/21 2-3 year timeframe for benefits delivery
Rapid response/ rapid assessment	Rapid response and assessment team respond quickly to urgent requests at home, with one of the boroughs employing a community geriatrician	Acute A&E Activity: 3% activity reduction (equiv. 10,000) with £1.2m gross saving in FY2020/21 1-2 year timeframe for benefits delivery
Prevention	STP-wide strategy to reduce the prevalence of alcohol-related conditions or episodes and impact on primary and acute	

3.1 - The Alliance plans - Variation and hospital reconfiguration (1/3)

Projects	Change Delivered	Outcomes
Urgent Care System **Model of Care 1**	S&O will consider the potential options for new models of A&E delivery – subject to further engagement 3 Trusts will have a Type I - 24hr A&E, but through shared rotas and federation of staff premium payments would be reduced. Modelling of staffing rotas and new working patterns/processes will improve productivity	Reductions in the consultant on call cover and presence Reduction in the use of locums /agency. Productivity improved through the use of best practice Alignment with commissioner interventions
Urgent Care System **Model of Care 2**	S&O will consider the potential options for new models of A&E delivery – subject to further engagement 3 Trusts will have a 24hr A&E High acuity patients will be transferred to the Emergency centre (for example: stroke, heart attack, compound fracture, burns, emergency dialysis, some trauma, GI Bleeds) By federating staff and remodelling of staffing rotas and new working patterns/ processes will improve productivity and reduce premium payments Alignment with commissioner demand management interventions	Accelerated flow through departments to achieve more optimal performance Reduction in the use of staff premium payments. Consultant presence and cover will reduce on call payment Activity transfer of patient numbers per year (one site) More effective use of bed capacity Redistribution of elective activity to other centres (To Be Determined)
Urgent Care System **Model of Care 3**	S&O will consider the potential options for new models of A&E delivery – subject to further engagement 1 Trust will have a Type I - 24hr A&E, 2 trusts will re-profile opening hours with activity flowing to other 24/7 centres Alignment with commissioner demand management interventions	Reductions in the consultant cover from 3 to 2 on call covering 3 sites. Reduction in the use of locums /agency staff. Activity transfer of 8,700-20,000 patients per year (one site) Increase in bed capacity of 80-150 beds required/freed up. Redistribution of elective activity to other centres To Be Determined
Stroke Services	The Acute vision is for Whiston to be the Hyper Acute provider for the LDS support by a 1 in 8 rota. Single point of contact and standardise referral process All ESD teams to have equal access to discharge plans for proactive discharge planning Single CCG lead for ESD and Community for cross organisational services Development of Unified ESD and Community teams.	Single provider for Hyper Acute, networked support across acute units and community teams Consistent approach across the Alliance Patients repatriated to local centre A reduction in premium payments

3.1 - The Alliance plans - Variation and hospital reconfiguration (2/3)

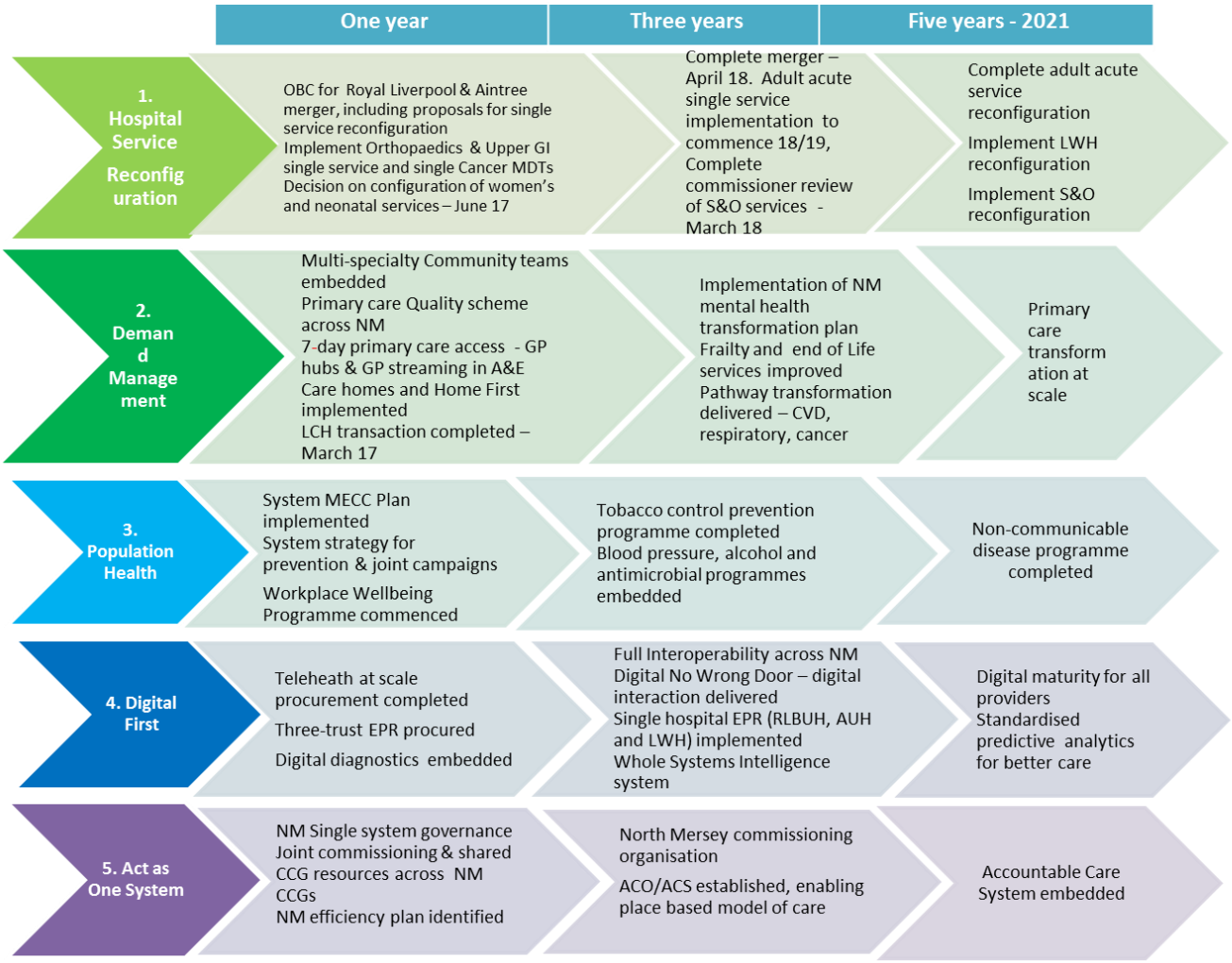
Projects	Change Delivered	Outcomes
Paediatric Services Review	Alignment with Vanguard Proposals for a 'Single Service' Move from 3x level 2 units to: 2x high acuity units & 1 lower acuity unit or 1x high acuity units & 2 lower acuity unit or Higher and Lower levels of Acuity **Acute Inpatient Unit – 24hrs** Paediatric A&E 24hrs GP hotline Outpatients Rapid access clinics HDU Inpatient unit Neonates: Level 1/2 Community home nursing sup. Day case surgeries Anaesthetic cover **Short Stay Unit – 12hrs** Paediatric A&E GP hotline Outpatients Rapid access clinics Neonates : level 1/2 Community home nursing sup. Day case surgeries APNPs Safe transfer to AIU	**High Quality** Resources, facilities and the care delivered in each site is tailored to the patient cohort treated ALL hospitals will be required to attain Quality and Safety standards. **Safe** Specialist consultant resources will be concentrated on the highest acuity patients Evidence shows that the more times a surgeon performs a procedure, the better the outcome. Focusing the delivery of highly specialist care in fewer locations means that our professionals will gain the volume and breadth of experience to deliver excellent quality care **Accessible** Better access to Primary care will alleviate pressure on services. Streaming the highest acuity cases to a Red Hospital means a Green hospital can deal efficiently with lower acuity demand Staffing levels will be standardised and ALL hospitals will be required to attain standards. This means quality care will be delivered in ALL our hospitals **Sustainable** This model proposed is a more effective use of existing resources
Maternity Services Review	Alignment with Vanguard Proposals for a single service	
Elective Services Review & Productivity Review	Improvement in Length of stay benchmarked against Better Care Better Value Ward reductions / closures based on reductions in Delayed Transfer of Care Premium pay reductions resulting from the application of standardised care pathways Benchmark against upper quartile and within the Alliance to move to the most productive amongst peers and best in class Exploration of a Factory Model for simple high volume procedures such as: • Orthopaedics • Ophthalmology • Plastics These could be scheduled for day case and short stay <72hrs procedures at Treatment Centres Alignment with commissioner demand management interventions	Better Care Better Value Reduction in Delayed Transfers Of Care Reductions in Premium Payments Reduction in bed days Reduced number of delayed transfers of care Reduction in costs Alignment with commissioner demand management interventions Reduction in variation of care and outcome Higher productivity levels Improved utilisation of theatres Lower length of stay

3.1 - The Alliance plans - Variation and hospital reconfiguration (3/3)

Projects	Change Delivered	Outcomes
Sub-scale Services Review	Federate services to make them more clinically sustainable and reduce the premium payments , see above Urology; Dermatology, Rheumatology; Diabetology, Orthodontics; Respiratory Medicine; Acute Medicine, Geriatric Medicine	Clinically Sustainable Services Reduction in on-call rotas Reduction in premium payments amounts to around £4.7m Alignment with commissioner demand management interventions
Pathology	Moving from a Bi-partite arrangement between STHK and S&O to a tri-partite arrangement to include WHH	Lower unit costs Reduced investment required Increased productivity Consolidation of staffing levels 4% reduction in costs year on year
Pharmacy	Opportunity to outsource/ create a JV for outpatient dispensary Alignment with STP Review, sub regional solution likely	VAT advantages 4% reduction in costs year on year
Radiology	Alignment with STP Review, sub regional solution likely	4% reduction in costs year on year

3.2 - North Mersey approach and plans

The North Mersey plan builds upon and joins-up established transformation programmes; including *Shaping Sefton* and *Healthy Liverpool,* which was established in 2013 in response to the city's Mayoral Health Commission. The commission's ten recommendations recognised that such was the extent of poor health outcomes, and the relentless pressures on resources, that only a whole-system approach to the transformation of health and care would succeed. The commission's insight and mandate to the local NHS and partners to deliver change has given the North Mersey delivery system a three year head start in identifying and now delivering the whole system transformation plans that are set out in the Cheshire and Merseyside STP. It is represented by this 'Plan on a Page':



Each of the programmes above has a delivery plan that clearly lays out the projects that are being mobilised, the expected outputs and outcomes and forecast benefits.

Overleaf are North Mersey's plans for each of these programmes

3.2 - North Mersey plans for hospital reconfiguration

Programmes	Projects	Outputs	Start Date	End date
Single service system-wide delivery for adult acute services **Plan** SOC completed OBC commenced Project plan in development	Reconfiguration of 35 adult acute services across RLBUH, AUH and LHCH, to establish single service, system-wide services. Detailed service reconfiguration plan to be set out in an Outline Business Case, currently in development	• Single service pathways across all adult acute services • Single clinical workforce for adult acute services across 3 trusts • Site rationalisation across 4 to 5 hospital sites in the city	April 2016	March 2021
Merger of the Royal Liverpool, Aintree and Liverpool Women's Hospitals **Plan** As above	Establish a single organisation from 3 NM trusts - RLUH, AUH and LWH Milestones: • Strategic Options Case – approved by boards, June 16 • Outline Business Case – to be completed June 2017 • Joint HLP and trust PMO to be established, Nov 16 Full Business Case and approval by regulators and mobilisation for a new trust by 1st April 2018	• Single trust to deliver the majority of adult acute service sin the city from April 2018	April 2016	March 2018
Reconfiguration of women's and neonatal services **Plan** Project plan completed and delivery on track (see below)	Women's and Neonatal Review. The objective is to achieve clinical and financial sustainability through a reconfiguration of the services provided by Liverpool Women's FT NHS Trust. Milestones: •Pre-consultation engagement – completed Aug 16 •PCBC – Oct 16 – completed •Assurance process – Sept – Nov 16 • Public consultation Jan17 •Decision May/June17	• Reconfiguration of services which address the clinical and financial challenges of delivering these services, as set out in the Review Case for Change • Improved access to essential co-dependent acute services, for example blood transfusion services, associated surgical expertise, diagnostics , interventional radiology etc • Increased scope for involvement in and patient benefits from research and innovation • Reduced transfers of care • Protecting the future delivery of specialist services within the city	Jan 2016	Decision: May 17
Neuro Network Vanguard **Plan** Programme plan	The programme objective is for a clinically and cost effective comprehensive whole system neuroscience service. People with neuro or spinal problems will receive the appropriate clinically effective care to assured standards, wherever they live, via local access points, and have an efficient and person centred experience.	• Integrated, high quality neuro, rehabilitation and pain pathways across Cheshire & Merseyside, delivered via a hub and spoke model of care • More care delivered in community settings	2016/17	2020/21
Southport & Ormskirk NHS Trust **Review of Services**	The objective is to achieve clinical and financial sustainability facilitated by a review of the services provided by Southport and Ormskirk NHS Trust. Milestones: Establish formal commissioner led major service review in a multi-stakeholder partnership. • Process, Governance and Stakeholder Mapping (Jan-March 2017) • Case for Change (April-June 2017) • Pre-consultation engagement (July-September 2017) Further milestones will follow in accordance with NHSE published "Planning, assuring and delivering service change for patients"	• Expansion of current integrated care organisation strategy. Emphasis on partnership, standardised pathways and self care in the community and primary care setting. • Reconfiguration of services which address the clinical and financial challenges, as determined by the Reviews "Case for Change" • Implementation of specialist commissioned strategy for the North West Regional Spinal Injuries Centre	January 2017	July 2018

3.2 - North Mersey plans for demand management – community 1/2

Programmes	Projects	Outputs	Start Date	End date
Integrated Multi-disciplinary Community Teams	Delivering proactive care through multidisciplinary teams operating on neighbourhood footprints of 30-50k. MDT to include general practice, community nursing, mental health, social care and a range of relevant care professionals relevant to an individuals' care.	• Reconfigured integrated multi-disciplinary teams operating on smaller neighbourhood units of 30-50k • Shared records platform • Single multi-agency assessment process (GATE Framework) • Single point of access	2015	March 2018
Primary Care Transformation	Transformation of primary care aligned to the GP Forward View and forming an essential component of the Community Model of Care Consideration of the Liverpool GP Specification across NM	• Increased integration of services across primary care • Improved workforce capacity and skill mix • Improved optimization of prescribing solutions • Standardised approach across the NM footprint	June 2016	March 2019
Primary Care Demand Management in Acute	1. Addressing activity at the front door of NM AEDs through the provision of GP streaming 2. Developing capacity and utilization of primary care through the creation of primary care hubs in the community for routine and urgent care 7 days a week	• Increased capacity to provide same day access to routine and urgent primary care 7 days per week • Urgent delivered closer to home • Increased integration of the urgent care system	Jun 2016	TBC
Effective Discharge Plan Borough specific plans in operation.	Implementation of whole system approach to support effective discharge for patients into community/home care. Focus on discharge to assess to deliver required assessments and reablement services in the patient's home (or community facility).	• Agreed pathways across whole system for discharge to home/community • Consistent protocols across the NM system • Clear system of escalation • Increase in levels of domiciliary care provision • Integration of health and social care resources • Single assessment process	Oct 2016	Mar 18
Organisational Transition **Decision October 2016 (New provider in place by April 2017)**	Transition of community services to new provider arrangements, delivering a new specification aligned to the NM community model.	• Enabler to embed the new model of care for out of hospital services • Financial sustainability	Jan 2015	Apr 17
Mental Health Plan Implement pan NM approach to Mental Health. Plan to be developed.	North Mersey Mental Health Health Transformation Board has been established. • Agreement of approach to implement new model for mental health care including: • Integration with physical health services • Implementation of new national standards/requirements Merseycare delivery of 5 year financial plan	• Integration of mental health into community model of care • Financial efficiencies	July 2016	Mar 2021
Enhanced Care Home Model **Plan** Elements in operation within South Sefton. Implementation within Liverpool from November 16.	Delivering proactive care through multi-disciplinary teams to provide regular MDT reviews in older peoples care homes. Introduction of telehealth with 24/7 access to a clinical telehealth hub	**Outputs** • Introduction of telehealth into care homes • Increase in the uptake of telehealth and telecare • MDT approach introduced • Increase in the numbers of people with a Comprehensive Geriatric Assessment	Nov 2016	Mar 2018

3.2 - North Mersey plans for demand management – community 2/2

Programmes	Projects	Outputs	Start Date	End date
Cardiology **Plan** North Mersey delivery plans in place and on-track	Whole system approach to delivering a single service delivery for cardiology services aimed at improving value from cardiology spend and improving outcomes. Six workstream areas: • Chest Pain • Cardiac Rehab • Breathlessness • Heart Rhythm • Healthy Imaging • Prevention	• Reduction in Consultant to Consultant referrals • Reduction in Outpatient appointments • Reduction in duplicate diagnostics • Reduction in inter-hospital transfers • Strengthening business continuity to support 7 day working	Oct 2015	Mar 2018
Respiratory **Plan** Plan in place but to be reviewed in line with wider North Mersey delivery arrangements	Development of a new model of integrated respiratory care with city wide delivery	• Single service pathways across all adult respiratory services. • Single clinical workforce for all adult respiratory services across the City	Jan 2016	Mar 2018
Children	Redesign of children's service infrastructure across multiple partners and sectors with a focus on integrated, community based services; primary care / general practice, community services, social care, CAMHS, education and voluntary sector. At the core is a proactive approach to health, wellbeing and care delivery, focused on children and families, utilising the Levels of Need and the Early Help tools. Prime focus on prevention and early identification of need via universal services.	• There is a clear set of objectives for this programme and a clinical blueprint is being developed to underpin the integration of teams & services.	Oct 2016	TBC
Telehealth and Assistive Technologies **Plan** Delivery plan to be reviewed in line with revised North Mersey delivery arrangements. Currently in procurement to deliver scale requirements.	• Significant scale up of the telehealth programme across North Mersey • Telehealth procurement route and specification complete; new contract enabling scale up to be implemented in December 2016 to March 2017. • Clinical technology hub embedded in community service, with amended specification.	• Full telehealth monitoring for patients with COPD, Diabetes or Heart Failure with a risk of admission above 25% and also pass the clinical suitability gateway. • Provision of 'light touch' and self care telehealth systems and apps for patients below 25% risk and for a wider range of diseases. • North Mersey wide clinical engagement and referral routes established to take advantage of economy of scale.	Apr 2016	Mar 2019

3.2 - North Mersey plans for demand management – population health

Initiatives	Projects	Benefits	Start Date	End Date
Non-communicable disease prevention strategy for North Mersey	health policy initiatives that make the healthy option the default social option.	Outcomes • Improved health outcomes • Reduced emergency admissions • Improved quality of life • Reduced years of life lost	Jan 2017	March 2021
Making Every Contact Count (MECC)	NM MECC Plan to be developed – Dec 16 Phased implementation plan across all providers	Outcomes • Improved health outcomes • Reduced emergency admissions • Improved quality of life • Reduced years of life lost	Sept 16	March 17
Tobacco control	Prevention programmes for young people Smokefree areas Reduce outlets selling tobacco and licencing Implementing PH guidance 48 on Smoking: acute, maternity and mental health services	Outputs • Stop smoking pathway adopted across all disciplines, which includes electronic referral to the stop smoking services • Number of staff trained • 100% of patients with recorded smoking status & given brief advice • 50% of smokers electronically referred to community stop smoking service & 50% achieve a 4-week quit Outcomes • % reduction in smoking-related hospital admissions • Improved health outcomes • Reduction in smoking prevalence	Apr 17 Apr 17 Oct 17	Ongoing Mar 18 Sept 18
Workplace Wellbeing Programme	Develop programme, charter and accreditation framework Roll out across NHS and care system first Extend to NM workplaces	Outputs Numbers of accreditations and reaccreditations achieved Evidence within 6 months of accreditation through audit of hospitals as health promoting environments e.g. • Increase in physical activity programmes at work • Increase in vending machines using healthy foods and drinks • Longer term measures - 6 months/1 year • Reduction from an agreed baseline - sickness absence, staff turnover Outcomes • Improved health outcomes • Reduced hospital admissions	Dec 16	March 18

3.2 - North Mersey plans – digital roadmap

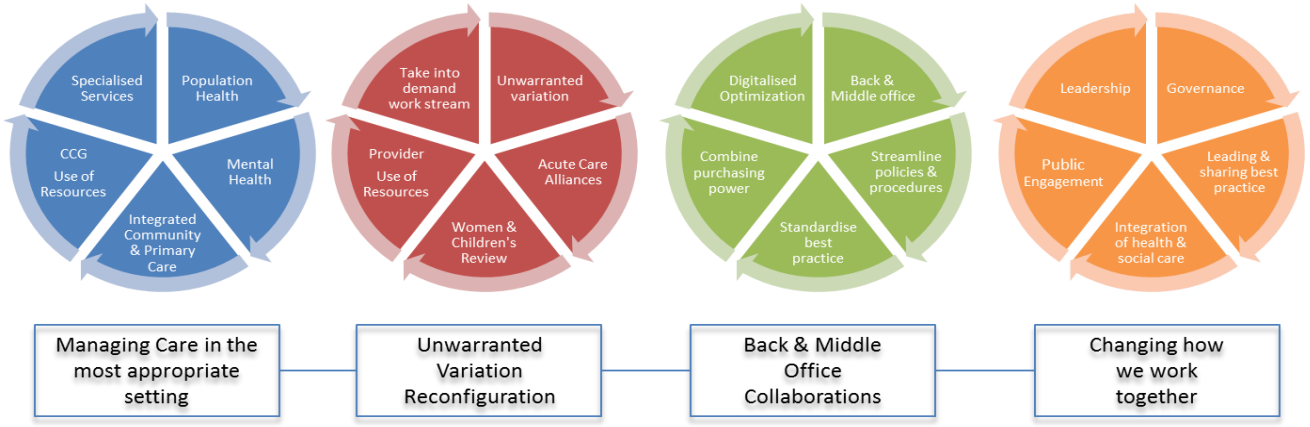
Programmes	Projects	Benefits	Start Date	End Date
Digitally Empowered People **Digital No Wrong Door & Assistive Technology** **Plan** Digital no Wrong Door plan in development Telehealth scale up in procurement phase	**Digital No Wrong Door** • Digital No Wrong Door; enabling people to interact digitally and online with the health and care system, as well as supporting population health Programmes	**Digital No Wrong Door** Outputs • A single source and platform to access information, advice and services • Online consultations with care providers and online appointments. • Use their choice of device and app to manage their care • Patients to be enabled to use assistive technology to manage their care and interact with professionals, and to access information about their own health and conditions to support them to self care. • Establish a workforce that is digitally skilled with the appropriate technology and culture to enable effective working through technology.	16/17	18/19
	Assistive Technology • Establish a range of assistive technologies that can be deployed across North Mersey in primary care, community and acute settings. This work supplements the demand management plans for deployment at scale. • Support integration and interoperability with clinical systems for improved intelligence, referral mechanisms (to increase scale and sustainability) and clinical decision making.	**Assistive Technology** Outputs • Increase in available technology • Wider range of conditions supported by assistive tech • Interoperability with clinical systems Outcomes • Further reduced emergency admissions • Improved patient experience • Improved health outcomes • Improved access to digital services	16/17	18/19
Connected Health and Social Care Economy **Plan** Plans fro all lines developed sharing agreements in place EPR procurement for 3 trusts in progress	To ensure that information is available to the right people, in the right place, at the right time Delivery of Information Sharing Framework • Digital maturity transformation of all H&S Care providers • Interoperability Programme –joining up key systems to deliver information sharing framework • Single Adult Acute Hospital EPR (3 trusts) • Maximisation of technology in Community Care Teams • Consolidated Infrastructure; enabling work across sites and better patient access **Delivered through implementation of the Merseyside Digital Roadmap**	Outputs • Every health and social care practitioner will directly access the information they need, in near real time, wherever it is held, digitally on a 24x7 basis. • Consolidated and rationalised Electronic Patient Record systems moving to a common system for out of hospital care and a common system in our hospitals with interoperability between the two. • Duplication and paper processes will be removed. • Standardised, structured, digital clinical records across all providers in the pathways of care. • No patient will need to 'repeat' their story. • All health and social care professionals record clinical information in a consistent way, digitally, at the point of care, by 2018/19. • All clinical correspondence between professionals caring for patients is sent digitally and integrated into core clinical systems by 2017/18. • Community care teams can integrate for person-centred care with technology that "just works", by 2017/18. • Individuals interact with their care services digitally should they choose to by 2018/19. • All clinicians can order diagnostic tests electronically and view share diagnostics results around a patient by 2016/17. • Single Service Teams have a single EPR to operate as a team by 2018/19.	15/16	18/19

3.2 - North Mersey plans – act as one

Programmes	Projects	Outputs	Start Date	End Date
Single-System Governance	Establish North Mersey system governance for strategic oversight, delivery of the LDS Plan and input into STP delivery. Healthy Liverpool Leadership Group to extend to NM. Financial Governance; establish governance framework for single-system accountability for managing financial risks and benefits, to achieve NM control totals and financial balance by 2021.	• Robust, embedded governance model to enable whole-system accountability and decision-making • Financial risk sharing to achieve system control total	July 16	Oct16
Commissioning Arrangements	Objective: to establish the optimum commissioning arrangements to deliver NM LDS Plan: • Establish joint commissioning programmes, with clear lead roles and resourcing across NM CCGs, Local Authorities and NHS England • New organisational arrangements for NM commissioning; reflecting Devolution and ACS plans.	• Integrated commissioning model across health and social care for North Mersey system • Single commissioner in organisational form • Place-based strategic commissioning plan for North Mersey to enable transformation	July 16	March 18
BAU Efficiency Programme - Organisational	Develop a detailed NM plan for Level 1 BAU efficiencies for: • Royal Liverpool • Aintree • Liverpool Women's • Alder Hey • Walton Centre • Liverpool Heart & Chest • Clatterbridge Cancer Centre • Merseycare • Liverpool Community Health • Liverpool CCG • South Sefton CCG • Southport & Formby CCG	• Organisational BAU efficiency plans for every NM provider • Merger of three adult acute trusts with associated efficiencies	July 16	March 2021
Collaborative Efficiency Programme – North Mersey	• Develop North Mersey plan for back office, clinical support and non-viable services • Implementation of plan – prioritised & phased	• North Mersey plan aligned for collaborative efficiencies, aligned and part of wider C&M STP plan	July 16	18/19
Accountable Care System	Explore options for the development of an Accountable Care System to support the radical step change required to manage demand and improve health outcomes. <u>North Mersey System Control Total</u> The North Mersey Leadership Group has agreed to explore the submission of an expression of interest for a North Mersey system control total, which would be submitted to NHSE by 31.10.2016 in line with the opportunity set out in the NHS Planning Guidance.	• Establish an accountable care system/organisation with the right geography and scope, providing optimal model for improved outcomes and sustainability. • Whole pathways of care managed across provider and commissioner boundaries • Establish a sustainable financial model for shared benefit and risk	Oct 16	Marc19

3.3 - Cheshire and Wirral approach

We have identified four priorities to make our health and care system sustainable in the near, medium and long-term. To transform our services, we need to reduce demand, reduce unwarranted variation and reduce cost. To comprehensibly address these we must priorities the areas that we will have the greatest impact to our system. Based on our knowledge of our local challenges, and as a result of engagement across the system, we have identified the following four priorities:



Demand Management

1. Prevention £14m
2. Integrated Out of Hospital £37.9m
3. QIPP/BAU £26m
4. Accountable Care £3m
5. Specialised Services £30m

Total £110.9m

Variation / Reconfiguration

1. Unwarranted Variation and Standardisation £24m
2. NHS Provider Collaboration £8m
3. Women & Children's £2m
4. Accountable Care £3m
5. Model Hospital/BAU £107

Total £144m

Back & Middle Office

1. Back & Middle Office £3.75m
2. Streamlining £1.4m
3. Best Practice £1.2m
4. Combined P`Power £22.5m
5. Digitalisation £1 m

Total £28.8m

Ways of Working

1. Outcomes Commissioning £1m
2. Patient based need £1m
3. Systems Leadership £1m
4. Collaborative working £2m
5. Learning partnership £1m

Total £6m

The following pages provide further detail of the projects and outputs these programmes will drive. We still have a lot to do in respect of determining:

1. Capability & capacity at STP and Local Delivery System level (LDSP)
2. Full development of schemes and business cases including quality and impact assessments.
3. True impact of each of the programmes on each other. (Critical interdependencies /impact and activity assumptions – STP and LDSP).
4. Robust governance driven bottom up that Governing Bodies and respective Boards and Local Authorities recognise and be part of (including local leadership groups)
5. Capital requirements need to be refined and better linked to benefits realisation.
6. Subject to the outcome of stages 1-5 above any material service changes would follow an appropriate consultation processes.

3.3 - Cheshire & Wirral plans for demand management 1/3

Projects	Change Delivered	Outcomes/Benefits
Alcohol Strategy (NHS, Local Authorities. Police, Community and Voluntary sector)	System wide interventions to reduce alcohol related harm: • Social Marketing Campaigns. • Schemes to restrict high strength alcohol sale. • Cumulative impact policies (reduced opening hours) • Children and Young persons interventions to reduce alcohol use. • GP Screening and life course setting approach. • 7 day alcohol care team within acute hospitals. • Alcohol assertive outreach teams.	• Per 100 alcohol dependent people on treatment planned reduction of 18 AE visits, 22 hospital admissions saving approximately £60k. • Cost benefit ratio £1-£200 per £1 spent • Assertive outreach services expected to return £1.86 per £1 invested. • Net benefit by 2021 estimated at £4.76m. • A reduction in adverse child events.
Hypertension (High Blood Pressure)	Implementation of the Pan Cheshire Hypertension Strategy: • A model of care that focuses on empowering patients and communities, enhancing the role of community pharmacies in detecting and managing high BP, and high quality BP management in primary care. (including reducing variation in care)	• For Cheshire and Wirral up to 300 heart attacks and strokes could be prevented per year through optimising blood pressure treatment alone. • If all GP practices performed as well as the 75th best percentile for managing known BP patients, over 5 years could prevent 183 strokes, 118 heart attacks, 256 cases of heart failure, 96 deaths. • It is estimated that a 15% increase in the adults on treatment controlling BP to <140/90 could save £120m of related health and social care costs nationally over 10 years. • Net benefit by 2021 estimated at £2.8-£3.3m.
Accountable Care introduced across CW plus introduction of strategic commissioner.	Building on the 4 existing Transformational Programmes, Discussions are underway to support the introduction of: • Accountable Care established in the four areas across Cheshire and Wirral. For example in Central Cheshire the development of "Primary Care Home "can be developed as a model for Accountable Care. • Budget Alignment on population outcomes • Risk Sharing Arrangements across commissioning and delivery of services as per Accountable Care. • Delivery of new contract mechanism. • Clear operating model. • New population health management systems. It is recognised that to support Primary and Community Care, resources are required to deliver these changes.	• Improved population health management. • Care will be managed in a more appropriate setting . • Better Patient and Client Experience.
Referral Management	Implementation of referral management schemes across Cheshire and Wirral.	• Reduction in elective and non-elective referrals.
Primary Care Prescribing	Encourage and deliver better management of primary care prescribing. (through self-care, over the counter medicines and waste associated with repeat prescriptions)	• Reduction in prescribing expenditure.
Respiratory Strategy	Exploring best practice and options for a single approach across Cheshire and Wirral to integrate Respiratory Services; • Building on the Healthy Wirral respiratory model of care (clinical registries)we will seek to develop a collaborative approach to respiratory services across Cheshire and Wirral.	Fewer hospital visits, fewer unplanned primary care visits (>1000 Emergency Admissions Avoided) • Easier and earlier access to care and support. • Earlier, evidence-based treatment e.g. pulmonary rehab. • Improved data sharing across Wirral health care economy. • Improved diagnosis and case finding (undiagnosed population < England Avg 2.91% (<7,800)) • Consistent approach to care. • Better case management . • Improved targeting of services to meet population need. • Earlier identification of people with certain respiratory conditions. • Improved knowledge and awareness of population. • Improvement of lifestyle factors e.g. reduced smoking/higher quit rates. (<18 per 100,000) • It is anticipated that if a satisfactory option can be developed that a transformational approach to respiratory care could deliver a system saving £2m by 2021.
Diabetes Programme	Implement at scale a national evidence-based diabetes prevention programme capable of reducing not only the incidence of Type 2 diabetes but also the incidence of complications associated with Type 2 diabetes; heart, stroke, kidney, eye and foot problems. Deliver services which identify people with non-diabetic hyperglycaemia who are at high risk of developing Type 2 diabetes and offer them a behavioural intervention that is designed to lower their risk of onset of Type 2 diabetes.	• It is forecast that over 56,000 Cheshire and Wirral residents suffer from Diabetes Mellitus and a further 99,000 residents suffering from non-diabetic hyperglycaemia. • Assuming programme growth to 5000 patients, Cheshire and Wirral LDP anticipate an annual saving of over £500k per annum by 2021 with significant additional wider-systems savings resulting from a reduced incidence of diabetes.

3.3 - Cheshire & Wirral plans for demand management

Projects	Change Delivered	Outcomes/Benefits
Mental Health **Delivery of the priorities set out in the 5Year Forward View for mental health and the Prime Ministers challenge on dementia (2020) Including :** • **Prevention and Early Detection** • **Better Mental Health Care for people with Physical conditions.** • **Improved services for people with severe Mental Health Conditions**	Reducing variations in clinical practice – through the development of consistent care pathways, developing standard approaches to key processes such as assessment, access, discharge and caseload review. Improving patient safety – including a commitment to 'zero suicide.' Improving effectiveness – through a focus on care pathways with clear outcomes and evidence-based practice. In year 1, a priority will be the establishment of fully functioning mental health liaison services across Cheshire and Merseyside. Cost of investment expected to be funded from central allocations as per planning guidance.	• Better health and care outcomes for Patients and their families. • Improved opportunities for community based social prescribing and enhanced employment opportunities. • Reducing pressures on acute services within Hospital, Primary Care and Community setting. • Enhanced primary care support for mild to moderate mental health need.
Specialised Commissioning • **A collaborative approach that will seek to address the current inequality in access for Cheshire and Wirral residents.**	The early interventional programme identified above will ensure that patients are seen and treated earlier so reducing the need for consultant to consultant referrals. In partnership with NHS England, Cheshire and Wirral will adopt an approach to reducing the £30m overspend in specialised commissioning.	• Referral pathway improvement to ensure services are patient centred and outcome based. • Improve productivity and value of these services.
High Impact Community Based Integrated Care Schemes:	As detailed in the four Transformation Programmes (Healthy Wirral, West Cheshire Way, Connecting Care, Caring Together) we will strengthen and expand primary and community care services. • Integrated Community Teams • New Models of Primary Care • Long Term Conditions Management • Intermediate Care • Care Homes Support • Intermediate Care Development • Integrated Discharge Processes • Community Services MCP This will be done with reference to the Five Year Forward View for General Practice and the development of integrated health and social care. It is recognised that to support Primary and Community Care, resources are required to deliver these changes.	• Improved Patient Experience. • Reduction in non elective admissions. • Reduction in Length of Stay. • Reduction in Delayed Transfers of Care. • Shift in activity and associated resources from acute to community sector.
Neurology (Cheshire and Merseyside) ***This supports the work that has been lead across Cheshire and Merseyside as a cross cutting theme.*** **The Neuro Network neurology model aims to achieve a clinically and financially sustainable integrated neurology service by enhancing the community support, clinical pathways and advice and support for primary and secondary care.** **The spinal model is to implement a whole system spinal services network, integrating the two key components of the national Spinal Transformation Project.**	Explore best practice and the options around 7 day acute inpatients, specialist diagnostics, subspecialty/MDT clinics, access to neurosurgery, specialised pain and rehabilitation. DGH satellite services from visiting neurologists plus support: outpatient clinics, weekday ward consultation service, supported from the centre by: • Acute referral pathways • 7 day advice line • Telemedicine • Second opinion/specialist neuroradiology reporting via PACS • Community nurse clinics, nurse specialist support, homecare drugs, home telemetry • GP referral pathways • Ready communication between community and specialist neurology services for advice and practical help • Standards and clinical governance: common standards across network delivered services, with a single clinical governance structure, developing and using clinical outcomes as available. A network for the provision of spinal surgical procedures, managed from the centre with partner services in secondary care, working to common standards, and outcome measures, with MDT discussion of complex cases and all specialised surgery undertaken in a centre fully compliant with national specialised serviced standards. Implementation of a single whole system patient pathway through a network of all providers of spinal services, with common and audited service standards and outcome measures.	• It is projected to save up to £3.2m a year recurrently by 2020-21 compared with the do nothing scenario. • Hospital services reconfiguration: with its single service system wide delivery, providing a specialist centre well placed for future consolidation, and networks of specialised providers and hub and spoke models to improve collaboration across tertiary and secondary care.

3.3 - Cheshire & Wirral plans for demand management

Projects	Change Delivered	Outcomes
Thresholds and Procedures of Limited Value	Following NICE guidance maximise the outcome of clinical procedures optimising the effective use of resources.	• Improved utilisation of available capacity. • Increased awareness of self-care. • Resources will be targeted to deliver effective interventions.
Cheshire and Wirral Cancer Strategy	Targeted interventions to address areas of low screening uptake. Focus on improving the key worker arrangements for cancer patients and roll out the Recovery Package. Diagnose or exclude cancer within 28 days by creating multi-disciplinary diagnostic centres and new pathways for patients with vague cancer symptoms. Address together our capacity, workforce and organisational bottlenecks, which are preventing delivery of the 62 day cancer standards.	• Seeking to improve early stage cancer detection rates, associated with better survival and lower cost impact. • To limit emergency presentation rates during treatment and the follow-up costs of delivering cancer care respectively.
Operational Control Centre For Risk Stratified Population	Use technology enabled shared patient care records to identify and better coordinate care for the top 5-10% highest users of healthcare services, this will be achieved by using a centralised control facility to signpost and direct appropriate care services to those managing their conditions more effectively in the community and reducing inappropriate hospital admissions.	• Effective and personal communication with a vulnerable cohort of patients across Cheshire and Wirral in a coordinated manner. • Improved navigation of Vulnerable Patients through Health and Social Care systems. • Improved clinical outcomes for Patients. • Reduction in variation and ability to control demand.
Cheshire & Wirral Shared Care Records	Further development of Cheshire and Wirral shared care records.	• Improved patient experience by only having to tell their story once. • Less time wasted by staff tracking down important clinical records. • Reduction in repeat diagnostics and avoidable errors. • Use of near real-time data. • Enabler for key measures in all workstreams.
Implementation of Continuing Healthcare Collaborative Commissioning	Improved joint working with local authorities and across CCGs. Improved team metrics (reducing sickness and turnover rates).	• Planned reduction in outstanding reviews, improved experience for patients, family and carers. • Delivery of assessment targets. (i.e. 28 days) • Reducing the number of dispute cases.
New Models of Primary and Community Care	Delivery of a range of physical and mental health initiatives designed to deliver care closer to home and reduce demand on acute services. Introduction of new models of primary care and community care. Explore the resource requirements that would be associated with this.	• Reductions in non-elective admissions. • Reductions in Length of Stay. • Reduction in Delayed Transfers of Care. • Shift in activity from acute to community sector.

3.3 - Cheshire & Wirral plans - variation and hospital reconfiguration

Projects	Change Delivered	Outcomes
Organisational structures and system architecture	We are planning: • An integrated Cheshire & Wirral strategic commissioner. • Accountable Care established in the 4 respective geographies that will determine the shape and form of health and social care delivery across Cheshire and Wirral. • A provider collaborative, the shape and size to be determined.	A change in the Commissioning and Provider landscape that will support : • Better patient experience • Care closer to home • Health and Social care integration • Better use of resources • Strengthen local clinical commissioning
Enhanced technology supporting care through the development of strategic alliances and relationships with subject matter experts	Technology that support s and enables the delivery of integrated health and social care services: • Single IT/ informatics platform to support management of variation • Examples such as clinical registries, patient and asset tracking, operational control centre Access to global thought leadership/ expertise in management of variation.	Effective IT and information flows across all sectors supporting the management of variation/optimum approach to management of variation.
Development of a common approach to the delivery of clinical support service	A common approach to: • Medicines Management • Infection Prevention Control • Pharmacy • Radiology • Pathology	Optimised clinical support services to ensure clinical, operational and financial sustainability.
Development of model care pathways	Development of care pathways (across primary, secondary and social care) for high cost/ high volume diagnoses.	Optimum management of high cost/ high volume diagnoses including: • Pneumonia/ upper respiratory tract infection • Cardiac disease • Acute abdomen • Alcohol • Ophthalmology • Orthopaedics • Dermatology Standardised care pathways. Reduced length of stay.
Improved system performance to match best decile NHS England performance	Benchmark ourselves against national metrics to match or better NHS England best decile for: • Admissions • Overnight stays • Average Length of Stay • A&E attendances • Outpatient referrals and follow ups Participate in the NHS Right Care programme. Model impact to understand extent of overlap with other work streams.	• Management of demand in appropriate setting will produce a range of between £30-£60m.. • Appropriate use of secondary care services.

3.3 - Cheshire & Wirral plans - variation and hospital reconfiguration

Projects	Change Delivered	Outcomes
In-line with existing transformation work streams, (Caring Together) a remapping of elective and emergency care models in Eastern Cheshire	Agreed long term models for elective and emergency care in Eastern Cheshire are being developed based on strategic hospital partnerships, building on existing relationships, including those with hospitals in Greater Manchester. A number of emerging clinical models are being developed and will form the basis of an option appraisal. Clinical modelling covers emergency care (including options to retain the A&E department or the development of an urgent care centre) and elective care. The frailty pathways being developed will be explored to share best practice with other parts of Cheshire and Wirral.	Clinically , operationally and financially sustainable services .
In-line with existing transformation work streams, (Connecting Care) a remapping of elective and emergency care models in Central Cheshire	Agree long term models for elective and emergency care in Central Cheshire based on strategic relationship both within Cheshire and Wirral and surrounding localities so as to reflect patient flows.	Clinically , operationally and financially sustainable services .
Explore an option to consolidate elective care between the Countess of Chester Hospital NHS Foundation Trust and Wirral Teaching Hospital NHS Foundation Trust on the Clatterbridge Hospital site	Develop an options appraisal in relation to the future delivery of elective care in order to support : • Consolidation of elective care • 7 day working • Improved referral to treatment waits • Centre of excellence in recruitment and retention with potential to reduce reliance on specialised service activity flows if appropriate.	Clinically , operationally and financially sustainable services . .
Explore the consolidation of Acute Care Alliance between Countess of Chester Hospital NHS Foundation Trust and Wirral University Teaching Hospital NHS Foundation Trust – creation of integrated low and high dependency units for women's and children's services	Creation of a clinically integrated service between providers with the consolidation of high and low dependency care as appropriate. (Women and Childrens)	Clinically , operationally and financially sustainable services .
Explore the development of Cheshire and Wirral wide clinical services at scale .	Building from the review of clinical services undertaken by the Trust Medical Directors, we will benchmark all specialities against clinical effectiveness and outcome indicators so that we can deliver improvements to clinical care .(Advancing Quality, NHS Right Care) The emerging clinical models will also be developed in conjunction with Primary Care.	Clinically , operationally and financially sustainable services .
Specialised / 3° services	Explore the options for provision of Maxillo facial services Oesophago-gastric services, plastic surgery to 3° providers in Manchester, Wirral, Chester, Liverpool, North Midlands and North Wales. Where existing arrangements are in place that optimise clinical and financial sustainability then they would remain in place.	Clinically , operationally and financially sustainable services .

3.3 - Cheshire & Wirral plans - collaborative productivity

Projects	Change Delivered	Outcomes
Cheshire and Wirral Local Delivery System recognises that the projects outlined below focus on a Cheshire and Wirral approach to collaborative productivity This is to optimise the speed of delivering those benefits. A Cheshire and Merseyside solution will also be considered and implemented where appropriate for back office and clinical support functions.		
Payroll Workforce, Process & Product	Across Wirral & Cheshire – • Standardise services • Streamline services • Explore the integration and centralisation of teams	A single centralised payroll will reduce duplication, improve efficiency and responsiveness, improve access for staff, reduce queries, and reduce software licensing costs.
Model Hospital & Delivery of Business As Usual Efficiencies	Model Hospital (LOS) Model Hospital (Theatre Utilisation) Model Hospital (New Opat Models) Model Hospital (Other efficiency gains)	Delivery of Provider Business As Usual efficiencies. Delivery of higher quality service for patients.
Procurement Workforce	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	Reduced cost of overheads and duplication, Improved efficiency and responsiveness, and standardised processes. Economies of scale.
Procurement Purchasing Power	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	Procurement cost savings at scale. Greater purchasing power, standardisation and consistency. Compliance with Carter recommendations.
Library Service	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	More efficient service Cheshire and Wirral focus
Occupational Health	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	Clinical Sustainability
Occupational Health Streamlining of Process	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	Reduced duplication of localised management.
Recruitment Services	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	Reduced duplication, improved efficiency and responsiveness, and standardised processes. Economies of scale.
Comms and Engagement	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	Reduced duplication, improved efficiency and responsiveness, and standardised processes. Economies of scale.
Litigation service	Explore the development of an in-house legal service across Cheshire & Wirral	Reduced duplication, improved efficiency and responsiveness, and standardised processes. Economies of scale.
Finance Workforce	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	Reduced duplication, improved efficiency and responsiveness, and standardised processes. Economies of scale.
Finance Processes Transactional Services	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	Reduced duplication, improved efficiency and responsiveness, and standardised processes. Economies of scale.
Pathology	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	Automated processes scaled up to provide a service that is more cost effective and efficient and responsive so as to speed up diagnostic support.

3.3 - Cheshire & Wirral plans - collaborative productivity

Projects	Change Delivered	Outcomes
Capital Estates Planning and Hard Facilities Management	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	Regional Estates Team Reduced duplication, improved efficiency and responsiveness, and standardised processes. Economies of scale.
Cheshire and Wirral Informatics Workforce	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	Reduced duplication, improved efficiency and responsiveness, and standardised processes. Economies of scale.
Cheshire and Wirral Informatics Processing and Coding	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	Reduced duplication, improved efficiency and responsiveness, and standardised processes. Economies of scale.
Utilities management approach across Cheshire and Wirral	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	Reduced overall cost of utilities. Single supplier for all organisations. Economies of scale and consistency. Intelligent energy procurement.
Teletracking	Introduce new technologies in order to undertake the tracking of Assets in support of patient care. The use of real time data will also enable the management of patient care in the most appropriate setting. This technology will be used across all 4 Hospital sites, 2 community trusts and mental health providers.	Better matching of resources and capacity to demand, reduce duplication, improve efficiency and responsiveness.
Pharmacy	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	Reduced duplication, improved efficiency and responsiveness, and standardised processes. Economies of scale.
Agency Cost Reduction	Reduction in Agency Staff use by investment in substantive roles where required and using a joint strategy as 1 organisation approach	Substantive recruitment of staff in order to reduce overall agency costs by £2m, by 2021.
Clinical Commissioning Group (CCG) Business As Usual Quality Innovation Productivity & Prevention (QIPP) and Cost Improvement Programme (CIP)	Single approach to QIPP with best practice and learning being adopted across Cheshire & Wirral	Economy of scale, rapid acceleration and adoption – contribute toward year on year savings.
CCG Business as Usual QIPP Continuing Healthcare (CHC) and Funded Nursing Care (FNC)	Cost reduction from Cheshire and Wirral approach	Harnessing collaboration to reduce cost of Continuing Health Care and Funded Nursing Care Packages.

3.3 - Cheshire & Wirral plans - ways of working

Projects	Change Delivered	Outcomes
Shared Care Records	All our providers will have the ability to access shared care records in a local setting and face to face with the patient in real time. Avoiding Duplication	Improved and consistent patient care across the system Reduces cost due to patients not being lost in system.
Real time data	A single digitalised platform that we will facilitate a population health management approach. When integrated with respective risk stratification tools and the shared care records this will manage the rising risk of future patients	A preventative approach that will identify patients at risk and enable supportive intervention before the patient's needs become urgent.
Outcome based commissioning	Outcomes-based commissioning seeks to solve the issue of how financial flows and the commissioning process can best support quality and efficiency improves across the health care system.	Clear outcomes associated with all service areas, which will increase the clarity and therefore quality of provision.
Meeting patients' needs	Costs can be reduced significantly if patients are at the heart of decision making and that clinical decision making is based on outcomes with incentives aligned to doing less rather than more work.	Patients will be engaged at all levels, from shaping NHS plans to the development of services around patient need, and in decisions about their own individual care.
Clinical and Systems leadership	A new and heightened role for clinical networks, clinical leadership and multi-disciplinary working. A single Cheshire and Wirral approach to Organisational Development and cultural change with the public sector and NHS Leadership Academy and Health Education England.	Improved communication and information sharing across the system. System leaders and staff who fully support and are engaged with system leadership. Connect into the systems leadership work from Planning guidance
Collaborative working	Driving out costs where there is a benefit of procurement at scale. We will examine opportunities for integration both vertically within local systems and horizontally across providers	A system that works effectively and efficiently, driving out duplicated processes and costs.
Accountable care.	Commitment to providing accountable care, on a population health management approach in all 4 geographies within Cheshire and Wirral.	Care Systems that will focus on system benefit and change rather than organisational benefit.
CW Health & Social Care Teaching & Learning Partnership	support the creation of a sustainable local supply and the ongoing development of existing staff	workforce development to underpin national and local priorities – e.g. reception and clerical staff training and support leaders to develop system wide transformation skills

4 - Closing the Cheshire & Merseyside financial gap

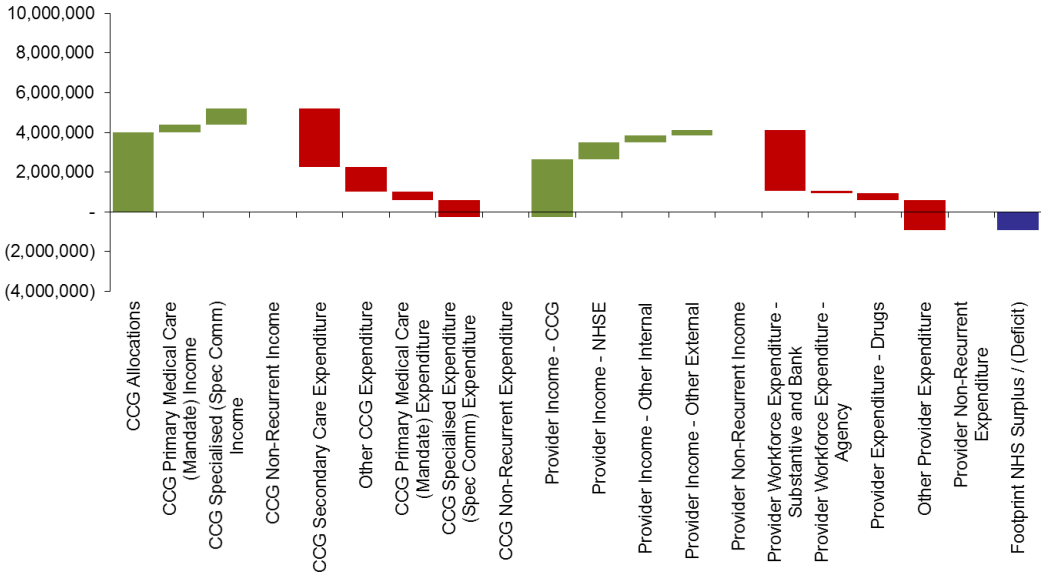
Financial Gap – current position

The 'do nothing' affordability challenge faced by the Cheshire & Merseyside health economy is forecast to be **£908m**, as illustrated below. The drivers of the affordability gap is a growing population that accesses health care more often, and are – positively – living longer but often with one or more long term conditions.

This challenge has narrowed from the £999m in our June submission, to £908m driven by the following:

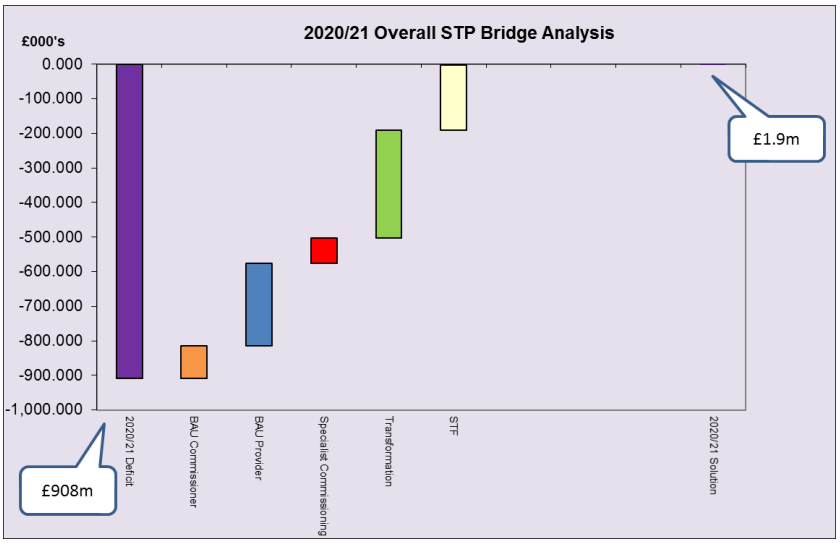
- The gap now reflects the fact that some cost reduction plans are already being delivered in 2016/17, which is year 1 of the 5 year plan
- The remaining gap now reflects the four year period 2017/18 – 2020/21

However, there is still risk associated with the delivery of organisation's 2016/17 financial plans, which at this stage may not fully reflected within the forecast gap.



The 'Do Something' position

After the impact of our transformation solutions, our business as usual and specialist commissioning efficiencies, and the expected STF funding the 'do something' gap is £1.9m, as illustrated below:



Risks to delivery

- Whilst the plans at this stage show a balanced position there is still a significant amount of further planning required on many of the solutions before we could present them as robust and with confidence of delivery
- We will continue to pursue further solutions in order to provide a contingency for when the current plans do not deliver the levels of savings currently forecast in the plan. In particular the focus will be on extending the opportunities in the strategic programmes at STP level.

4 - Closing the Cheshire & Merseyside financial gap

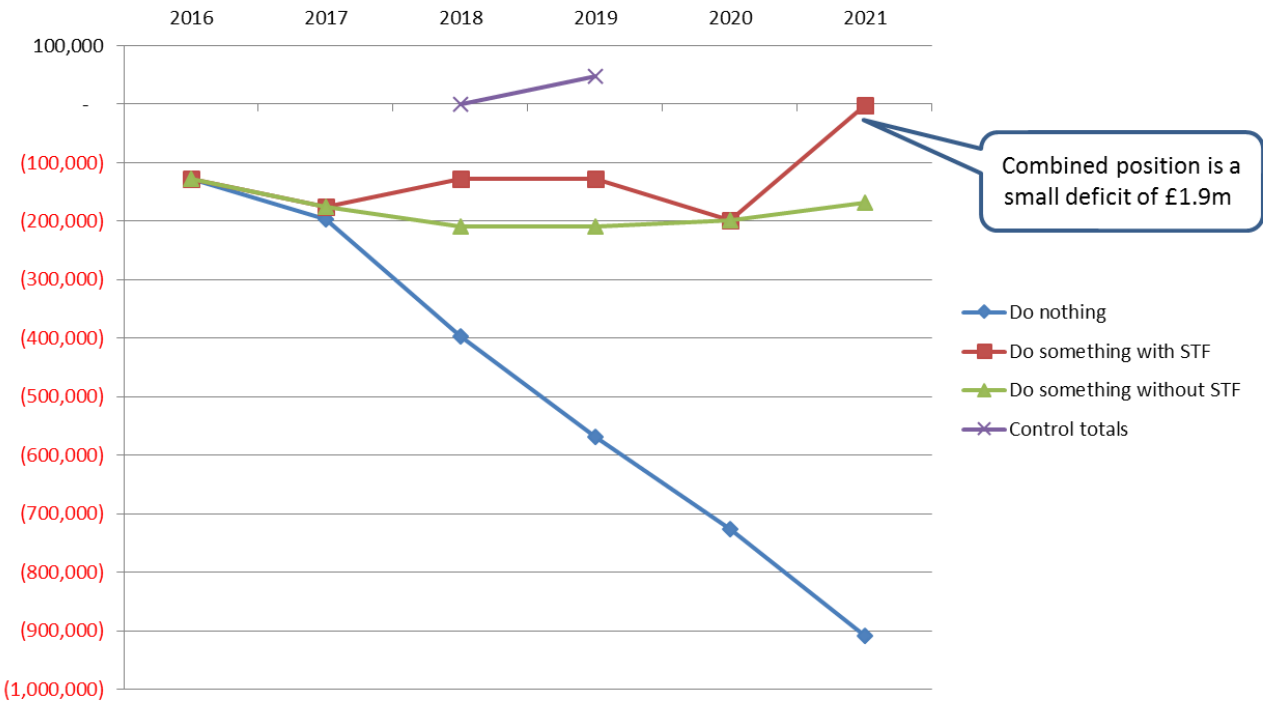
Capital

- We recognise that these plans are heavily dependent upon capital – up to £755m additional funding requirement in current plans as shown below. However we recognise there is still significant work to do before these high level requirements are turned into robust business case ready solutions. In particular to fully articulate the cost/benefits associated with the proposed investment.
- We also understand that Capital funding is extremely limited and that we will need to focus investment in those schemes that provide the most beneficial impact on our STP plans. In doing so we recognise that there may be schemes that do not get approved and the STP will therefore the benefits will also need to be reassessed.

Capital	£000s
Do Nothing	
Locally funded	726,150
Business case funding approved	150,785
Other funding source	47,634
Funding identified/approved	**924,569**
Funding not yet approved/identified	
Do Nothing	387,012
Do Something	368,232
Total funding not yet identified/approved	**755,244**
Grand Total	**1,679,813**

Pace of Change

Whilst we are forecasting balance in 2021, the profile of our solutions reflect that many of the benefits are forecast to be achieved in the latter half of the plan. Therefore the current financial plan does not demonstrate delivery of the aggregate Control Total across Providers and Commissioners for both 2017/18 and 2018/19. We will need to do further work to identify where pace can be increased, and to ensure that we are capturing all the quick wins that might be available.



Next Steps

In addition to addressing the issues noted above our focus now will be on strengthening the financial modelling through development of a demand and capacity model at STP level. This will enable us to more accurately and quickly reflect the impact of our solutions through a more thorough understanding of the drivers of costs across the system.

5 - Delivering the change

Successful delivery of transformation this size requires:

- *Governance enabling decision making*
- *Strong leadership*
- *Robust programme management*

Governance

A successful governance structure will enable leaders to govern with confidence, making timely decisions using high quality management information

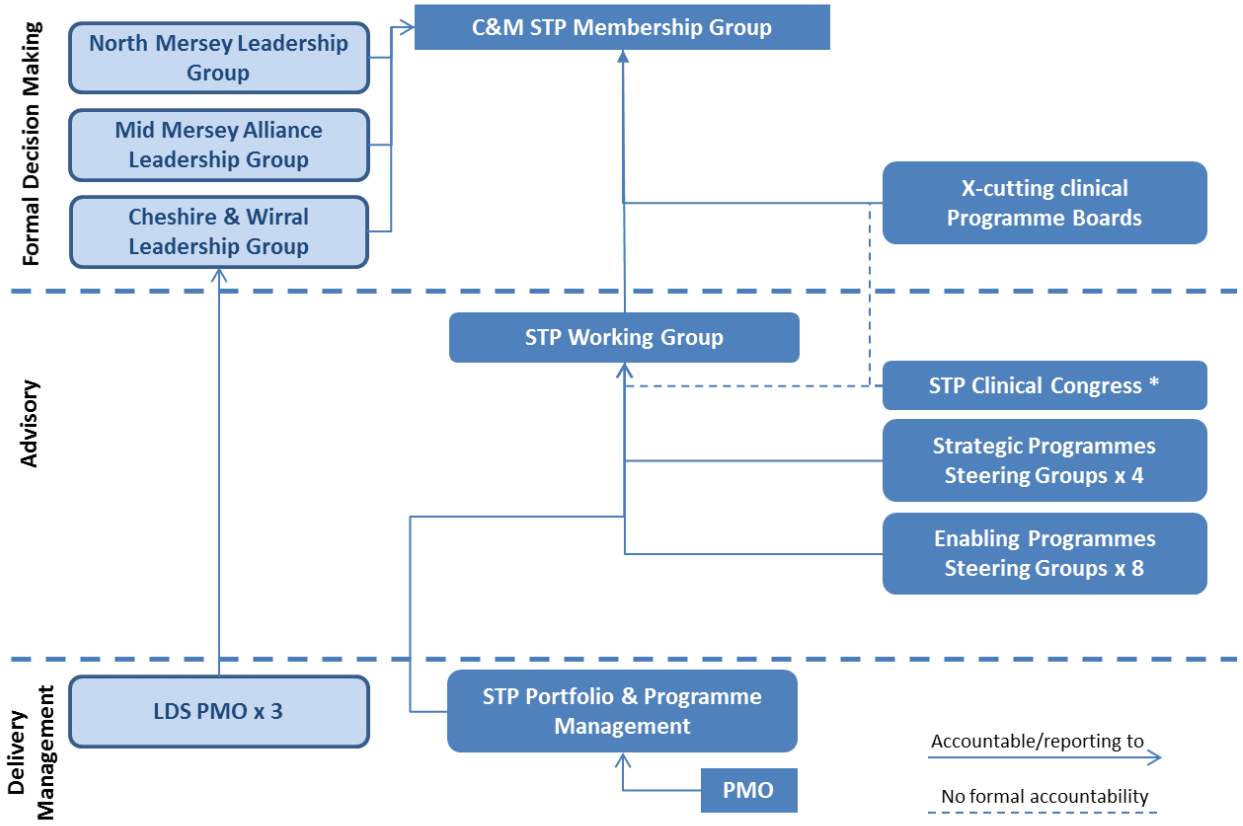
Effective governance of a programme is fundamental to successfully delivery and alignment with the STP strategy and direction, and are built on some key principles:

Each LDS already has its own Governance arrangements that will underpin the STP, and be responsible for the delivery of local programmes of work.

We will look to define governance arrangements early and comprehensively as this will create clear roles and responsibilities at all levels and allow for effective and timely decision making throughout the transformation plan.

We have drafted a Memorandum of Understanding and shared this with the STP Working Group. Once approved this will provide a sound footing to move forward from.

The current governance structure is shown below. This will be developed by the Membership Group in the short term so that Terms of Reference and membership details are agreed across C&M quickly.



** The Clinical Congress constitutes the clinical leadership of the member organisations (medical and nursing directors) and will be led by the STP Clinical Advisory Group which is the clinical advisory group to the STP Working Group. All of the three local delivery systems, four strategic workstreams and eight cross cutting themes will have a nominated senior Clinical Lead/Sponsor who will represent their workstream, their organisation, their sector, and their local delivery system and will also be expected to take a 'holistic' clinical view across the whole STP. The STP Clinical Advisory Group will be chaired by Dr Kieran Murphy, NHSE Medical Director (C&M).*

5 - Delivering the change

The ambitions within the STP will only be delivered under strong leadership

A programme of this size and complexity will need strong leaders with sufficient knowledge, experience and skill to operate at C&M level, while having a national network.

These leaders should also be freed up from their day job in order to provide the necessary system leadership to deliver at pace.

Leadership and Organisational Development

The aim of this section is to set out the forms of leadership and leadership development required to implement, sustainably realise and maximise the impact and benefits of the Cheshire and Merseyside Sustainability and Transformation Plan for the citizens of the region. In particular, to realise the benefits of inclusive, integrated service design, delivery and on-going development, that has the potential to significantly contribute towards improved population health and the reduction of health inequalities. STPs are more than just plans. They represent a different way of working, with partnership behaviours becoming the new norm. What makes most sense for patients, communities and the taxpayer should always take priority over the narrower interests of individual organisations.

Context and Drivers

The context and drivers for change and new forms of leadership and leadership development within the region are both complex and diverse including factors, such as, both the national agenda, as expressed in the 'Five Year Forward View' and the region's, political, economic, social, demographic, legislative, technological, geographical, physical, industrial, agricultural, commercial, educational and service sector history and current architecture, infrastructure and landscape.

The opportunities and challenges within the region's, sub-region's, cities, sub-cities, rural and urban environments are incredibly diverse and distinctive. However, all share the vision of a healthier population for all. A vision within which: -

- the assets and talents of local communities and populations are rigorously harnessed
- health inequalities are proactively addressed
- the promotion of health and well-being is the primary focus
- health and well-being services are integrated, resilient, culturally appropriate and sustainable

Regional Leaders

This vision requires regional leaders able to act, engage, learn, influence, challenge, develop, initiate and sustain change within differing volatile, uncertain, complex, ambiguous and diverse environments (VUCAD). We need to identify, develop, support and future proof inclusive, culturally competent leaders to become more impactful 'place' based, collaborative system leaders, implementing and continually developing fully integrated health and well-being strategies and services. This strategy to then support leaders to articulate and 'live' the ambitious Cheshire and Merseyside vision, and gain 'buy in' towards/for it from a range of stakeholders.

Conclusion

Twenty-first century leaders are expected to be VUCAD leaders; Cheshire and Merseyside leaders are no different. They are expected to respond to these environments by providing vision, understanding, clarity, and adaptability, to possess a VUCA approach, to fully immerse themselves in place, to work in place with individuals, groups and communities with an asset based approach, harnessing the talents of all diverse stakeholders, listening to and learning from differing perspectives, responding with agility and humility, whilst remaining personally resilient. Acting at all times as Inclusive Leaders, Cheshire and Merseyside leaders do and will work with others to ensure the successful achievement of the Cheshire and Merseyside STP, promoting innovation, creativity, entrepreneurism and inclusive, sustainable growth.

A Cheshire and Merseyside leader is and will be fulfilling an exciting, demanding, innovative and often challenging role and will need differing levels, forms and opportunities for development. This STP will work with the NHS North West Leadership Academy (NHS NWLA), and other agencies, to support the development of leaders and the region's leadership community, spanning Cheshire and Merseyside leaders within, across and beyond organisations, systems, and place. It is recognised that the NHS NWLA's experience developing, supporting, stretching, growing and caring for a diverse and inclusive leadership community can support the Cheshire and Merseyside leadership community in the vital role of supporting new and existing leaders to excel in role, to excel in new 'bigger' roles, to excel in identifying new talent and in making the region's health and well-being services world leading.

5 - Delivering the change

Robust Programme Management

The Cheshire & Merseyside STP comprises a significant number of programmes. Programmes are about managing change, with a strategic vision and a route map of how to get there; they are able to deal with uncertainty about achieving the desired outcomes. A programme approach should be flexible and capable of accommodating changing circumstances, such as opportunities or risks materialising. It co-ordinates delivery of the range of work – including projects – needed to achieve outcomes, and benefits, throughout the life of the programme.

A programme comprises a number of projects. A project has definite start and finish dates, a clearly defined output, a well-defined developmental pathway, and a defined set of financial and other resources allocated to it; benefits are achieved after the project has finished, and the project plans should include activities to date, and both measure and assess the benefits achieved by the project.

For a portfolio of this size and complexity, the illustrative model below tells us that successful delivery is wholly dependent upon having the right set of capabilities in place. Any significant weaknesses in the capability generated to deliver projects, at any level of the programme, are likely to impact negatively upon delivery.

The aim is to ensure that the right people are in a team and a clear and transparent project resourcing process is in place; this will mean that ways of working are understood.

Project Management

All members of the project teams must be committed to the vision and plan; moreover, impacted stakeholders should be willing to put in the additional effort required to deliver the programme. The use of milestone trackers, with enough detail to monitor on a weekly basis, and that are understood and agreed by the project lead and team, is critical.

Accountability

There must be clear accountability for project delivery of benefits (including savings) and the consequences of non-delivery understood. The work-stream lead is accountable for project delivery as delegated to them by the Executive Sponsor for each project.

Document Sharing

An intranet knowledge base should be established for the projects that comprise the programme. The use of the programme 'SharePoint' facility is an efficient and effective medium for joint viewing arrangements for documents, specifically workbooks, as well as maintaining good configuration (version) control.

The project teams will be responsible for ensuring that the latest version of the project documentation is always available on the SharePoint site. The access to the workbooks in terms of editing rights will be restricted to the Programme Assurance Framework, work stream and project team members.

Training & Development

The Programme Assurance Framework will promote exemplars of best practice project documentation. All staff completing these documents should be trained (by means of on-the-job training) during the development phase of that project.

Progress Meetings

Each project team will be expected to meet with the Programme Assurance Framework on a monthly basis. The objective of the meeting will be to gather evidence to ensure that the assurance update to the programme dashboard is based on documented evidence and is factually correct.

The conduct of the meeting will be based on a comprehensive review of the project documents as the evidence base. The progress meeting will also be an opportunity for the project to raise any issues for which the assistance of the Assurance Framework/Steering Group may be required to address to 'unblock' the route ahead.

The Programme Assurance Framework will ensure that there is a sufficiently formal process in place to ensure that any assurance reports are produced for governance meetings. This will support the embedding of an appropriate accountability framework and the provision of escalation reports, by exception, to the sub-committees; this latter process will form part of the role of the Programme Assurance Framework.

Programme Dashboard

The Programme Dashboard is intended to enable the governance bodies a more qualitative view of the development and implementation of projects. It will provide cues to focus executives on the strategic issues that require a degree of anticipation, like communications with stakeholders, or problems that need unblocking, for example questions relating to financial investment. The Programme Dashboard will also assist with the monitoring of milestones, KPIs, financial status and risks. Specifically, the dashboard reporting allows executive sponsors to review all of their projects easily, at a glance. Furthermore, it will include a responsibility matrix – given the complexity of the programme - identifying the key staff needed to deliver the project and identifies the dedicated resource required.

5 - Proposed resources required

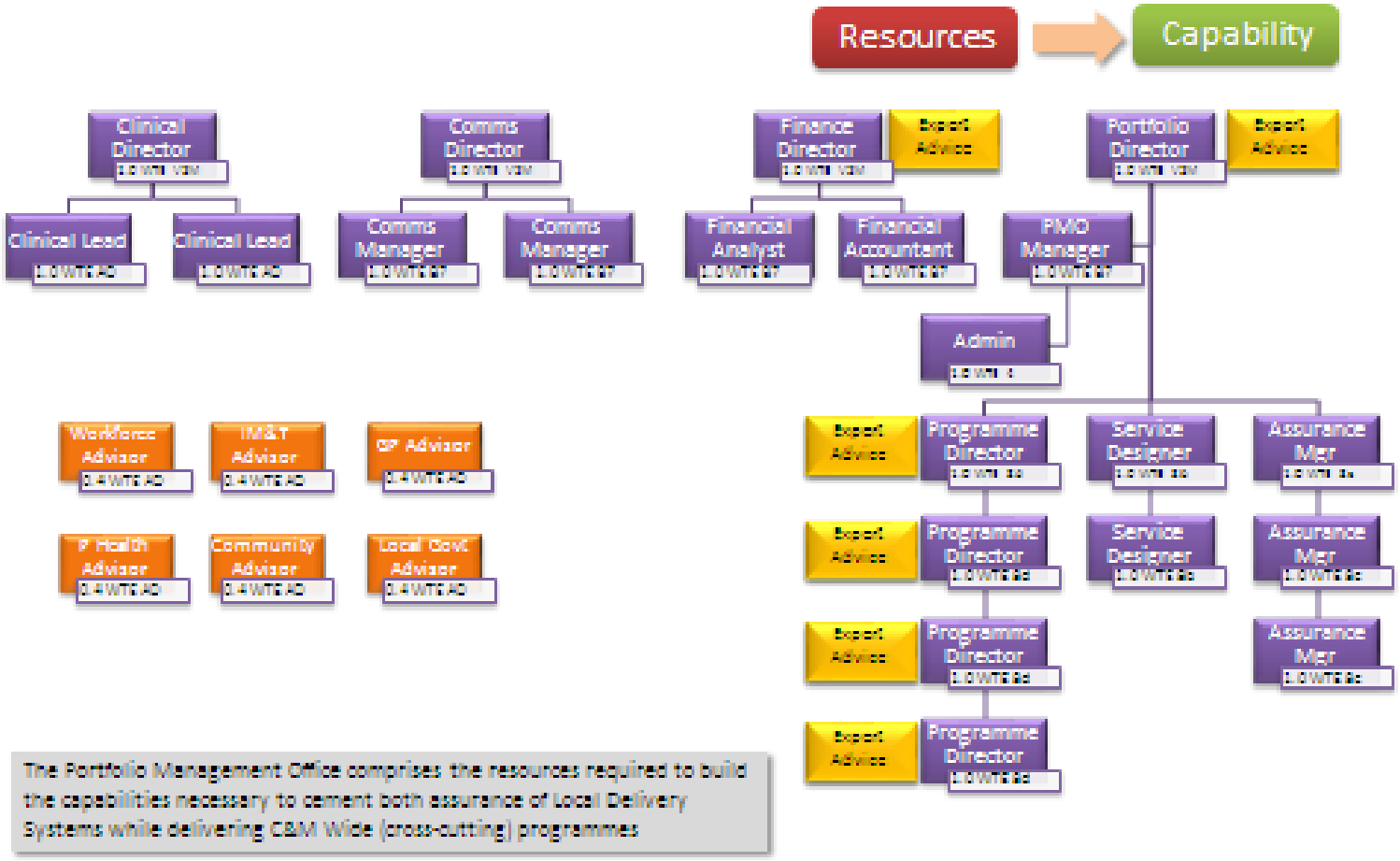
The current proposals before the Cheshire & Merseyside STP Working Group are shown below. The resource and skill mix may come from a number of sources and the capability sets will need to change as programmes mature through the gated phases.

The Portfolio management Office will reside at the centre of the STP, as the engine room, meeting the demands and requests of external stakeholders while directing and assuring the programmes (as appropriate and cognisant of local governance arrangements) that fall within the agreed scope of the STP.

Similar structures will need to be agreed and mobilised, where they do not already exist, for the work of the Local Delivery Systems and each of the programmes within the Portfolio.

Delivering the change

Portfolio Management Office



The Portfolio Management Office comprises the resources required to build the capabilities necessary to cement both assurance of Local Delivery Systems while delivering C&M Wide (cross-cutting) programmes

5 - Proposed communications and engagement plan - subject to further work and detailed discussion, including with individual governing bodies

Introduction

Our communications & engagement strategy sets out the approach to communicating the STP across Cheshire & Merseyside and engaging in an open & honest manner, with patients, public, staff and stakeholders. Stakeholders are recognised in terms of their level of interest and influence, and the corresponding level of engagement and communication is applied to enable each audience to have the opportunity to comment on proposed changes to health service provision.

This STP is a 'live' document that is subject to regular revision throughout the programme, and recognises and documents the work that has already taken place and is still ongoing at a local level. Much engagement work has already taken place to support area transformation plans such as 'Healthy Wirral', 'Healthy Liverpool' and 'Connecting Care' and this work is currently in the process of being scoped and logged.

The plan has been developed in collaboration with the Communication & Engagement Leads for each of the three 'Local Delivery Systems', providing a joined up, partnership approach across the region, and utilising all available channels to reach stakeholders.

What stage are we at now?

The Cheshire and Merseyside Sustainability Programme (STP) is still at a developmental stage. We are in the design phase of a programme that will help to create healthier NHS services across Cheshire and Merseyside for future generations.

We know that these changes can't happen overnight and that they shouldn't. Some NHS care models haven't changed much in over fifty years and it is unrealistic to expect them all to be suitable for a growing, aging, online population with changing expectations and needs.

This is why we are taking time to create an STP that is worthy of consideration by the public, patients, clinicians and the wider health economy and why the STP itself is still expected to go through a number of changes and adaptations – beginning with a phase of review and revision after the 21st October.

An initial period of pre-engagement will follow this date - setting the scene, considering and communicating available options and making sure that we are having the right conversations with the right people. The conversations that we have started about this process are extremely valuable and we will continue to engage with all of our stakeholders.

Engagement & Communications Objectives

The communications and engagement strategy has a number of over-arching aims. It is based on the three LDS areas being the "engine room" for developing and implementing any plans for transforming services. At a Cheshire and Merseyside level a joint Communications and Engagement Steering Group will be established to oversee the following:

- Establish standards for communication and engagement with members of the public, NHS staff and other stakeholders, taking into account the needs of any groups of people with protected characteristics, so that local people have the opportunity to contribute to discussions about NHS services. These standards will build on existing good practice and draw on expertise from partner organisations
- Where there is a need to formally consult with the public, staff and stakeholders on options for making major changes to services, ensure that standards of best practice are adhered to. Provide peer support, advice and guidance to support this and if necessary seek external expertise
- Build on existing good practice in order to transform how the NHS engages with members of the public, staff and stakeholders for the future.

Our Local Delivery Systems

A joint calendar will be created for the three LDS areas, identifying key milestones, which will be dependent on the priorities for each area. Communications and engagement activity will be planned to support these milestones. Where appropriate this activity will take place across LDS areas.

A senior communications and engagement lead has been identified for each LDS. Each lead will be responsible for overseeing the co-ordination of activity in their LDS area, providing strategic advice and guidance to their LDS chair and delivery board and will be a member of the Cheshire and Merseyside wide communications and engagement steering group.

STP Key Messages

- All health and social organisations across Cheshire and Merseyside are committed to delivering sustainable services that deliver the best care for local people
- We need to think differently about how we deliver services to meet the changing needs of our population
- We know we need to use our limited resources wisely, to meet the demands on the system and stay within our allocated budgets. By working together we can plan our services to deliver the maximum benefit for patients

5 - Strategic Risks

Financial Sustainability challenge. Since the June 2016 submission of the Cheshire & Merseyside STP, we have taken the opportunity to commence some initial steps to create a common standard of assurance across the footprint. What we have since received in the STP Working Group is a set of high level assurance assessments, both documented and verbally, which demonstrates that our current plans are extremely unlikely to close this gap.

The size of the current gap is an estimate and more work to agree the future assurance framework is yet to be completed. However, two dimensions can be described in that: firstly, the current level of planning has no level of contingency (indicatively 25-50%) that would normally be associated with programmes of this size and complexity ; secondly, the robustness of the 'plans' and associated risks regarding measurability, capability and deliverability all serve to make us discount the current value of the whole by a figure of 30% equating to some £300m.

Decision-making. As we stated in our June submission, while there is an emerging clarity about what needs to be done to deliver system-wide change, the challenge of delivering the decisions to effect this should not be underestimated. The strategic aim of the STP to deliver a work stream entitled 'How We work together to Make it Happen' is progressing but now needs to accelerate to agree the draft Memorandum of Understanding that has been circulated, define the governance bodies going forward (evolving the current Membership Group, Executive Group and Working Group) and cement the growing relationship with local Authorities. In due course, t is likely that a number of the decisions required may face public resistance and political challenges. We therefore need to have mature and well oiled governance mechanisms to receive and involve the concerns of our staff and our communities with their representatives.

Internal capacity. The issue of the capacity and capability needed to generate and coordinate detailed design and the delivery of the STP has still to be resolved. Attempting to deliver a change programme of this scale without freeing up key members of staff from other duties, or without bringing in additional resource, is destined to fail. The lack of transformation capacity and expertise released from within the system will result in momentum being lost. We are at a watershed moment and the Membership Group has recently agreed to consider all requests for capacity and skills in the light of insufficient progress being made to exploit the goodwill and discretionary efforts of all those contributing to this plan to date.

Appendices

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A3: Communications and Engagement Plan	
A3: Cross cutting Clinical Programme PIDs	

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16 November 2016

Dear Colleague

Cheshire and Merseyside Sustainability and Transformation Plan (STP)

We are writing to let you know that the Cheshire and Merseyside STP is being published today on all local NHS websites.

You will be aware that this is an ambitious draft plan to improve the health and well-being of the 2.5 million people living in the region.

The draft plan is one of 44 such plans being developed across the country in response to NHS England's Five Year Forward View (5YFV), a national plan that set out a vision for a better NHS.

The Cheshire and Merseyside Sustainability and Transformation Plan (STP) sets out our core purpose, which is to ensure that the people of Merseyside and Cheshire continue to have access to safe, good quality and sustainable services and ensuring that we make the best use of the funding we will receive over the next five years.

Ideas have come together in the Cheshire and Merseyside STP, which sets out four main priorities to address the challenges set out in the NHS Five Year Forward View; health and wellbeing, care and quality, and funding. The STP proposes to address those challenges by focusing on:

1. Support for people to live better quality lives;

2. The NHS working with partners to deliver joined up health and social care;

3. Designing hospital services to meet modern clinical standards and reducing variation in quality;

4. Becoming more efficient by reducing costs and maximising value.

Some of the proposals in the plan will be delivered in an integrated way across the whole region. However, due to the diversity of Cheshire & Merseyside, we are also working in three smaller partnerships called Local Delivery Systems (LDS) – North Mersey; the Alliance and Cheshire & Wirral. They will each deliver the same four key priorities but may tailor delivery to reflect the particular needs of each area and the local health and care system. Each of the Local Delivery Systems are at a different stage in their thinking. For example, plans to transform services have been in

development for some time through programmes such as *Healthy Liverpool* or *Caring Together* in Eastern Cheshire. For the other areas, where partners have been collaborating for a shorter time, ideas are at an earlier stage. This means that there will be opportunities at a very early stage for people to give their views and to get involved in shaping proposals.

The publication of the Cheshire and Merseyside STP on 16th November 2016 marks the start of further engagement on a way forward for local health and social care services. Over the next weeks and months we will be raising awareness and understanding about the need for change and will listen to ideas or concerns about any aspect of the plan.

We are committed to active involvement from patients, public, carers, staff and stakeholders in further shaping our ideas and proposals. Any emerging proposals to substantially change any service would be subject to thorough engagement and consultation with populations affected. We will only take forward proposals that are supported by strong clinical evidence and where we can demonstrate a positive impact in terms of quality, safety and sustainability.

We welcome your views on the content of the Cheshire and Merseyside STP.

Enclosed are additional documents in addition to the full STP document, including a public summary and frequently asked questions.

We expect you will also want to have conversations about the STP with your local clinical commissioning group, hospital trusts and other stakeholders. We look forward to receiving your feedback in order to help inform the next version of this plan.

The STP will be also discussed at all Health and Wellbeing Boards across Cheshire and Merseyside and we will engage with Overview and Scrutiny Committees on their requirements with regard to the plan.

We will continue to keep you informed and seek your views as proposals develop.

Can we take this opportunity to thank you for your interest and support for the NHS and social care system. We hope we can work with you to forge a constructive relationship to secure the best possible future for patients and the population of Cheshire and Merseyside.

Yours sincerely

Louise Shepherd
Cheshire and Merseyside STP Lead/
Chief Executive – Alder Hey Children's NHS Foundation Trust

Cheshire and Merseyside Sustainability and Transformation Plan (STP)

Frequently Asked Questions

1. What is the STP?

The STP is the local approach to delivering the national plan called the Five Year Forward View, which, published in 2014 sets out a vision for a better NHS, the steps that should be taken to get there and how everyone involved needs to work together to improve health and care.

There are 44 STPs being developed across the country to address the current challenges faced by health and care nationally. Much more focus is needed on preventative care; working together to find new ways of meeting people's needs and identifying ways of doing things more effectively and efficiently. Overall, all partners need to work together to improve health, finance and quality of care to meet the future needs of patients. Cheshire and Merseyside is the second largest of these covering an area with a population of 2.5 million people.

Cheshire and Merseyside is a diverse region; with urban areas that have higher levels of poor health and a greater concentration of hospital services, alongside towns and rural areas that have different challenges, including physical access to services.

There are some ideas that are being considered across the whole region. However, due to the diversity of Cheshire and Merseyside, we are also working in three smaller partnerships called Local Delivery Systems (LDS) – North Mersey; the Alliance (Mid Mersey) and Cheshire & Wirral.

2. Who has produced the STP?

The STP is a joint piece of work between the health and care organisations across the Cheshire and Merseyside area. This includes 12 NHS Clinical Commissioning Groups (who buy services), 20 NHS provider organisation (who provide services such as hospitals and community care) and nine local authorities. A list of all the organisations involved in the STP is provided below.

3. Why does the STP cover such a large area as Cheshire and Merseyside?

The area covered was decided after local discussions. Factors that were considered included existing working relationships across the health and care system and where patients go to receive treatment. It was also decided that the larger scale gave more scope in some parts of the plan to deliver a greater impact, particularly for schemes designed to improve health and wellbeing on a population level.

4. When did work on the STPs begin?

The STP footprint was decided in January 2016. Partners have been working together to develop the ideas contained in the plan since spring 2016.

5. So what has happened since then?

The organisations involved have been working together to identify the challenges faced in delivering the best services and how those challenges can be overcome based on needs of local patients and communities. This has been brought together into one document called the STP document published on 16th November 2016.

6. How were footprint leads agreed?

The way that footprints have chosen their leads has varied from place to place. Some areas have chosen existing system leaders, and others have carried out ballots following nominations. Each STP has a senior leader from inside the local health system. In Cheshire and Merseyside the STP Lead is Louise Shepherd, CEO at Alder Hey Children's Hospital.

7. What is the role of the STP footprint lead?

Footprint leads are responsible for leading and facilitating the open and honest conversations that will be necessary to secure sign-up to a shared vision and plan. They are part of an emerging national network of system leaders who will drive health and care transformation.

This is a new kind of leadership role, working across organisational boundaries. Footprint leaders will help to build consensus and ownership in their communities for their local plans, while providing the leadership to drive the transformation needed to improve the quality of care, health and wellbeing, and finance and efficiency.

8. Why do we need change?

It is estimated that if the local NHS does nothing there will be a financial shortfall of over £900 million by 2020/21 in Cheshire and Merseyside alone. By working more collaboratively and using joint resources we believe we can address this gap and break even. We know that by working more co-operatively across organisations we can reduce duplication, waste and unnecessary cost while providing a better health experience for patients. A key element of our plan is about improving the health and wellbeing of our population, thereby reducing reliance on NHS and care services.

9. Will STPs override existing plans and working processes across Cheshire and Merseyside?

The Sustainability and Transformation Programme isn't a body in its own right. It is an over-arching framework, which is designed to help drive forward existing plans, partnerships and initiatives across the region (many of which have been in existence since before the publication of the NHS Five Year Forward View in 2014.)

The STP isn't designed to erode organisational identity and recognises existing relationships and partnerships with local communities and organisations.

The local, statutory architecture for health and care remains, as do the existing accountabilities for chief executives and accountable officers. This is about ensuring that organisations are able to work together at scale and across communities to plan for the needs of their population, and ultimately deliver the Five Year Forward View – closing the gaps in quality, health and NHS finances by 2020/21. Organisations are still accountable for their individual organisational plans.

10. Will the STP replace other local NHS governance structures?

No. NHS organisations won't lose their identity or autonomy and existing plans will remain in place. This is about ensuring that organisations are able to work together at scale and across communities

to plan for the needs of their population. STPs will essentially act as umbrella plans for more cooperative working.

11. How do STP footprints fit with other health and care footprints?

The boundaries used for STPs will not cover all planning eventualities and there are layers of plans which sit above and below STPs. For example, neighbouring STP areas will need to work together when planning specialised or ambulance services or working with multiple local government authorities. Other issues will be best planned at a Local Delivery System level, others at clinical commissioning group (CCG) level.

12. So has there been any scrutiny of the STPs yet?

Yes, early versions of the plans were submitted to NHS England – the national body responsible for providing NHS care in June 2016. The feedback received has informed the development of the more detailed plans that were submitted on 21st October. This scrutiny was to ensure that plans have clear goals that are in line with national priorities.

13. What is the aim of the STP?

There's general agreement that the emphasis needs to be on health and care systems collaborating effectively to respond to the challenges we face, rather than organisations working individually. That's because we have increasing demands on services and constrained growth in funding over the next five years.

14. What are the financial considerations?

Demand is increasing at a greater rate than the growth in NHS funding over the next five years. That means that every pound has to be spent as effectively as possible. This will require change to ensure that services remain of good quality and are sustainable.

15. How big is that spending gap?

If we do nothing, the NHS faces a £22 billion funding gap by 2021. For Cheshire & Merseyside our share of this funding gap is £908m.

16. So how will that be prevented?

We know that these issues require us to think more radically about how best to address the problems we face together otherwise we will fail to support the needs of our communities into the future. In 2014, NHS England published a document titled *The Five Year Forward View (FYFV)*, which identified three priorities for the NHS to focus on in order to improve services and the health of our country: health and wellbeing – supporting people to stay well; quality of care – providing good services consistently; NHS finances – maximising efficiency and reducing duplication in services.

17. What are the priorities in the plan?

Our core purpose is to ensure that the people of Merseyside and Cheshire continue to have access to safe, good quality and sustainable services, which also means making the best use of the funding we will receive over the next five years. The plan has four main priorities:

1. Support for people to live better quality lives by actively promoting what we know will have a positive effect on health and wellbeing.

2. The NHS working together with partners in local government and the voluntary sector to develop joined up care, with more of that care offered outside of hospitals to give people the support they really need when and where they need it.

3. Designing hospital services to meet modern clinical standards and reducing variation in quality; people should be confident that they will receive similarly high standards of hospital care regardless of where they live.

4. Becoming more efficient by reducing costs, maximising value and using the latest technology; reducing unnecessary costs in managerial and administrative areas, maximising the value of our clinical support services and adopting innovative new ways of working, including sharing electronic information across all parts of the health and care system.

18. How can you manage demand when people will always get ill?

Many illnesses are preventable. Stopping people becoming ill is always preferable to treating them when they are ill. A good example of preventable illness is Type 2 Diabetes which currently accounts for roughly 10% of everything the NHS spends, and which in most cases could be avoided through improved lifestyles, particularly diet and physical activity.

We also want more “early intervention” – being able to detect problems before they become a crisis that could need hospital treatment.

19. How can you redesign hospital services safely?

We need to ensure that everyone has access to good quality hospital services.

Across Cheshire and Merseyside we will be reviewing clinical services across all our hospitals to identify where there are variations in quality and to look at how we can establish consistently high clinical standards. Our plans for hospital services will lead to greater collaboration and sharing of expertise and resources. The work to review variation and standards is at a very early stage and will take some further time to deliver impact.

Planning for the way we want hospitals to look, in most cases, is at an early stage and there won’t be any major changes without proper involvement, engagement and consultation with patients, appropriate to the level of change being considered.

20. What other costs can be reduced without having an impact on safety and quality of care?

Reducing costs will involve looking at our administrative and clinical support services, where could also improve standards and access to services such as radiology, pharmacy and pathology. When it comes to administrative support, our principle is to share resources across organisations, where this makes sense, in areas such as finance, human resources and IT, to achieve maximum efficiency.

21. What are the next steps?

Now that the STP is published we want as many people as possible to be aware of the ideas in the plan and to have opportunities to provide feedback. In preparing the Cheshire and Merseyside Plan local partner organisations have so far involved senior doctors and system leaders in drawing up

ideas, and many more will be involved in developing the plans to take forward the four priorities for action.

The publication of the Cheshire and Merseyside STP on 16th November 2016 marks the start of further engagement on a way forward for local health and social care services.

22. How will we involve patients?

Over the next weeks and months we will be talking to people to ensure there is a good level of awareness and understanding about the need for change and to listen to ideas or concerns about any aspect of the plan.

Every partner organisation is committed to actively involving patients, carers, staff and local people in shaping future plans and ensuring they have their say on how services will look in the future. Any proposal to substantially change any service will be subject to thorough and detailed engagement and consultation with those people potentially affected by any suggested change. We will only take forward proposals that are supported by strong clinical evidence and where we can demonstrate a positive impact in terms of quality, safety and sustainability.

23. How are you engaging with local authorities?

Local authorities are part of the local partnership of health and care organisations that have developed these plans. Their guidance and involvement is vital and will help to set the strategic direction of health and care service development locally.

Local authorities also have a scrutiny role, democratically representing their population in reviewing plans, both through Health and Wellbeing Boards and through Health Overview and Scrutiny Committees.

24. When will you be asking local people and stakeholders for their views?

In some parts of the region there are existing change programmes, such as Healthy Liverpool, and Shaping Sefton on Merseyside and Caring Together in Cheshire, that have already carried out significant engagement with local people and stakeholders on plans that are now well advanced. In some other areas ideas are at an early stage, which provides people with opportunities for ongoing engagement to help shape detailed proposals.

Some of the proposals focus on changes to back office functions which will not have any impact on patients at all but may impact staff. In addition there will be a greater emphasis on prevention and health improvement, supported by behaviour change campaigns.

In terms of any proposals to change services, where there is an impact on local people, we will ensure that these proposals are subject to local engagement and formal consultation in line with normal arrangements and legislative requirements.

25. Are there any plans to merge CCGs or Trusts?

Nationally, some CCGs are currently exploring ways in which they can work better together, and it is possible that in future some trusts may explore options for collaboration or consolidation. The only merger proposal contained in the STP relates to the potential coming together of the Royal Liverpool and Aintree Hospitals. Any future proposals would be subject to defined and transparent processes and would include public and staff engagement.

26. Are there plans for STP or LDS footprints to share a single total budget?

As set out in the recently published NHS planning guidance for 2017/18, STP footprints may apply to operate what is called a *single system control total*, which in effect is working to a high level single budget, although each organisation will still be responsible for managing its own resources and statutory financial duties.

27. What improvements should clinical staff expect to see?

The Cheshire and Merseyside STP has been developed with input from clinicians across the region. The STP reflects the support clinicians have shown for new models of care that improve quality, reduce variation and deliver more efficient care.

The options for change discussed in the STP are also designed to reduce duplication and waste in the delivery of services and embrace new, innovative practices to improve the quality of services patients receive. Reduced spend in the back office will enable additional spend and effort to be directed towards front line services.

Better integration of health and social care services would mean closer working in areas like community services, mental health and alcohol prevention and will create more opportunities for earlier patient intervention – leading to healthier communities and less reliance on NHS and care services.

28. Will any jobs be lost as part of this process?

We are still at a very early stage in our ideas and there will be opportunities for staff, trade unions and other stakeholders to get involved in the coming months on what the next steps will be.

STPs have been developed in a very collaborative way across partner organisations, guided by principles around social value and fairness.

29. How do STP footprints fit with other health and care footprints?

The boundaries used for STPs will not cover all planning eventualities. As with the current arrangements for planning and delivery, there are layers of plans which sit above and below STPs, with shared links and dependencies. For example, neighbouring STP areas will need to work together when planning specialised or ambulance services across the North West or working with multiple local authorities and, for areas within a proposed devolution footprint that cross STP boundaries, further discussion will be required in working through the implications. Other issues will be best planned at clinical commissioning group (CCG) level.

30. What does success look like?

If we get this right, everyone will understand the challenges that are driving the case for change and we will take clinicians, patients, staff and communities with us as part of the process of transformation.

We will develop services that reflect the needs of patients and improve outcomes by 2020/21, closing all three gaps around wellbeing, quality and funding. We will mobilise energy and develop the ownership, relationships and governance necessary to deliver any agreed changes.

This is a new type of planning process that requires the NHS at both local and national level to work in partnership across organisational boundaries and sectors, and will require changes not just in process, but in culture and behaviour.