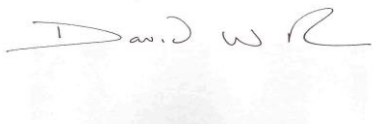
Public Document Pack

Health and Wellbeing Board

Wednesday, 6 July 2016 2.00 p.m.
The Halton Suite - Select Security Stadium, Widnes



Chief Executive

Please contact Gill Ferguson on 0151 511 8059 or e-mail gill.ferguson@halton.gov.uk for further information.
The next meeting of the Committee is on Wednesday, 12 October 2016

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

Part I

HEALTH AND WELLBEING BOARD

At a meeting of the Health and Wellbeing Board on Wednesday, 9 March 2016 at The Halton Suite - Select Security Stadium, Widnes

Present: Councillors Polhill (Chairman), Woolfall and Wright and S. Banks, L. Birtles Smith, P. Cook, G. Ferguson, T. Hill, L. McDonnell, A. McIntyre, E. O'Meara, D. Parr, M. Pearson, M. Pickup, C. Samosa, M. Saville, S. Semoff, R. Strachan, L. Thompson, S. Wallace Bonner, S. Yeoman

Apologies for Absence: Councillor Philbin and D. Lyon and H. Patel

Absence declared on Council business: None

ITEM DEALT WITH
UNDER DUTIES
EXERCISABLE BY THE BOARD

Action

HWB35 MINUTES OF LAST MEETING

The Minutes of the meeting held on 13th January 2016 having been circulated were signed as a correct record.

HWB36 INTEGRATING CHILDREN'S SERVICES

The Board considered a report which advised on developments for integrating Children's Services. An Integrating Child Health in Halton Workshop was held on 8th May 2015 with local acute trusts, community trusts, children's services, NHS CCG Halton and Public Health. The key note speaker was Dr. Hilary Cass President of the Royal College of Paediatric and Child Health. The outcome was consideration to pilot an innovative programme of joint working between providers and the placement of a local paediatrician in the local community. The report outlined the drivers for change towards an integrated service and the aims and outcomes which an integrated service could achieve.

Members were advised that the next steps in Halton would be to:

- agree a financial plan and work plan for a paediatrician in the community;

- agree GP hosts and pilot sites; and

- liaise with Health Education England for recognition as a pilot site.

RESOLVED: That the Board –

1. note the contents of the report; and

2. note that a paediatrician is available to work in the Halton Community from Warrington and Halton Hospital Trust.

HWB37 WELL NORTH PROGRAMME

The Board considered a report which provided information on the successful Well North bid that Halton Partners had submitted. The Board was advised that Well North was a Department of Health (DH) response to the Due North Report which highlighted the disparity in wealth and circumstances between the North and the South of England. The DH Well North team had allocated up to £9m to be available to nine local areas to improve health via innovative approaches.

It was noted that the programme must be delivered in wards in the top 10% of Index of Multiple Deprivation and the approach was to develop, test and pilot a set of linked interventions to improve the health of the poorest. The Well North methodology would involve co-production between Halton's partners and the Well North team. Full details of Halton's successful bid were outlined in the report.

As part of the next steps, a team of Halton staff from across key agencies and service areas would work with local communities and the Well North team through an initial stage to further define the proposals and intended outcomes for Halton. Initial sessions and visits had already taken place to provide a sense of place for the Well North team and a trip to Bromley by Bow for Halton partners to see a successful Wellness Place based approach in action. It was proposed that a two day workshop would be programmed for May 2016 to develop plans.

RESOLVED: That

1. the contents of the successful Well North bid and an

update of commencement of implementation be noted; and

2. any comments be fed back to the Director of Public Health and Director of Commissioning and Service Delivery.

HWB38 DELIVERING THE FORWARD VIEW: PLANNING GUIDANCE 2016/17- 2020/21

The Board was advised that the National Health and Care Bodies in England had come together to publish shared NHS Planning Guidance for 2016/17 – 2020/2021, setting out the steps to help local organisations deliver a sustainable, transformed Health Service and improve the quality of care, wellbeing and NHS finances. A copy of the guidance had been previously circulated to Members of the Board.

As part of the new planning process, NHS organisations had been asked to develop two plans.

1) A wider health and care system "Sustainability and Transformation Plan, covering the period October 2016 to March 2021; and

(2) A plan by organisation for 2016/17.

It was noted that the guidance had indicated that planning by individual organisations would increasingly be supplemented with planning by place for local populations. Providing a Sustainability and Transformation Plan (STP) on a larger geographical footprint would encourage a joint approach. On the 29th January it was confirmed that Halton would form part of the Cheshire and Merseyside STP footprint.

Members were advised on access to future transformation funding which was outlined in the Government Spending Review as an additional dedicated funding stream for transformational change, building up over the next five years. The most compelling and credible STPs would secure the earliest additional funding from April 2017 onwards. In addition the report also set out the timetable for submission of the Operational Plan and completion of the five year Cheshire and Merseyside STP. It also outlined nine "must do" priorities for local health economies which NHS England and the other NHS organisations had identified.

RESOLVED: That

1. the contents of the report be noted; and

2. the Council works collectively with Halton CCG and One Halton delivery partners to develop a local 5 year Sustainability and Transformation Plan with accompanying 12 month Operational Plan and contribute to the wider Cheshire and Merseyside footprint Sustainability and Transformation Plan.

HWB39 COMPLEX DEPENDENCY/EARLY INTERVENTION

The Board considered a report which detailed the arrangements for the introduction of Multi-Agency Front door as part of Complex Dependency Early Intervention model in Halton.

One of the key aims of the Complex Dependency Early Intervention project was to create a single, multi-agency front door for identification and assessment of complex individuals, Children and Families. In order to deliver a multi-agency front door in Halton, the process and practice of the current Contact and Referral Team (CART) had been reviewed. Through the implementation of the revised front door the aim was to provide a proportionate, timely and co-ordinated partnership approach to children, families and vulnerable adults. This approach should lead to a more appropriate allocation of resources to those children, families and vulnerable adults that required additional support due to them having multiple and complex needs.

Members of the Board were advised on staffing roles within the new integrated team, known as I-CART and noted that there would be a soft launch of the new approach at the end of March 2016.

It was noted that the aim of I-CART the aim was to see less inappropriate and repeat referrals, closer partnership working and clearer accountability, supported by information sharing protocols and pathways, improve confidence for those who access the service, identification of possible gaps in service and cost benefits.

RESOLVED: That the Board notes the progress to date in implementing a multi-agency front door and recognise the benefit of a defined route to services through a single point of access by a dedicated multi-agency team.

HWB40 SUMMARY OF CQC INSPECTION REPORTS OF GP PRACTICES

The Board considered a report of the Chief Officer, NHS Halton CCG, which presented a summary of the outcomes of the first wave of CQC inspections of general practices in Halton undertaken in September 2015. Of the eight practices inspected, seven received an overall rating of good, and one an overall rating of outstanding. An overview of each general practice inspection was detailed in the report.

RESOLVED: That the good outcomes of the first wave of CQC inspections of GP practices in Halton be noted.

HWB41 NHS ENGLAND UPDATE FOR LEARNING DISABILITIES PAPER - KAREN POWELL NHS ENGLAND

The Board considered a report from NHS England, which provided an update of the national, regional and local programme of work with regard to Transforming Care for people with Learning Disabilities. The Transforming Care programme was a national programme of work, aimed to improve care for people with learning disabilities and/or autism and behaviour that challenged (learning disabilities). The five areas in the Transforming Care programme were –

- Empowering individuals;
- Right care in the right place;
- Regulation and inspection;
- Workforce; and
- Data and information.

RESOLVED: That the report be noted and the Board support the implementation.

HWB42 PUBLIC HEALTH ANNUAL REPORT

The Board received an update on the development of the Halton Public Health Annual Report (PHAR) from the Director of Public Health. The Annual Report was the Director of Public Health's professional statement about the health of local communities, based on sound epidemiological evidence and interpreted objectively.

Each year a theme was chosen for the PHAR and for 2015 – 16 it was noted that the report would focus on the work on the Public Health Evidence and Intelligence Team. This topic had been chosen to highlight some key pieces of work and how they had been used or would be used by Halton Borough Council and its partner organisations. The

final version of the report would be presented to the Board in July however, prior to this an electronic copy would be circulated to Members of the Board for feedback.

RESOLVED: That the theme and development of the Public Health Annual Report be noted.

HWB43 POSITIVE BEHAVIOUR SUPPORT SERVICE

The Board considered a report of the Strategic Director, People and Economy, which provided an update on the activity of the positive Behaviour Support Service (PBSS), which had been operational since November 2011. The service was jointly funded by NHS Halton CCG and was a specialist service for children and adults with the primary purpose of improving life quality for those individuals who present with behaviours that challenged services. Eligibility criteria for the service were moderate to severe Learning Disability, including those with a diagnosis of Autistic Spectrum Condition. The service was currently supporting 15 adults and 18 children in the Halton area. In addition, it would also be supporting the return of 6 adults to Halton from out of borough placements in January 2016.

It was noted that the cost of the PBSS to Halton was less than the savings achieved. The report detailed examples of annual savings to the Council.

RESOLVED: That the report be noted and the ongoing work of the PBSS be supported.

Meeting ended at 3.00 p.m.

REPORT TO: Health and Wellbeing Board

DATE: 6th July 2016

REPORTING OFFICER: Cheshire Fire Service

PORTFOLIO: Health and Wellbeing

SUBJECT: Presentation: Cheshire Fire Service

WARDS: Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To receive a presentation from Mike Larking, Cheshire Fire Service on how the Service will support the health and wellbeing agenda in Halton.

2.0 RECOMMENDATION: That the presentation be received and the work of Cheshire Fire Service on the health and wellbeing agenda be supported.

3.0 SUPPORTING INFORMATION

3.1 As received in the presentation to Members.

4.0 POLICY IMPLICATIONS

4.1 Health and Wellbeing Boards have a key role to play in supporting how the local area meets the needs of the health of the population and the work of the Cheshire Fire Service supports this.

5.0 OTHER IMPLICATIONS

5.1 N/A

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children and Young People in Halton

Improve outcomes for children and young people in relation to family health and wellbeing and accidents.

6.2 Employment, Learning and Skills in Halton

N/A

6.3 A Healthy Halton

The work of the Cheshire Fire Service supports Halton's Health and Wellbeing Strategy.

6.4 **A Safer Halton**

The work of the Cheshire Fire Service will ensure local residents are more aware of safety issues.

6.5 **Halton's Urban Renewal**

None.

7.0 Risk Analysis

N/A

8.1 Background Reports

See presentation.

REPORT TO: Health and Wellbeing Board

DATE: 6th July 2016

REPORTING OFFICER: Operational Director - Education, Inclusion and Provision

PORTFOLIO: People and Economy

SUBJECT: Presentation – Meeting the Needs of Children and Young People with special educational needs and/or disabilities

WARDS: Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To receive a presentation on how effectively Halton meets the needs of and improves the outcomes of children and young people who have special educational needs and/or disabilities as defined in the Act and described in the Special Educational Needs Code of Practice: 0 to 25 years.

RECOMMENDATION: That

(1) Members receive the presentation; and
(2) Consider how the work of the Health and Wellbeing Board supports children with special educational needs and disabilities locally.

3.0 SUPPORTING INFORMATION

3.1 The Children and Families Act 2014 placed new duties on local areas in relation to the provision for children and young people with special educational needs and/or disabilities. These new duties came into force in September 2014.

4.0 POLICY IMPLICATIONS

4.1 Health and Wellbeing Boards have a key role to play in supporting how the local area meets the needs of children and young people with special educational needs and disabilities

5.0 OTHER IMPLICATIONS

5.1 From May 2016 Ofsted and the Care Quality Commission have commenced inspecting local areas on their effectiveness in fulfilling the new duties.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children and Young People in Halton**

Improve outcomes for children and young people with special educational needs and/ or disabilities

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

Improve education and employment opportunities for children and young people with SEND

6.3 **A Healthy Halton**

Support children and young people so that they can be as healthy as possible in adult life

6.4 **A Safer Halton**

Ensure children and young people with SEN feel safe

6.5 **Halton's Urban Renewal**

None.

7.0 Risk Analysis

7.1 Inspections of local areas will evaluate how effectively the local area meets its responsibilities.

8.1 Background Reports

Children and Families Act 2014

Special educational needs and disability code of practice: 0 to 25 years

The framework for the Inspection of local areas' effectiveness in identifying and meeting the needs of children and young people who have special educational needs and/or disabilities

REPORT TO: Health and Wellbeing Board

DATE: 6th July 2016

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Wellbeing

SUBJECT: Director of Housing & Wellbeing

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 This report updates the Board on the expansion of Halton Housing Trust's (HHT) Director of Housing role to include Health & Wellbeing.

1.2 This expanded role reflects ongoing discussions between HHT, NHS Halton Clinical Commissioning Group and Halton Borough Council's Director of Public Health to develop a role with joint housing and health responsibilities. This strategic role will enable further development of the positive joint working approach developed over the last few years.

2.0 **RECOMMENDATION:**

It is recommended that the contents of the report are noted and that the Health and Wellbeing Board supports the creation of a Director of Housing and Wellbeing.

3.0 **SUPPORTING INFORMATION**

3.1 Housing is a key determinant of health and Halton Housing Trust is committed to improving the health and wellbeing of its customers, and the wider Halton community. The integrated role will enable an understanding of housing as a wider determinant of health and the development of partnership work to reduce health inequalities. Halton Housing Trust tenants are among the most vulnerable in our communities with higher levels of poverty, unemployment and physical and mental ill health. Halton Housing Trust have a strong track record of working with partners to improve the health and wellbeing of its residents and this development strategic role seeks to build upon this and develop joint working further.

3.2 The Director of Housing & Wellbeing will be responsible for the following aspects:

1. Coordination of integrated wellbeing programmes within the housing sector on behalf of NHS England, Halton CCG and Halton Public Health. This will ensure closer working with wider statutory partners including the voluntary sector, Halton Health Improvement Team, emergency services, Warrington & Halton NHS Trust, Bridgewater Community and 5 Boroughs Mental Health Trust.

2. To coordinate the Housing & Environmental aspects of NHS England, Halton CCG and Public Health's Health and Wellbeing Strategies and the proposed Cultural Strategy.

3. Represent NHS England, Halton CCG and Public Health within Housing aligned meetings with input from Halton's Environmental Health Team, Trading Standards Team and other partners as appropriate.

3.3 The Director of Housing & Wellbeing will inform HHT's cultural shift towards becoming a health sustainable organisation. The integrated

role will drive partnership working and the planning of health and housing services together. Agreed work will be aligned to the Halton HWB priority areas and will align the housing element of the preventative lines within the NHS 5 year forward view.

3.4 There will be a focus upon developing coordinated approaches to address those aspects of health that have a connection with housing. The initial agreed shared key priorities for Halton are :

- Tackling loneliness and reducing social isolation
- Preventing falls
- Reduction in cardiovascular and respiratory disease – through the promotion of healthy lifestyles promotion of NHS health checks, tackling fuel poverty and ensuring people live in warm healthy homes
- Promotion of immunisation and screening
- Reducing debt and promoting mental wellbeing

3.5

The initial suggested ways that HHT, Halton CCG and Public Health could work more cohesively to achieve these shared objectives included a number of awareness campaigns and initiatives around:

- Keep Warm Keep Well
- Slips, trips and falls (building upon the previously successful ‘Sloppy Slippers’ Campaign)
- Healthy lifestyles opportunistic advice.
- Analysis of the detailed customer profiling data to initiate targeted interventions.
- Dementia early signs training for front line staff.
- Raising awareness of scams which target older vulnerable people

3.6

In addition to targeted campaigns the role will also support the continued development of a strategic overview to ensure the CCG

3.7 realises maximum return on its estate disposal programme.

It has been agreed that the role will adopt the following responsibilities:

- To be the housing representative on the HWB, Healthy Lifestyles and One Halton Boards
- To act as the primary housing link to the other housing associations working across the Borough and act as a conduit back into key contacts points within the CCG and Public Health Teams
- Attend the last section of the CCG Management Team meetings to pick up on any areas discussed and/or arising from the agenda and papers.

3.8 Line management responsibility will be retained by HHT and health supervision provided by Public Health Halton.

3.9 Halton CCG has agreed they would be able to make an initial contribution of £10K towards the cost of this role. This will be reviewed after an initial 12 month period.

4.0 POLICY IMPLICATIONS

4.1 Housing is a key determinant of health. The Director of Housing & Wellbeing will enable an understanding of housing as a wider determinant of health and the development of partnership work to reduce health inequalities. The Director of Housing & Wellbeing will inform HHT's cultural shift towards becoming a health sustainable organisation. The integrated role will drive partnership working and the planning of health and housing services together. Agreed work will be aligned to the Halton HWB priority areas and will align the housing

element of the preventative lines within the NHS 5 year forward view.

5.0 FINANCIAL IMPLICATIONS

5.1 Halton CCG has agreed they would be able to make an initial contribution of £10K towards the cost of this role. This will be reviewed after an initial 12 month period.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

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

6.2 Employment, Learning & Skills in Halton

None.

6.3 A Healthy Halton

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

6.4 A Safer Halton

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

6.5 Halton's Urban Renewal

None.

7.0 RISK ANALYSIS

7.1 There are no risks associated with the contents of this report.

8.0 EQUALITY AND DIVERSITY ISSUES

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

9.0 IMPLEMENTATION DATE

The date for implementation is 1st April 2016.

REPORT TO: Health and Wellbeing Board

DATE: 6th July 2016

REPORTING OFFICER: Simon Banks, Chief Officer

PORTFOLIO: Health and Wellbeing

SUBJECT: Financial Recovery and Sustainability Plan

WARDS: Borough Wide

1.0 PURPOSE OF THE REPORT

To inform the Health and Wellbeing Board of the actions being undertaken by NHS Halton CCG to achieve financial recovery and sustainability.

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

3.0 SUPPORTING INFORMATION

3.1 Over the previous three financial years (2013/14, 2014/15 and 2015/16) NHS Halton CCG had managed to deliver with the business rules set for the organisation by NHS England. The achievement of these business rules, which include a statutory requirement to deliver a balance year end budget and a 1% surplus, was challenging but the scale of this challenge for the next five years is immense. To deliver financial recovery and sustainability will involve some difficult and potentially contentious decisions about what services NHS Halton CCG chooses to commission or decommission and what partnerships and activities we invest in and disinvest in.

3.2 Table 1 shows NHS Halton CCG's allocations and projected expenditure through to 2020/21. This shows that the core allocation, including delegated co-commissioning of general medical services, will increase over the next five years. However, this increase does not keep pace with the costs of commissioning services over the same period of time and the requirement to continue to deliver a 1% surplus. These initial figures suggest that, over the next five years, NHS Halton CCG will need to find a cumulative total of £55.6m in savings.

	Notified 2016/17	2017/18	2018/19	2019/20	2020/21
Total Allocation	213,662	217,961	222,215	226,861	235,018
Total Costs	219,933	223,578	228,583	233,644	238,761
QIPP Requirements	(8,408)	(11,680)	(12,506)	(12,997)	(10,071)
Surplus/Deficit	2,136	2,180	2,222	2,269	2,350

Table 1: NHS Halton CCG projected allocations and expenditure

3.3 On 7th April 2016 the Governing Body of NHS Halton CCG agreed an annual budget for 2016/17 that included the achievement of £8.4m cost savings in year. The Governing Body also agreed, based on the above forecasts, that a Financial Recovery and Sustainability Plan was required by July 2016 to deliver recurrent savings over the next five years to deliver more efficient and effective health and care services.

3.4 NHS Halton CCG's Financial Recovery and Sustainability Plan will explore four areas of action:

- improving health care
- improving value for money
- reducing costs by reviewing existing services
- considering more difficult decisions

Focus will be placed on:

- reducing planned (elective) and unplanned (non-elective) activity in secondary care settings whether new or follow up, by using and, where necessary, developing integrated community service provision, including general practice, to manage demand for secondary care services.
- continuing to invest in preventative services that deliver high returns for low investment.
- focusing resources and targeting those people who use secondary care services most frequently to reduce their dependency on these services.
- utilising contract management to reduce spend in secondary care settings around coding, high cost tariffs, consultant to consultant referrals and procedures of low clinical priority.
- full review of all commissioned services and each budget line against the triple aim principles (better care, better outcomes and value for money) – which may result in some services being decommissioned or disinvested in.

- full review of all clinical commissioning policies and guidance to ensure implementation in practice, this will include joining with other CCGs to look again at the Procedures of Lower Clinical Priority Policy and explore prior approval processes – which may lead to further restrictions on the treatments and interventions that the NHS can support.
- internal budgetary management and efficiencies.

3.5 NHS Halton CCG has always sought to work in partnership with local people and the organisations that serve those people. It is our intention that the development and implementation of our Financial Recovery and Sustainability Plan will be taken forward openly, transparently and honestly. On 2nd June 2016 the Governing Body agreed to some core principles and a process for decision making on cost improvement identification to contribute to financial sustainability. The supporting document can be found in the NHS Halton CCG Governing Body papers which are available at http://www.haltonccg.nhs.uk/about/governing-body-meetings. The process that has been agreed will ensure that the impact of any commissioning decisions, whether about investment or disinvestment, takes into account quality and equality issues and are taken forward following engagement with interested parties.

4.0 POLICY IMPLICATIONS

NHS Halton CCG remains committed to delivery of the 'must do' objectives and targets set out in *Five Year Forward View* and the associated guidance. All the activity of the organisation will therefore be focused on delivery of the service transformation required to deliver these 'must do' areas and deliver financial recovery and sustainability.

5.0 OTHER IMPLICATIONS

By producing a Financial Recovery and Sustainability and Recovery Plan and reporting a £8.4m cost improvement plan for 2016/17 it is likely that NHS England will place NHS Halton CCG under additional scrutiny. This may include bring in an external consultancy/turnaround agency.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children and Young People in Halton

None as a result of this report, although the Financial Recovery and Sustainability Plan will look at all commissioned services and partnerships including those involving children and young people.

6.2 Employment, Learning and Skills in Halton

None as a result of this report.

6.3 A Healthy Halton

The Financial Recovery and Sustainability Plan will potentially impact on all commissioned services, expenditure and partnerships that NHS Halton CCG is currently committed to.

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

Risks will be managed within the governance framework of NHS Halton CCG.

8.0 EQUALITY AND DIVERSITY ISSUES

These are taken into account as part of the Financial Recovery and Sustainability Plan and the processes that will be put in place for its development and implementation. NHS Halton CCG will ensure that it is compliant with the statutory duties of the Equality Act 2010.

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

Not applicable.

REPORT TO: Health and Wellbeing Board

DATE: 6th July 2016

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health

SUBJECT: Public Health Annual Report: Assessing Needs and Taking Action

WARD(S) Borough wide

1.0 PURPOSE OF THE REPORT

1.1 The purpose of this report is to provide some background information for the presentation on the Public Health Annual Report. (PHAR).

2.0 RECOMMENDED: That the Board note the contents of the report and supports the recommendations.

3.0 SUPPORTING INFORMATION

3.1 Since 1988 Directors of Public Health (DPH) have been tasked with preparing annual reports - an independent assessment of the health of local populations. The annual report is the DPH's professional statement about the health of local communities, based on sound epidemiological evidence, and interpreted objectively.

3.2 The annual report is an important vehicle by which a DPH can identify key issues, flag problems, report progress and, thereby, serve their local populations. It will also be a key resource to inform local inter-agency action. The annual report remains a key means by which the DPH is accountable to the population they serve.

3.3 For 2015-16 the Public Health Annual Report focusses on the work of the Public Health Evidence and Intelligence Team. This topic has been chosen to highlight some strategic pieces of work, their key findings and how they have been used or will be used by Halton Borough Council and its partner organisations.

3.4 The report uses a life-course approach around the following chapters:

- Starting Well
- Living Well

- Ageing Well

3.5 Each chapter covers the following areas:

- Summary of piece of work
- Why and how it was done
- How the work has been or will be used

3.6 The pieces of work highlighted in the report are:

- Children's Joint Strategic Needs Assessment (JSNA)
- GP JSNA
- JSNA on Long Term Conditions
- Older People's JSNA

3.7 The Public Health Annual Report 2015-16 will be available in July 2016 in hard copy and online at www.halton.gov.uk/PHAR.

4.0 POLICY IMPLICATIONS

4.1 The Public Health Annual Report should be used to inform commissioning plans and collaborative action for the NHS, Social Care, Public Health and other key partners as appropriate.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 None identified at this time.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

Improving the Health and Wellbeing of Children and Young People is a priority in Halton. The PHAR will highlight the Children's JSNA, which is a key piece of work for commissioners.

6.2 Employment, Learning & Skills in Halton

The above priority is a key determinant of health. Therefore improving outcomes in this area will have an impact on improving the health of Halton residents

6.3 A Healthy Halton

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

6.4 **A Safer Halton**

Reducing the incidence of crime, improving Community Safety and reducing the fear of crime have an impact on health outcomes particularly on mental health.

There are also close links between partnerships on areas such as alcohol and domestic violence.

6.5 **Halton's Urban Renewal**

The environment in which we live and the physical infrastructure of our communities has a direct impact on our health and wellbeing.

7.0 RISK ANALYSIS

7.1 There is no risk associated with the publication of the Public Health Annual Report.

8.0 EQUALITY AND DIVERSITY ISSUES

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

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

None

Report Prepared by: Katherine Woodcock, Public Health
Contact: 0151 511 6851 katherine.woodcock@halton.gov.uk

REPORT TO: Health & Wellbeing Board

DATE: 6th July 2016

REPORTING OFFICER: Director Adult Social Services

PORTFOLIO: Health and Wellbeing

SUBJECT: Better Care Fund 2016/17

WARD(S): Borough-wide

1.0 **PURPOSE OF REPORT**

1.1 To inform the Health and Wellbeing Board of the submission of the Better Care Fund 2016/17

2.0 **RECOMMENDATION: That the content of the report and associated documents be noted.**

3.0 **SUPPORTING INFORMATION**

3.1 The Better Care Fund for 2016/17 is a continuation of the fund from 2015/16. The Department of Health and NHS England in partnership with the Local Government Association and the Association of Directors of Adult Social Services were keen to see progress in the 2016/17 submission of the various schemes and system changes that would support the key metrics

3.2 For 206/17 additional metrics have been developed in relation to the management of Delayed Transfers of Care (DToC), integration of IT systems and the development of case coordination and care planning.

The success of the Halton implementation and achievement of the key performance indicators in 2015/16 has enabled us to develop further on community initiatives that bring care and support closer to people's homes and family context.

This aligns to the Sustainability and Transformation Planning required of NHS Halton CCG and the locality where key risk management and sharing across the system is planned for.

The achievement of the Non-elective Admission performance target has removed the requirement to have a 'pay for performance' component in Halton and we have used this to support a contingency fund that will support fluctuations in demand and capacity.

Much of the 2016/17 submission remains a continuation of the

successful approach in 2015/16 and intial feedback suggests that Halton will be approved unconditionally. This will be confirmed by 30th June 2016.

There has been a slight increase to the CCG minimum contribution of £40,000.00 and the whole of adult social care Disabled Facilities Grant and the capital allocation is now included in the Better Care Fund.

A renewed Joint Working Agreement between Halton Borough Council and NHS Halton CCG is in place for a further 3 years and therefore the Better Care Fund forms part of this wider pool. This is attached for information

4.0 **POLICY IMPLICATIONS**

4.1 None identified at this stage

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 The Better Care Fund sits within the wider pooled budget arrangement and the financial context of the local health and social care environment. The pooling of resources and integrating processes and approach to the management of people with health and social care needs will support effective resource utilisation.

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

6.1 **A Healthy Halton**

Developing integration further between Halton Borough Council and the NHS Halton Clinical Commissioning Group will have a direct impact on improving the health of people living in Halton. The plan that is developed is linked to the priorities identified for the borough by the Health and Well Being Board.

7.0 **RISK ANALYSIS**

7.1 Management of risks associated with service redesign and project implementation are through the governance structures outlined within the Joint Working Agreement.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 None identified at this stage

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

None within the meaning of the Act.

Better Care Fund Plan 2016/17

Local Authority	**HALTON BOROUGH COUNCIL (HBC)**
Clinical Commissioning Groups	**NHS HALTON Clinical Commissioning Group (CCG)**
Boundary Differences	**Co-terminus**
Date agreed at Health and Well-Being Board:	**29th April 2016**
Date submitted:	**29th April 2016**
Minimum required value of BCF pooled budget: 2016/17	**£10,868,899**
Total agreed value of pooled budget: 2016/17	**£10,868,899**

Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	
By	Simon Banks
Position	Chief Officer
Date	29/04/16

Signed on behalf of the Council	
By	David Parr
Position	Chief Executive
Date	29/04/16

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Rob Polhill
Date	29/04/16

Table of Contents

1.0 Introduction

Halton's Better Care Fund (BCF) in 2016/17 builds on the work undertaken by the fund in 2015 and develops further some key areas to enable people to access services they need more quickly and closer to their own home. The BCF focuses resources on a wide range of integrated, complex and responsive services either fully funding services or contributing additional resources to increase capacity. This approach supported the achievement of key targets in the last BCF. In addition the BCF supports maintaining the eligibility criteria for social care. Some areas funded in the last iteration of the Plan were either specific to that period and no longer require funding or were supported by funding sources from other parts of the system. The BCF is integrated with the local Sustainability and Transformation Plan (STP) and therefore much of the narrative in this document is congruent with the STP.

1.1 Our Vision

NHS Halton Clinical Commissioning Group (CCG), Halton Borough Council (HBC) and Public Health are driven by a burning ambition to make Halton a healthier place to live and work. We are committed to ensuring that local people get the right care and support at the right time and in the right place. We will continue to uphold the rights of people under the NHS Constitution, appropriate legislation e.g. Care Act 2014 etc. and positively push the boundaries of quality standards and patient experience.

Our vision is **'to involve everyone in improving the health and wellbeing of the people of Halton'**.

1.2 Our Purpose

Our purpose is to improve the health and wellbeing of the population of Halton by empowering and supporting local people from the start to the end of their lives by preventing ill-health, promoting self-care and independence, arranging local, community-based support whenever possible and ensuring high-quality hospital services for those who need them.

We want to support people to stay well in their homes, in particular to avoid crises of care that can result in hospital admission. General practices will support and empower individuals and communities by promoting prevention, self-care, independence and resilience.

We will work with local people and with partner organisations including healthcare providers and the voluntary sector. This will ensure that the people of Halton experience smooth, co-ordinated, integrated and high-quality services to improve their health and wellbeing.

1.3 Our Values

The key values and behaviours at the heart of our work are:

Partnership: We will work collaboratively with our practices, local people, communities and with other organisations with whom we share a common purpose.

Openness: We will undertake to deliver all business within the public domain unless there is a legitimate reason for us not to do so.

Caring: We will place local people, patients, carers and their families at the heart of everything we do.

Honesty: We will be clear in what we are able to do and what we are not able to do.

Leadership: We will be role models and champions for health and wellbeing in the local community.

Quality: We will commission the services we ourselves would want to access.

Transformation: We will work to deliver improvement and real change in care.

1.4 One Halton – Five Areas of Focus

One Halton is about working better together to improve the care and wellbeing of the people of Halton.

It requires a change in the mind-set and the involvement of everybody; the public, volunteers, carers, practices, social workers, care homes, hospitals and other providers.

There is already a lot of good work that is going on in Halton and improvements are being made. ***One Halton*** will involve more people, bringing a boarder perspective and a more integrated approach resulting in efficient, smooth and effective care.

Our aim is to achieve a happier and healthier population and a happier and healthier workforce.

Our goal is to create a health and social care system that:

- works around each individual's needs;
- supports people to stay well; and
- provides the very best in care, now and for the future.

Therefore, the objectives that have been developed for One Halton are:

1) To work better together regardless of discipline;
2) To find or identify those 'hidden' people who don't access care;
3) To treat and care for people at the right time, in the right place by the right people;
4) To help people stay healthy and keep generally well; and
5) To provide the very best in care, now and in the future.

The seven priority areas previously agreed by the Health and Well Being Board have been consolidated into five areas of focus:

1) Families and children;
2) The generally healthy;
3) People with mental health conditions;
4) People with Long Term Conditions (LTCs); and
5) Older people.

Each intention by the CCG, Local Authority or Public Health will be evaluated on the impact against these five areas of focus as well as the triple aim in the NHS Five Year Forward View and the nine national must dos in 'delivering the forward view'

1.5 Delivering the Forward View – Nine national 'must dos'[1]

Whilst developing long term plans for 2020/21, the NHS has developed a clear set of plans and priorities for 2016/17. These will be addressed in more detail in the 2016/17 operational plan section, however Halton must demonstrate how each of the following are being addressed:

1. Develop a high quality and agreed **STP**, and subsequently achieve what you determine are your most locally critical milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the **Forward View**.

2. Return the system to **aggregate financial balance**. This includes secondary care providers delivering efficiency savings through actively engaging with the Lord Carter provider productivity work programme and complying with the maximum total agency spend and hourly rates set out by NHS Improvement. CCGs will additionally be expected to deliver savings by tackling unwarranted variation in demand through implementing the RightCare programme in every locality.

3. Develop and implement a local plan to address the **sustainability and quality of general practice**, including workforce and workload issues.

4. Get back on track with **access standards for A&E and ambulance waits**, ensuring more than 95 percent of patients wait no more than four hours in A&E, and that all ambulance trusts respond to 75 percent of Category A calls within eight minutes; including through making progress in implementing the urgent and emergency care review and associated ambulance standard pilots.

5. Improvement against and maintenance of the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from **referral to treatment**, including offering patient choice.

[1] https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf

6. Deliver the NHS Constitution **62 day cancer waiting standard**, including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and make progress in improving **one-year survival rates** by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.

7. Achieve and maintain the **two new mental health access standards**: more than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral; 75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks. Continue to meet a **dementia diagnosis** rate of at least two-thirds of the estimated number of people with dementia.

8. Deliver actions set out in local plans to transform care for people with **learning disabilities**, including implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy.

9. Develop and implement an affordable plan to make **improvements in quality** particularly for organisations in special measures. In addition, providers are required to participate in the annual publication of **avoidable mortality** rates by individual trusts.

1.6 Five Year Forward View: Delivering the Triple Aim

Some fundamental challenges face the health and social care system.

Long term health conditions, rather than illnesses susceptible to a one off cure, now take up 70% of the health budget. Technology is transforming the ability to predict, diagnose and treat disease, new treatments are being made available and care can be delivered and organised differently, Local Authority and Public Health funding are facing real cuts and health service funding is unlikely to return to the 6%-7% real annual increases seen in the first decade of this century.

It is not sustainable to rely on short term schemes to preserve services and standards and more long term sustainable transformations are required to address three key gaps:

1) Health and wellbeing gap;
2) Care and quality gap; and
3) Funding and efficiency gap

Halton's sustainable and transformative approach to these three areas is at a local level and as part of the wider Cheshire and Merseyside sustainability and transformation footprint.

Over the next five years, Halton has agreed some critical milestones to ensure that the triple aim is achieved.

2.0 An Evidence Base Supporting the Case for Change

2.1 Opportunities for Change

We want people to live longer, healthier and happier lives. We are acutely aware that we are working within scarce resources. It is a well-known fact that over the next five years NHS Halton CCG, HBC, Public Health and our partners face significant financial challenges. These financial challenges are driving us to do things differently and transform all aspects of health, social care and wellbeing in Halton over the next five years, beginning with an ambitious 5-year strategy and robust 1 year operational delivery plan.

Halton continuously analyses a wide range of data and evidence to identify where opportunities exist for the health and social care economy to change the configuration and delivery of services to provide better outcomes and value for money whilst ensuring that acute services only need to be used by people in acute need. Most of this analysis is available in the Joint Strategic Needs Assessment (JSNA) but additional sources of information are also used such as Right Care's Commissioning for value pack[2], local insight through patient engagement and local analysis of trend data.

The analysis highlighted that both A&E attendances and hospital admissions for certain conditions, most notably respiratory, were significant areas where opportunities for change existed. Opportunities also existed in improving cancer outcomes especially with regard to screening and length of time to start treatment. Other areas highlighted included prevention work around obesity, childhood accidents, health checks and child development. The use of hospital services by frail older people is also identified as a key opportunity in both providing alternative pathways of care and reducing length of stay where admission occurs.

By redesigning primary care access we aim to enable 7 day GP access same day appointments. By integrating Acute and Community services we aim to align clinical pathways enabling a seamless approach to patient care. Focusing on the vulnerable through Multi-Disciplinary Teams (MDT) will allow for significant efficiencies. The BCF will play a key role in these areas

Evidence gathered from our residents and acute hospitals indicated that 23% of the A&E attendances did not warrant acute care and that almost half of patients required no medical care. In 2016/17 we plan to expand the services available in our Urgent Care Centres in Widnes and Runcorn to provide real alternatives to A&E. Utilising GP and Consultant oversight will offer a central location for 7 day GP access, speedy diagnostics and a 'one stop' approach to minor illness and injury. Funding from the BCF will support this further development.

[2] http://www.rightcare.nhs.uk/index.php/commissioning-for-value/

Building on these innovative solutions and experiences, the people of Halton will experience a fully integrated system that puts people at the heart of decision making about their care.

NHS Halton CCG and Public Health will work together to develop pro-active prevention, health promotion and identifying people at risk early, when physical and / or mental health issues become evident, will be at the core of all our developments, with the outcome of a measurable improvement in our population's general health and wellbeing.

The Local Authority and the CCG will work together to develop services centred around care homes, including medication and dementia screening and strengthen clinical nursing support for residents and staff alike. An additional allocation of resources from the BCF in 2016/17 will enable this work to continue.

Choice, partnership and control will continue to be developed based on integrated approaches to needs assessment. Bringing care out of acute settings and closer to home will be an essential part of providing health and social care over the next five years. The BCF will support the developing Rapid Clinical Assessment Team, with consultant oversight and utilising the diagnostic capacity at the Urgent Care Centres.

The 5-year sustainability and transformation plan is totally aligned with the BCF and has been developed in collaboration with the Local Authority, Public Health, providers and the public.

As outlined earlier this integrated approach as part of One Halton has identified 5 priority areas where the opportunities are greatest to transform our healthcare delivery, these are;

- Mental health needs – including learning disabilities
- Older People – particularly the over 75's and falls
- People with long term conditions – such as cancer, CVD, stroke
- Women and Children – including troubled families, maternities and neonates
- Generally well – including prevention and wellbeing

By working together as a single system, Halton will achieve both the triple aim and the nine national must do's alongside addressing the local needs of the local community.

2.2 The nine 'must dos' for 2016/17 for every local system:

As outlined earlier (see Section 1.5) the NHS has developed a clear set of plans and priorities for 2016/17. Detailed below are how the Halton health economy is addressing the nine national "must do's":

a) Develop a high quality and agreed STP, and agree critical milestones

There is a requirement for local health and care system to come together to create its own ambitious local blueprint for implanting the forward view. NHS Halton CCG through One Halton has defined several footprints for health and care dependent upon the level of

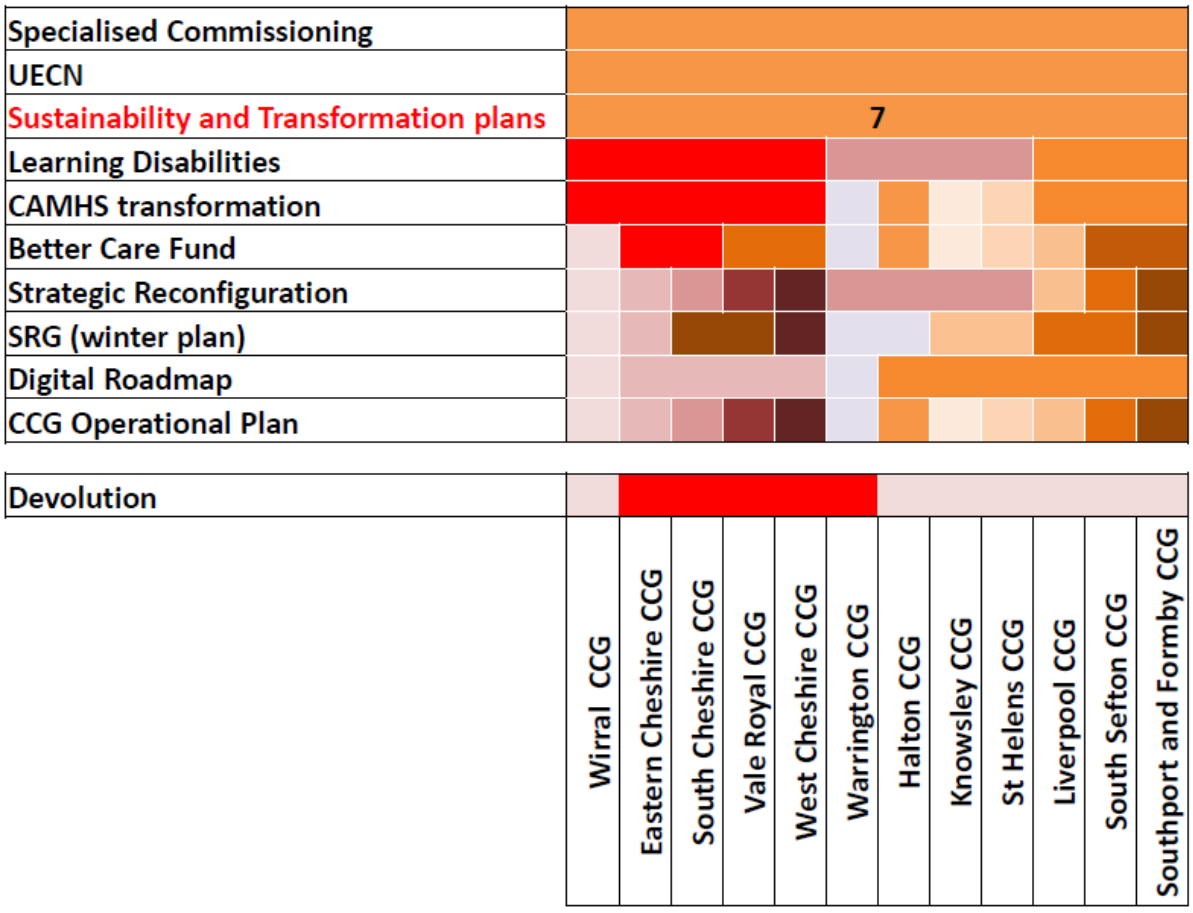
delivery required, this may involve care being delivered out of individual practices, at a town level, for example through the urgent care centres in Widnes and Runcorn, at a Borough level, or with partners outside of the borough including neighbouring local authorities and CCGs. For the five year sustainability and transformation plan NHS Halton CCG has agreed that the Cheshire & Merseyside footprint forms a natural geography where services can be delivered at scale. Halton will still retain its own commissioning intentions and local STP plan and these will form part of the wider Cheshire & Merseyside sustainability and transformation plan.

The regions signed up to the Cheshire and Merseyside STP are:

- NHS Eastern Cheshire CCG, NHS Halton CCG, NHS Knowsley CCG, NHS Liverpool CCG, NHS South Cheshire CCG, NHS South Sefton CCG, NHS St Helens CCG, NHS Southport and Formby CCG, NHS Vale Royal CCG, NHS Warrington CCG, NHS West Cheshire CCG and NHS Wirral CCG

NHS Halton CCG is also party to other strategic plans across the Cheshire and Merseyside region, often covering slightly different footprints. Figure 1 below shows how NHS Halton CCG fits with the wider planning footprints across Cheshire and Merseyside.

Figure 1: Cheshire & Merseyside Planning Footprints



Halton has developed its operational plan which is a shared plan across NHS Halton CCG, HBC and Public Health, and a Halton five year plan which will be the basis of Halton's delivery of the wider Cheshire & Merseyside Sustainability and Transformation Plan.

b) Returning the system to aggregate financial balance

b1) Financial Forecast

The close working relationship between HBC and NHS Halton CCG is exemplified by posts jointly funded and an existing pooled budget arrangement of in excess of £41 million with a BCF component of £10.3 million. It is expected that this total pool may increase to around £43 million for 2016/17. This will support the protection of social care services as well as realise efficiencies in the integrated commissioning and contracting of services.

The CCG has seen significant pressures in 2015/16 with regards to expenditure at St Helens & Knowsley Teaching Hospitals NHS Trust (STH&K). In 2015/16 the CCG has managed this over performance by offsetting against underperformance at other acute trusts as well as bringing this activity more in line with the plan. Additional CCG pressures are within prescribing; work is on-going by the medicines management team to bring this back in line. The Continuing Healthcare pool with the Local Council is working well and is forecast to achieve a balanced year end position. Mental health placements remain an issue for the CCG particularly Out of Area placements. Work is on-going to bring this into a prime vendor model in 2016/17 and it is envisaged that this will bring the expenditure back in line. The BCF will provide some of the financial resources to support the development of services for people with mental health issues.

Investments have been made in primary care with GPs being given £5 per head of population. This was a non-recurrent allocation, however primary care leads have assessed the need for this to continue - and it is likely that this will become recurrent as the proposal is to set up locality "hubs", sharing good practice. This will aid the reduction in Non-elective admissions and A&E attendances and help the achievement of significant QIPP target. This is supported by the ongoing development of the MDT model wrapped around primary care with resources from the BCF.

The 2016/17 CCG plan to mitigate the over performance at StH&K going forward includes the purchase of both outturn and growth (taking into account the impact of the new Widnes Urgent Care Centre). The CCG's main investment during 2014/15 and 2015/16 was into two new Urgent Care Centres with allocation from the BCF. The Runcorn Urgent Care Centre opened earlier in 2015/16 and we have seen the impact of this with reductions to Non elective admissions, A&E attendances and direct access radiology at Warrington and Halton Hospitals NHS Foundation Trust. The Widnes Urgent Care Centre opened later in the year and therefore the full effect has not yet materialised within the data received for StH&K

hospitals. However, it is forecast that the impact will materialise and this has therefore been reflected in early contract negotiations.

The 2016/17 Prescribing budget will purchase 2015/16 outturn plus 1% inflation. The addition of pharmacy support to care homes through the BCF will support the management of the prescribing budget through regular reviews.

b2) Tackling unwarranted variation

Halton have analysed the commissioning for value pack produced by RightCare which allows CCG's to identify where unwarranted variation may lie. The NHS Halton CCG's performance is compared to that of the 10 most similar CCGs and highlights where variation exists, the statistical relevance of that variation and the potential costs, (both financial and non-financial) associated with that variation. The full pack is available on the website: https://www.england.nhs.uk/wp-content/uploads/2016/01/halton-ccg-16.pdf

b3) Develop and implement a local plan to address the sustainability and quality of General Practice

Halton has developed the "Strategy for General Practice services in Halton - Creating sustainable out of hospital care for the people of Halton"[3]

This Strategy recognises the challenges General Practice services face but also seeks to address them within Halton by building upon the foundations of good work that are already in place.

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

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

The emerging themes and care model from the General Practice Strategy have led to a broader borough-wide partnership approach called One Halton (see Section 1.4). This

[3] Strategy for General Practice services in Halton - Creating sustainable out of hospital care for the people of Halton 2014/15 – 2019/20

embraces the MCP approach and provides a greater focus on the wider Out of Hospital approach across Halton.

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

Data sourced from the Health and Social Care Information Centre[4] demonstrates that as of 30th September 2013, Halton had the following number of GPs (Full time equivalents - excluding Registrars and Retainers):

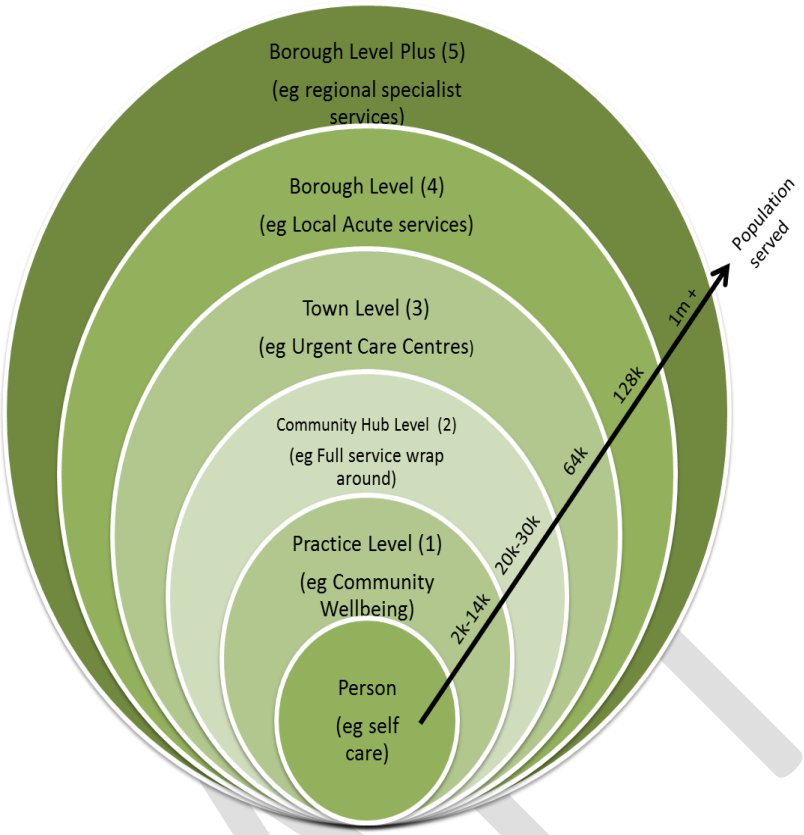
<30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	Total
2	9	9	9	10	8	12	5	1	66

This demonstrates that 27.1% of current practitioners in Halton are 55 and over.
Furthermore, according to the Seventh National GP Work life Survey[5], an increasing number of GPs (nationally) are considering their 'Intention to Quit' within the next five years.

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

Our future model of care will be established with services being centred around people in the community.

[4] Health and Social Care Information Centre (2014) [Online]. Available: http://www.hscic.gov.uk/workforce
[5] Institute of Population Health (August 2013), Seventh National GP Worklife Survey. Available: http://www.population-health.manchester.ac.uk/healtheconomics/research/FinalReportofthe7thNationalGPWorklifeSurvey.pdf



b4) Get back on track with access standards for A&E and ambulance waits

i) 95% - 4 hours wait;
ii) 75% - Category A Ambulance calls in 8 minutes;
iii) Making progress in implementing the Urgent & Emergency Care Review ; and
iv) Ambulance standard pilots

Work streams in the BCF in relation to Urgent Care, Frailty Pathway, Hospital Discharge and Intermediate Care supports this agenda.

b5) Referral to Treatment Times

Improvement against and maintenance of 92% patients on non-emergency pathways wait no more than 18 weeks, including offering patient choice.

Halton patients are consistently treated within the 18 week referral to treatment standard, however it has been observed in recent months that the level of performance has begun to drop) from very high levels of historical performance. The current model suggests that the national standard will continue to be met throughout 2016/17, however this is monitored closely and reported at the monthly System Resilience Group. Any underperformance will be reported immediately and Trusts will be expected to deliver an action plan to bring performance back to standard.

b6) Deliver 62 day cancer waiting standard

i) Securing adequate diagnostic capacity;
ii) Deliver 2 week wait standard;
iii) Deliver 31 day cancer standard;
iv) Progress in improving one-year survival rates;
v) Year on year improvement in cancers diagnosed at stage one & two; and
vi) Reducing the proportion of cancers diagnosed following an emergency admission

b7) Achieve & maintain two new mental health access standards

i) 50% of people experiencing 1st episode of psychosis commence treatment in two weeks;
ii) 75% of people with common mental health conditions referred to Improving Access to Psychological Therapies (IAPT) treated in 6 weeks;
iii) 95% of people referred to IAPT treated in 18 weeks; and
iv) continue to meet dementia diagnosis rate of at least 66.7%

In order to achieve and maintain the standards above the CCG have taken the following actions:

- Working with the provider to understand capacity/skill set required and internal data collection systems to facilitate access to the First Episode of Psychosis Service within the time frame. The CCG and have committed investment to increase capacity within the service to help meet additional demand.
- Additional investment on both a non-recurrent and recurrent basis has been invested in the IAPT service to meet the access targets. The provider has also invested in a bespoke IT system to ensure accurate and timely data collection to ensure that the service is delivering efficiently and individual staff members can be monitored for their performance. The additional capacity will increase through put of the service to meet the target regarding treatment completed within 18 weeks.
- In order to sustain and increase the dementia diagnosis rate the CCG is working closely with primary care and local nursing homes to identify those residents who have dementia but have not had a formal diagnosis or READ code added to their GP record. The Care Home Liaison service is supporting identification and diagnosis of residents with dementia.

b8) Local plans for people with learning disabilities

i) Implementing enhanced community provision;
ii) Reducing inpatient capacity; and
iii) Rolling out care & treatment reviews.

As part of the Mid Mersey Hub, Halton, St Helens, Knowsley and Warrington localities are working with the Cheshire and Mersey strategic network and have submitted a high level plan and a more detailed submission in line with the national timetable. The localities are

currently working to identify areas of focus which may include transition and supported housing.

Halton has already worked with 5Boroughs Partnership (5BP) and reduced the number of secure inpatient beds to just 8 covering the whole of the 5BP footprint. Following a review of cases with specialised commissioning there are no Halton patients in inpatient beds who are appropriate for step down into low secure or step down beds. Halton has just 4 patients funded through specialised commissioning in this way.

As part of the plan there is a mapping exercise to the current population in the JSNA to determine likely future provision, the CCG and Local Authority are working together to develop personalised supported accommodation as opposed to group homes. Halton is also working on developing post diagnosis support for people with autism.

b9) Improvements in quality, avoidable mortality

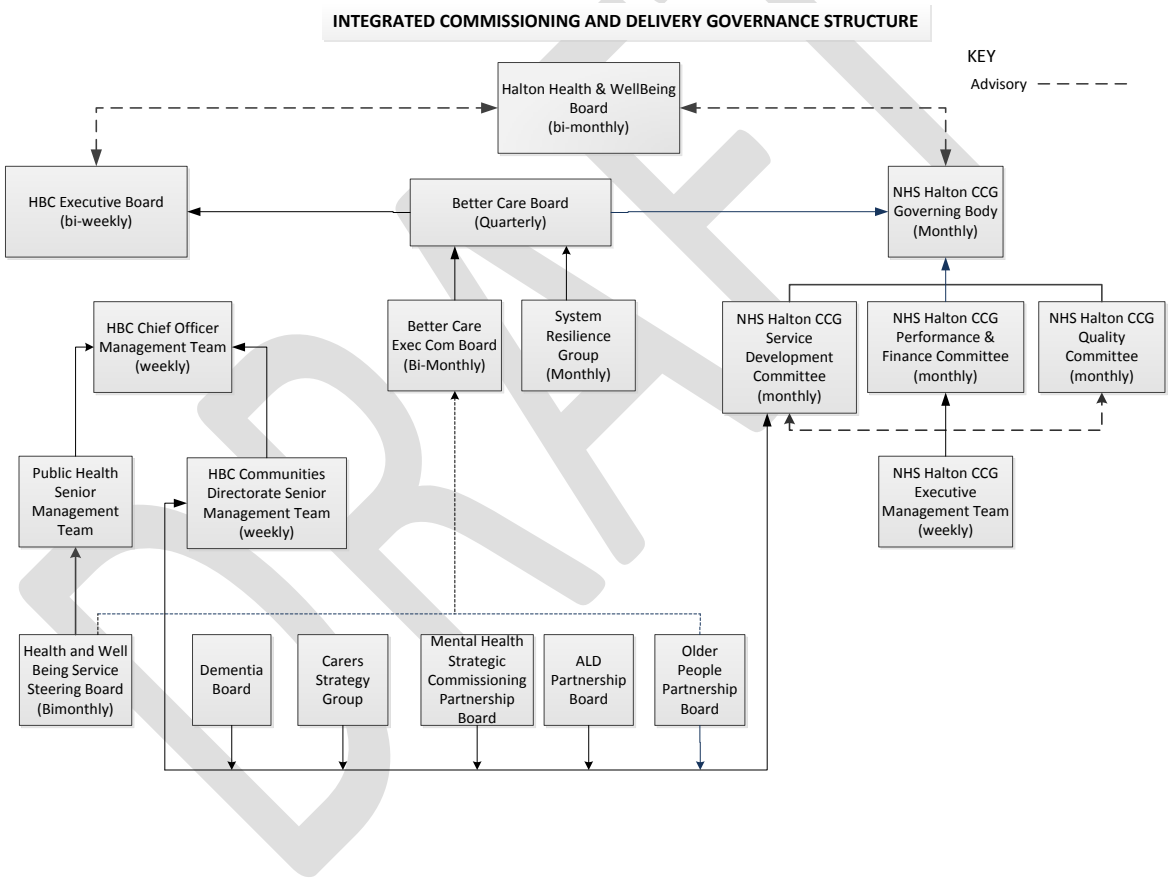
i) Develop & implement affordable plan to make improvements in quality; and
ii) Ensure annual publication of avoidable mortality rates by individual trusts

3.0 A Co-ordinated and Integrated Plan of Action for Delivering the BCF

The performance management and governance arrangements set up for the 2015 pool will continue for 2016/17. The governance structure is detailed below.

The overarching performance framework with the BCF metrics included within is attached here:

BCB Q3 template.xlsx



BCF Delivery Plan

SCHEME NUMBER	SCHEME NAME	Actions to be undertaken	Timescales	Lead(s)
1	Urgent Care	Continuation of Urgent Care Centres and expansion of clinical and social pathways Implement RCAT model and evaluate impact to inform future development	Ongoing Implement April 2016 Evaluate Nov 2016	Dr Neil Martin Damian Nolan
2	Intermediate Care	Monitoring and review of existing capacity and demand to consider redesign of pathways and resource base	Ongoing	Louise Wilson Damian Nolan
3	Telecare	Continue existing service with view to combining with telehealth developments	Ongoing	Helen Moir
4	Carers	Ongoing provision of Carers Centres	Ongoing	Steve Eastwood
5	Falls Prevention	Review of existing investment in primary and secondary prevention	Nov 2016	Lisa Taylor Mark Holt
6	Dementia	Evaluation of Admiral Nurse scheme	Dec 2016	Faye Gilston
7	Integrated Hospital Discharge	Continue with 7 Day working	N/A	Damian Nolan
8	Care at the End of Life	Continue with service	N/A	Kate Roberts
9	Integrated Social Care and Health	Continue MDT cluster model development	Ongoing	John Patton
10	Integrated Mental Health	Continue Outreach service	Ongoing	Lindsay Smith
11	PBSS	Continue Service	Ongoing	Paul McWade
12	LD Nurses and Therapy Services	Continue services	Ongoing	Damian Nolan

13	Integrated Services and Quality Assurance	Strengthen joint arrangements	Ongoing	Helen Moir
14	IT Strategy	Continue to deliver against priorities in particular intra-operability and shared records	Ongoing	Jonathan Greenough and Emma Alcock
15	Prevention	Continue implementation of strategy	Ongoing	Mark Holt
16	DFG and Equipment/Adaptations	Continue service provision	Ongoing	Helen Moir
17	Wellness Service	Continue service provision	Ongoing	Dave Sweeney
18	Frailty Pathway	Continue development of pathway and identify key areas for investment	Ongoing	Jan Snoddon and Sue Wallace-Bonner
19	Contingency Fund	Monitor activity across the pool to determine when additional investment is required to manage fluctuations in demand	Ongoing	Damian Nolan

4.0 A Clear Articulation of how the Plan will meet each National Condition

4.1 Signed off by H&WB and other CCG/LA committees

The plan will be signed off by the Health and Well Being Board leaders from across the Health and Social Care economy.

4.2 A Demonstration of how the area will maintain the provision of Social Care services in 2016/17

Resources in the BCF are allocated to maintain eligibility for social care services consistent with the joint approach to the provision of complex care services in the borough and agreements on the use of the former Section 256 and Reablement funding. Whilst the majority of this funding will be used for direct care provision in the community and in the care home sector and ensuring duties under the Care Act are maintained, funds will also be used to support the continuing integration of front line assessment and care / case management in the MDT approach.

Carers assessment and service provision features within the BCF through the integrated approach to the commissioning of Halton Carers Centre and access to a range of services that support carers to maintain their role.

The Disabled Facilities Grant allocation contained within the pool will be used flexibly to support infrastructure changes as well as traditional adaptations.

4.3 Confirmation of agreement on how plans will support progress on meeting 2020 standards for 7 day services, to prevent unnecessary non-elective admissions and support timely discharge

Additional capacity in the two Hospital Discharge teams will support 7 day access to assessment and care provision. This will be supplemented by an increase in the capacity of Intermediate Care to ensure that receiving services can meet identified need. Contractual arrangements already exist with domiciliary care and care home providers to accept weekend discharges and these will be strengthened through the integrated approach to the commissioning and contracting of complex care services.

The Urgent Care Centres provide 7 day access to medical care in the community and supplement both the existing GP out of hours contract and the extended access arrangements for Primary Care through the Prime Minister's Challenge allocation.

Work is ongoing with the acute sector and neighbouring CCG's and Local Authorities on the scope of 7 day service provision within hospitals. This is supported by the sustainability allocation to the acute trusts.

4.4 Better data sharing between Health and Social Care, based on the NHS number

System wide work is underway in relation to the joining up of IT systems to support the delivery of health and social care provision. This includes work with i-Mersey on ALP. Locally 79.4% of social care records now have the NHS number as the unique identifier with further work underway with the HSCIC to move to 100%. Plans are in place for the Urgent Care Centres to move within EMIS Web and form part of the primary care record whilst new schemes such as the Rapid Clinical Assessment Team in the community will have EMIS Web as it's IT platform.

The Council and Halton CCG are working together to develop a digital roadmap that integrates the Social Care and Health Records so that the patient is put at the heart of Social Care. The new iCart service for Children's Multi-Disciplinary Teams in surgeries as well as the Front Door service for Adults are all examples of partner based services in place or being planned that bring together key practitioners from key organisations to deliver a joined up approach.

In terms of using the NHS Number and enhancing Data Sharing, the Council already has 79% of live cases where the NHS Number is recorded, and the remaining 20% and new clients will need to be addressed. This is an essential requirement for integration of Local Authority and Health records, as it will provide a common patient reference.

Firstly, the CCG and Council are working together to align Information Sharing Protocols and Operational Support processes to ensure a high level of Change Control and Information Governance exists across the two organisations. It is important that these agreements and standards are in place to ensure ongoing compliance with IGSoC and the Councils Code of Connection for PSN. The expected deadline for the agreed standards to be in place is May 2016.

From a technical perspective, a prototype proof of concept has proved that connectivity between Health organisations and the Local Authority is achievable. Now the concept has been proven, before any further progress can be made, the Information Governance and change control outlined above must be in place. This connection will be used to pass secure information between the Health Community of Interest Network and the Councils secure Corporate Network. It is expected that this connection will be used to provide access to the Council and Health economy to local systems that are not hosted on N3 to facilitate closer integration.

The Council currently uses the PSN/N3 Interconnect to access N3 resources. Over time, this has proved to be a challenge for the Council to be able to gain access to the N3 resources that are necessary, so the Council is in the process of securing a dedicated N3 connection, using the St Helens and Knowsley Health Informatics service as the Registration Authority and the CCG as sponsor. It is expected that this will be live by June 2016. The dedicated link

will allow the Council to gain access to EMIS (used by the CCG) as well as CP-IS and NHS number matching.

The CCG and the Council are also looking into a shared approach to provide access to Health Professionals as well as Social Care staff to a single view of the Patient record. Some solutions have been explored, and the Council and CCG are working with the St Helens and Knowsley Health Informatics Service to develop a strategic, sustainable solution that can work now across the Halton footprint, whilst also being capable of integrating with other health footprints across the sub-region.

By proving access to the relevant information for Health and Social Care professionals, delayed discharge and extended working will be facilitated due to a reduction in the reliance on 9-5 working for administrative staff as well as paper based communication methods.

4.5 A joint approach to assessments and care planning, ensuring that where funding is used for integrated packages of care there will be an accountable professional

The work within the MDT approach is using a range of tools to identify people that would benefit from a case / care management approach to the management of their health and social care needs. This will further integrate the existing arrangements in place for the allocation of named professionals for people in receipt of health or social care funded services and incorporates a proactive approach to promoting self-care and management. The development of Halton's Frailty pathway incorporates and builds on this approach for older people. The work on Care and Treatment Reviews and the review of adult mental health pathways also support a pro-active and planned approach to the assessment and collaborative management of adults with complex needs. Resources allocated through the BCF support these programmes of work.


Joint care plan June 2016.pptx


Named Care Coordinator June 201

4.6 Agreement on the consequential impact of changes on the providers that are predicted to be substantially affected by the plans

Please refer to Halton's ***Sustainability and Transformation Plan*** – section on consequential impact of changes on the providers. These have been agreed with the 2 acute trusts Halton patients access through the contractual route. This includes agreement on the NEL target.

4.7 Agreement to invest in NHS commissioned out of hospital services, or retained pending release, as part of the local risk sharing agreement

The financial resource allocation identifies the key NHS commissioned out of hospital service areas. These include Intermediate Care, Mental Health, Integrated teams in the community and hospitals and the provision of end of life care.

The BCF has built in a capacity contingency fund of £518k to manage increases in demand during 2016/17 across the key outcomes for the Fund. This is in lieu of a pay for performance fund which does not feature in Halton's 2016/17 BCF plan. The contingency figure of £518,000 is for potential increases in demand across key service areas. This can only be spent through reports to the Executive Commissioning Board detailing the issues and proposed solutions. However, it is expected that other avenues should be explored in the first instance, e.g. redesign. The contingency fund now appears in the Delivery Plan.

4.8 Agreement on a local action plan to reduce delayed transfers of care (DTOC) and improve patient flow

Halton achieved the BCF DToC target in 2015. The ongoing analysis of the data and the operational work within the two acute trusts demonstrates that the key reasons for DToC's continue to be in relation to patient choice in respect of placement into long term care and timely access to Intermediate Care bed bases. Increases in capacity in the discharge teams and Intermediate Care will go some way to the management of DToC's.

Task	Detail	Timescales	Progress
Analysis of DTOC data	Weekly DTOC data supports changes to operational pathways. Monthly DTOC data is used to identify trends.	Ongoing	DTOC coding spreadsheet DTOC December 2015 YTD.zip
Analysis of operational pathways within the two acute trusts	Wider system analysis (NHS Improvement DToC work at Whiston and MADE at Warrington) and redesign of pathways within the acute sector will further support a reduction in this area.	Whiston – May 2016 Warrington – March 2016	Report going to SRGs and Action Plan will be developed Warrington MADE REPORT FINAL.docx Appendix 1 to MADE report.docx
Intermediate care capacity	Analysis reveals key area of demand is for sub-acute care. The development of the RCAT	Ongoing	

	model will support this along with ongoing monitoring of capacity and demand.	RCAT –see Delivery Plan	
Choice agenda	New national guidance issued in March 2016. Both acute Trusts reviewing against existing policy and practice.	Review complete May 2016 Implementation of new areas to commence June 2016	

5.0 An agreed approach to Financial Risk Sharing and Contingency

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

Insert signed copy of Section 75

Risk Assessment & Mitigation

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

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

Controls to mitigate against these risks fall into three categories.

1) **Financial systems**

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

2) **Internal governance**

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

3) **Commissioner and Acute Provider Risk Sharing**

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

Should the level of emergency admissions not reduce as planned this will impact on the total amount of funds available in the CCG budget, this may result in the prioritisation of commissioning intentions with those with the greatest impact taking priority and the possibility of some intentions being delayed or carried forward. The CCG may need to reduce the amount of money planned to be carried forward as a surplus or use the contingency to fund essential services. In addition the failure

to reduce emergency admissions may have an impact on the acute providers directly as this may impact on the capacity to provide timely planned admissions and increase waiting times. Reducing avoidable emergency admissions also improves the quality of life for people with long term conditions and their families. By investing resources into improving access to GP and community services, closer integration between Health and social care in the provision of care as well as ensuring that acute services are only used by those with acute needs by developing the urgent care centres and encouraging their use as an alternative to A&E this will prevent avoidable emergency admissions with the negative implications that arise.

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

Template for BCF submission 1: due on 02 March 2016

Sheet: 5. Health and Well-Being Board Better Care Fund Metrics

Selected Health and Well Being Board:
Halton

Data Submission Period:
2016/17

5. HWB Metrics

This sheet should be used to set out the Health and Wellbeing Board's performance plans for each of the Better Care Fund metrics in 2016-17. This should build on planned and actual performance on these metrics in 2015-16. The BCF requires plans to be set for 4 nationally defined metrics and 2 locally defined metrics. The non-elective admissions metric section is pre-populated with activity data from CCG Operating Plan submissions for all contributing CCGs, which has then been mapped to the HWB footprint to provide a default HWB level NEA activity plan for 2016-17. There is then the option to adjust this by indicating how many admissions can be avoided through the BCF plan, which are not already built into CCG operating plan assumptions. Where it is decided to plan for an additional reduction in NEA activity through the BCF the option is also provided within the template to set out an associated risk sharing arrangement. Once CCG have made their second operating plan activity uploads via Unify this data will be populated into a second version of this template by the national team and sent back in time for the second BCF submission. At this point Health and Wellbeing Boards will be able to amend, confirm, and comment on non-elective admission targets again based on the new data. The full specification and details around each of the six metrics is included in the BCF Planning Requirements document. Comments and instructions in the sheet should provide the information required to complete the sheet.

Further information on how when reductions in Non-Elective Activity and associated risk sharing arrangements should be considered is set out within the BCF Planning Requirements document.

5.1 HWB NEA Activity Plan

- Please use cell E43 to confirm if you are planning on any additional quarterly reductions (Yes/No)
- If you have answered Yes in cell E43 then in cells G45, I45, K45 and M45 please enter the quarterly additional reduction figures for Q1 to Q4.
- In cell E49 please confirm whether you are putting in place a local risk sharing agreement (Yes/No)
- In cell E54 please confirm or amend the cost of a non elective admission. This is used to calculate a risk share fund, using the quarterly additional reduction figures.
- Please use cell F54 to provide a reason for any adjustments to the cost of NEA for 16/17 (if necessary)

			Quarter 1		Quarter 2		Quarter 3		Quarter 4		Total (Q1 - Q4)	
Contributing CCGs	% CCG registered population that has resident population in Halton	% Halton resident population that is in CCG registered population	CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**	CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**	CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**	CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**	CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**
NHS Halton CCG	98.2%	96.7%	4,355	4,277	4,328	4,251	4,428	4,349	4,361	4,283	17,472	17,160
NHS Knowsley CCG	0.1%	0.2%	6,012	9	6,066	9	6,122	9	6,177	9	24,377	35
NHS Liverpool CCG	0.3%	1.1%	14,175	39	14,535	40	14,764	41	14,314	40	57,788	160
NHS Warrington CCG	0.6%	0.9%	6,319	35	6,388	36	6,388	36	6,248	35	25,343	141
NHS West Cheshire CCG	0.6%	1.2%	7,238	45	7,166	45	7,379	46	7,417	47	29,200	183
Totals		**100%**	**38,099**	**4,406**	**38,483**	**4,380**	**39,081**	**4,480**	**38,517**	**4,413**	**154,180**	**17,679**

Are you planning on any additional quarterly reductions?	No	
If yes, please complete HWB Quarterly Additional Reduction Figures		
HWB Quarterly Additional Reduction Figure		
HWB NEA Plan (after reduction)		
HWB Quarterly Plan Reduction %		
Are you putting in place a local risk sharing agreement on NEA?	No	
BCF revenue funding from CCGs ring-fenced for NHS out of hospital commissioned services/risk share ***	£2,697,060	
Cost of NEA as used during 15/16 ****	£1,490	Please add the reason, for any adjustments to the cost of NEA for 16/17 in the cell below.
Cost of NEA for 16/17 ****		
Additional NEA reduction delivered through the BCF		
HWB Plan Reduction %		

* This is taken from the latest CCG NEA plan figures included in the Unify2 planning template, aggregated to quarterly level
** This is calculated as the % contribution of each CCG to the HWB level plan, based on the CCG-HWB mapping (see CCG - HWB Mapping tab)
*** Within the sum subject to the condition on NHS out of hospital commissioned services/risk share, for any local area putting in place a risk share for 2016/17 as part of its BCF planning, we would expect the value of the risk share to be equal to the cost of the non-elective activity that the BCF plan seeks to avoid. Source of data: https://www.england.nhs.uk/wp-content/uploads/2016/02/bcf-allocations-1617.xlsx
**** Please use the following document and amend the cost if necessary in cell E54. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/477919/2014-15_Reference_costs_publication.pdf

5.2 Residential Admissions

- In cell G69 please enter your forecasted level of residential admissions for 2015-16. In cell H69 please enter your planned level of residential admissions for 2016-17. The actual rate for 14-15 and the planned rate for 15-16 are provided for comparison. Please add a commentary in column I to provide any useful information in relation to how you have agreed this figure.

		Actual 14/15*****	Planned 15/16*****	Forecast 15/16	Planned 16/17	Comments
Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	726.9	635.1	635.1	633.3	Please add comments, if required
	Numerator	153	138	138	142	
	Denominator	21,048	21,730	21,730	22,423	

*****Actual 14/15 & Planned 15/16 collected using the following definition - 'Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population'

5.3 Reablement

- Please use cells G82-83 (forecast for 15-16) and H82-83 (planned 16-17) to set out the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services. By entering the denominator figure in cell G83/H83 (the planned total number of older people (65 and over) discharged from hospital into reablement / rehabilitation services) and the numerator figure in cell G82/H82 (the number from within that group still at home after 91 days) the proportion will be calculated for you in cell G81/H81. Please add a commentary in column I to provide any useful information in relation to how you have agreed this figure.

		Actual 14/15	Planned 15/16	Forecast 15/16	Planned 16/17	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual %	65.4%	70.0%	65.2%	65.1%	For planned 16/17 we have based these figures on a 3% increase in population.
	Numerator	85	77	107	110	
	Denominator	130	110	164	169	

5.4 Delayed Transfers of Care

- Please use rows 93-95 (columns K-L for Q3-Q4 15-16 forecasts and columns M-P for 16-17 plans) to set out the Delayed Transfers Of Care (delayed days) from hospital per 100,000 population (aged 18+). The denominator figure in row 95 is pre-populated (population - aged 18+). The numerator figure in cells K94-P94 (the Delayed Transfers Of Care (delayed days) from hospital) needs entering. The rate will be calculated for you in cells K93-O93. Please add a commentary in column H to provide any useful information in relation to how you have agreed this figure.

		15-16 plans				15-16 actual (Q1 & Q2) and forecast (Q3 & Q4) figures				16-17 plans				
		Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)	Q1 (Apr 16 - Jun 16)	Q2 (Jul 16 - Sep 16)	Q3 (Oct 16 - Dec 16)	Q4 (Jan 17 - Mar 17)	Comments
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+).	Quarterly rate	568.1	568.1	568.1	565.4	560.0	540.7	568.1	565.4	638.4	626.2	759.0	840.8	
	Numerator	559	559	559	558	551	532	559	558	630	618	749	832	
	Denominator	98,391	98,391	98,391	98,683	98,391	98,391	98,391	98,683	98,683	98,683	98,683	98,958	

5.5 Local performance metric (as described in your approved BCF plan / Q1 return)

- Please use rows 105-107 to update information relating to your locally selected performance metric. The local performance metric set out in cell C105 has been taken from your 2015/16 approved BCF plan and 2015/16 Q1 return - these local metrics can be amended, as required.

		Planned 15/16	Planned 16/17	Comments
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+)	Metric Value	884.2	883.2	Please add comments, if required
	Numerator	191.0	198.0	
	Denominator	21600.0	22423.0	

5.6 Local defined patient experience metric (as described in your approved BCF plan / Q1 return)

- You may also use rows 117-119 to update information relating to your locally selected patient experience metric. The local patient experience metric set out in cell C117 has been taken from your 2015/16 approved BCF plan and 2015/16 Q1 return - these local metrics can be amended, as required.

		Planned 15/16	Planned 16/17	Comments
Do care and support services help you to have a better quality of life? (From Personal Social Services Survey of Adult Carers)	Metric Value	91.0	93.0	Please add comments, if required
	Numerator	618.0	633.0	
	Denominator	679.0	679.0	

HALTON BOROUGH COUNCIL

AND

NHS HALTON CLINICAL COMMISSIONING GROUP

JOINT WORKING AGREEMENT
Pursuant to S.75 of the National Health Service Act 2006

1st APRIL 2016 – 31st MARCH 2019

Relating to

Care and Support Services in Halton

Contents

THIS AGREEMENT dated **1st** day of **April** 2016

MADE BETWEEN the following parties:-

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

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

1. Definitions

1.1	**"the 2006 Act"**	means the National Health Service Act 2006
1.2	**"Budget Manager"**	means any manager in HBC or the CCG with responsibility for a budget (not Pooled Fund) relating to the Services
1.3	**"Better Care Fund"**	means the Better Care Fund as described in NHS England Publications Gateway Ref. No.00314 and NHS England Publications Gateway Ref. No.00535 as relevant to the Partners
1.4	**"Better Care Fund Plan"**	means the plan agreed by the Parties on 31st March 2016 and which is to be reviewed by the Parties and NHS England in April 2016 setting out the Parties plan for the use of the Better Care Fund
1.5	**"Capital Assets"**	means (but not by way of limitation) the purchase, construction or replacement of a tangible asset which has a life of more than 12 months and a value exceeding £5,000)
1.6	**"Capital Expenditure"**	means such sum exceeding Five Thousand Pounds (£5,000) expended from the Pooled Fund upon the purchase, construction or replacement of the Capital Assets
1.7	**"CCG"**	means the NHS Halton Clinical Commissioning Group
1.8	**"CCG Statutory Duties"**	means the Duties of the CCG pursuant to Sections 14P to 14Z2 of the 2006 Act
1.9	**"the Client/Clients"**	means a person or persons who satisfies the requirements of the Eligibility Criteria and is/are a member of the Client group.
1.10	**"the Client Group"**	means any person (adults) registered with a Halton GP and is a Halton resident, with care being provided for a disability or illness due to a physical, mental health or learning disability and satisfies the requirements of the Eligibility Criteria.

1.11	**"the Executive Partnership Board"**	means the Board whose role, function and rules are set out in Schedule 2 of this agreement
1.12	**"Eligibility Criteria"**	means the Criteria agreed between the Parties as to the conditions to be satisfied for a Client to be a member of the Client Group and which is for the purposes of this agreement more particularly set out in Schedule 1.
1.13	**"Exempt Information"**	means "such information which the Parties resolve that the remainder of their meetings be held in private because publicity would be prejudicial to the public interest or the effective conduct of public affairs etc…." as set out in Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960 and may include such matters as mentioned in Appendix 1
1.14	**"a Financial Year"**	means a year commencing on 1st April and ending on the following 31st March
1.15	**"Force Majeure Event"**	means one or more of the following: (a) war, civil war (whether declared or undeclared), riot or armed conflict; (b) acts of terrorism; (c) acts of God; (d) fire or flood; (e) industrial action; (f) prevention from or hindrance in obtaining raw materials, energy or other supplies; (g) any form of contamination or virus outbreak; and any other event, in each case where such event is beyond the reasonable control of the Party claiming relief
1.16	**"HBC"**	means Halton Borough Council
1.17	**"Health Related Functions"**	means such of the functions of HBC as are prescribed in Regulation 6 of the Regulations as far as they relate to the Client Group
1.18	**" the Host Party"**	means the organisation responsible for the accounts and audit of the Pooled Fund Arrangements as prescribed in Regulation 4 of the Regulations
1.19	**"HWB"**	means the Health and Wellbeing Board established by the Council pursuant to Section 194 of the Health and Social Care Act 2012
1.20	**"Integrated Commissioning"**	means arrangements by which both Partners commission Services on behalf of each other in the exercise of both the NHS Functions and Council Related Functions through integrated structures

1.21	**"Joint Commissioning"**	means a mechanism by which the Partners jointly commission a Service. For the avoidance of doubt, a joint commissioning arrangement does not involve the delegation of any functions pursuant to Section 75.
1.22	**"Lead Commissioner"**	means the Partner responsible for commissioning the Services
1.23	**"Lead Commissioning"**	means the arrangements by which one Partner commissions Services on behalf of the other Partner in exercise of both the NHS Functions and the Council Related Functions
1.24	**"NHS Functions"**	means such of the functions of the CCG as prescribed in Regulation 5 of the Regulations as far as they relate to the Client Group
1.25	**"the OCC"**	means the Operational Commissioning Committee whose role, functions and rules of procedure are set out in Schedule 3 of this agreement
1.26	**"the Parties"**	means HBC and the CCG (and "Party" means either one of the Parties)
1.27	**"the Pooled Fund"**	means the fund which shall include the Better Care Fund monies established from contributions by the Parties in accordance with the terms hereinafter appearing and in pursuance of the Pooled Fund Arrangements and which is pursuant to Regulation 7 of the Regulations
1.28	**"the Pooled Fund Arrangements"**	means the arrangements agreed by the Parties for pooling their monies and to be expended upon the costs of the Services and to be maintained in accordance with the requirements of clause 6 hereof
1.29	**"the Pool Manager"**	means the officer appointed by the Parties for the purposes of managing the Pooled Fund and authorising payments in accordance with the Scheme of Delegation from the Pooled Fund in respect of the costs of the Services. The Pool Manager is the Director of Adult Social Services for HBC.
1.30	**"the Provider"**	Means a provider or providers of any of the Services commissioned under the arrangements set out in this agreement.
1.31	**"the Regulations"**	means the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 SI No.617and any amendments and subsequent re-enactments
1.32	**"the Revenue Budget"**	means the annual budget agreed by the Parties made up of the Revenue Payments

1.33	**"the Revenue Payments"**	means such sums as contributed and paid by the Parties into the Pooled Fund at the commencement of the Term and thereafter on the 1st April of each subsequent year in accordance with the terms of Schedule 4 in respect of the costs incurred or to be incurred in paying for the Services
1.34	**"Scheme of Delegation"**	means the delegated limits which apply to such members of the Parties authorized to take decisions for and on behalf of the Parties and to the Pool Manager for incurring expenditure out of the Pooled Fund as more particularly set out in Schedule 5
1.35	**"the Service Contracts"**	means the Contracts entered into by either one or all of the Parties for the purposes of commissioning the Services provided that such contracts may be in the form of service level agreements and entered into with voluntary, independent and public sectors
1.36	**"the Services"**	means the services of care and support provided for a disability or illness due to physical, mental health or learning disability provided such clients satisfy the Eligibility Criteria and which shall be provided in accordance with the Service Contracts including inter alia the aims and objectives set out in clause 4 hereto
1.37	**"Section 151 Officer"**	means an Officer as required under Section 151 of the Local Government Act 1972. This requires local authorities to make arrangements for the proper administration of their financial affairs and appoint a Chief Financial Officer to have responsibility for those arrangements.
1.38	**"the Term"**	means the period beginning 1st April 2016 and ending 31st March 2019 subject to review as hereinafter set out

2. Recitals

2.1 Pursuant to Section 75 of the 2006 Act the Parties have agreed to establish a Pooled Fund which may subsequently also include either Joint Commissioning or Integrated Commissioning or Lead Commissioning arrangements for the purposes of commissioning the Services in the exercise of the Health Related Functions.

2.2 The objectives of the commissioning arrangements mentioned in clause 2.1 and the Pooled Fund Arrangements are to improve the services for Clients through closer working between the CCG and HBC and which is pursuant to the obligations upon the Parties to co-operate with each other as referred to in the Section 75 of the 2006 Act.

2.3 The commissioning arrangements mentioned in clause 2.1 and the Pooled Fund Arrangements proposed by this Agreement are intended to fulfill the objectives set out in the CCG's 5 Year Strategy 2014-2019 & 2 Year Operational Plan,

Halton's Health and Wellbeing Strategy, the duties of HBC under the Care Act 2014 and the Better Care Fund Plan.

2.5 The provisions of this Agreement shall take effect on the 1st April 2016.

3. Governance

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

3.2 The Parties have established an Executive Partnership Board, as a joint committee within the meaning of Regulation 10 (2) of the Regulations, for the purpose of monitoring and discharging their duties in relation to the strategic commissioning and provision of the Services as outlined in Schedule 1. The powers of the Executive Partnership Board to undertake this role is derived from the Executive Partnership Board's membership of Executive Members who have been given delegated authority from the Parties. The Executive Partnership Board is not an autonomous body and does not therefore have legal status.

3.3 Governance arrangements exist within the Parties to address the issues of clinical governance, public accountability and probity as well as satisfy HBC and the CCG Standing Orders and Standing Financial Instructions and the CCG's Statutory Duties and HBC's Statutory Duties. The Executive Partnership Board will monitor these partnership arrangements for the purposes of discharging these duties and governance arrangements when acting on behalf of the Parties and report to the Boards of the respective Parties as outlined in Schedule 2.

3.4 The Parties have established the Operational Commissioning Committee OCC. The OCC will report directly to the Executive Partnership Board. The OCC is not an autonomous body and does not have legal status and is responsible for implementing the strategic commissioning of the Services as advised by the Executive Partnership Board and reporting to the Executive Partnership Board upon the progress of the meeting those strategic objectives. Members of the OCC may if authorised by the Parties within their respective scheme of delegation authorise the commitment of expenditure and the entering into any Contracts for the provision of the Services

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

4. Executive Partnership Board

4.1 The aims and objectives of the Executive Partnership Board are to:

4.1.1 Determine the strategic direction and policy for the provision of the Services to those with identified care and support needs to improve quality, productivity and prevention.

4.1.2 Promote inter-agency cooperation, via appropriate joint working agreements/ arrangements, to encourage and help develop effective

working relationships between different services and agencies, based on mutual understanding and trust

4.1.3 Review all budgets, including the Better Care Fund, associated with the running of the Services supporting those with identified care and support needs, ensuring financial probity.

4.1.4 Drive forward the continued implementation of achieving a whole system coordinated approach, including the strategic aims outlined in Halton's Better Care Plan 2016/17 by overseeing the associated work of Partner organisations, monitoring performance, reviewing and evaluating services and taking assertive action where performance is not satisfactory.

4.2 Membership:

The membership of the Executive Partnership Board is outlined in Schedule 2.

5. Pooled Fund

5.1 A budget time table for agreeing the Pooled Fund in years 2017 and 2018 is outlined in Schedule 4. The Revenue Payments to be contributed by the Parties for the Financial Year beginning 1st April 2016 are set out in Schedule 4.

5.2 The Pooled Fund will cover the expenditure on both staffing and Service Contracts by the Parties during the Term of this Agreement, the costs of which will be agreed by the Parties prior to each Financial Year.

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

5.4 The management of and administration of the Pooled Fund shall be carried out in accordance with clause 6 and the terms and conditions set out in Schedule 4 and within the delegation limits set out in Schedule 5.

5.5 Initially there will be one Pooled Fund including the Better Care Fund, but the Parties may agree to establish other Pooled Fund in the event that other partnership arrangements are entered into for other services in which event details of those arrangements including the Host Party and the pooled fund manager will be agreed by the Parties.

6. Management of the Pooled Fund

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

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

6.3 The Pool Manager shall ensure that the standard budgetary controls, standing orders, financial contract regulations and monitoring arrangements of the Host Party are complied with and all actions are taken within the Scheme of Delegation.

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

6.5 The Revenue Budget for the Pooled Fund shall be agreed annually by the Parties and expenditure incurred shall be in accordance with the Scheme of Delegation. Revisions to the Revenue Budget must be agreed by the Parties and reflected in the bi monthly financial reports presented to OCC.

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

6.7 Where the Pooled Fund is administered by the HBC, it will arrange for the accounts of the Pooled Fund to be audited annually and shall request Grant Thornton or such other appointed Auditors agreed by the Parties to make arrangements to certify an annual return of those accounts under Section 28(1) (d) of the Audit Commission Act 1998.

7. Charges

7.1 Charges to Clients for Services funded by HBC within National Eligibility Criteria outlined within the Care Act 2014 for adult social care will be applied. This applies to HBC funded elements of joint funded services between the CCG and HBC and the income forms part of the HBC contribution to the Pooled Budget.

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

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

8. Pooled Fund Audit and Monitoring Arrangements

8.1 Grant Thornton or such other accountants agreed by the Parties will act as external auditors and will assume responsibility for auditing the Pooled Budget.

8.2 Where the Pooled Fund is administered by the HBC the Section 151 Officer of HBC will ensure the Pool Manager receives a retrospective bimonthly Pooled Budget statement not more than one month after the end of the previous month. This will form the basis of the bi monthly finance report referred to in 6.4.

8.3 The Pool Manager will monitor and scrutinise the Pooled Budget statement and investigate discrepancies and report such discrepancies to the OCC.

8.4 Where the Pooled Fund is administered by the HBC procurement of, and payment for, all services and goods from the Pooled Budget will be undertaken using HBC Agresso financial system.

8.5 The Pool Manager will ensure that detailed financial reports are presented to the OCC and the Executive Partnership Board and they reflect the latest financial position as previously reported at OCC.

8.6 Where the Pooled Fund is administered by the HBC, it will prepare an end of year financial memorandum of accounts and extract balance sheet. Once the memorandum has been certified by Grant Thornton (or such other appointed Auditors) it will be presented to the OCC, Executive Partnership Board and the Parties by the Pool Manager.

9. Staff and Accommodation Relating to the Pooled Fund

9.1 The Pool Manager shall for the purposes of this agreement be an employee of HBC or such other person as agreed by the Parties

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9.2 The Chair of the OCC shall lead within the OCC on implementing the commissioning priorities to achieve the required outcomes of this Agreement and the Pooled Fund Arrangements.

9.3 The Chair of the OCC will make recommendations to the Executive Partnership Board and the Parties upon the type and level of staff and support required to ensure the successful operation of the Pooled Fund in consultation with the Pool Manager

9.4 HBC and the CCG, following the recommendations of the OCC and the Executive Partnership Board, will provide the necessary staff accommodation and support services required in connection with the administration of the Pooled Fund Arrangements.

10. Commissioning and Contracting Arrangements

10.1 The OCC shall be responsible for overseeing the commissioning and contracting management of all the Services and prepare reports for the Executive Partnership Board on the same.

10.2 In developing new commissioning proposals the OCC will need to determine the appropriate contractual route for the provision of any of the Services. This may be the use of the NHS Standard Contract, a joint contract developed between the parties or a HBC contract. The Executive Partnership Board shall review commissioning and contracting proposals, determine the appropriateness or otherwise of the proposals, report to the Parties, and obtain approval to the implementation of the proposals. Services approved by the Parties and commissioned through contracts and / or service level agreements shall be authorised on behalf of the Parties by the chair of the OCC such members of the OCC acting within their respective Schemes of Delegation.

11. Duration and Termination of this Agreement

11.1 This agreement will commence on 1st April 2016 and terminate on 31stMarch 2019 provided that the Parties may agree to renew this Agreement at the expiration of the Term. Annual reviews of the viability of the agreement during the Term will be conducted by the OCC with recommendations to be made to the Parties by 1st March before the next relevant financial year.

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

11.3 Upon the termination:-

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

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

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

12. Review

12.1 The Executive Partnership Board will in addition to the OCC review this agreement during the Term and report and make recommendations as to it viability and on progress to the Parties by the 1st March before the next relevant Financial Year.

13. Complaints

13.1 Complaints and compliments relating to Services jointly-commissioned by HBC and the CCG serving the Client Group will be dealt with in accordance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

13.2 Any other complaints relating to the Services which are the statutory responsibility of either Party to commission shall be dealt with in accordance with their respective complaints policies.

14. Disputes

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

15. Contract (Rights of Third Parties) Act 1999

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

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

16. Risk Management

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

16.2 Subject to Clause 16.3, and 16.4, if a Party ("First Party") incurs a Loss arising out of or in connection with this Agreement or the Services Contract as a consequence of any act or omission of another Party ("Other Party") which constitutes negligence, fraud or a breach of contract in relation to this Agreement or the Services Contract then the Other Party shall be liable to the First Party for that Loss and shall indemnify the First Party accordingly.

16.3 Clause 16.2 shall only apply to the extent that the acts or omissions of the Other Party contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other Party acting in accordance with the instructions or requests of the First Party or the OCC.

16.4 If any third party makes a claim or intimates an intention to make a claim against either Party, which may reasonably be considered as likely to give rise to liability under this Clause 16. the Party that may claim against the other indemnifying Party will:-

16.4.1 as soon as reasonably practicable give written notice of that matter to the Other Party specifying in reasonable detail the nature of the relevant claim

16.4.2 not make any admission of liability, agreement or compromise in relation to the relevant claim without the prior written consent of the Other Party (such consent not to be unreasonably conditioned, withheld or delayed);

16.4.3 give the Other Party and its professional advisers reasonable access to its premises and personnel and to any relevant assets, accounts, documents and records within its power or control so as to enable the Indemnifying Party and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary defending, the relevant claim

16.5 Each Party shall ensure that they maintain policies of insurance (or equivalent arrangements through schemes such as those operated by the National Health Service Litigation Authority) in respect of all potential liabilities arising from this Agreement.

16.6 Each Party shall at all times take all reasonable steps to minimise and mitigate any loss for which one party is entitled to bring a claim against the other pursuant to this Agreement

17. Data Protection

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

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

17.3 The Parties will agree an Information Sharing Protocol for the sharing of the Client Group information if the need arises.

18. Conflict of Interest

18.1 The Partners shall comply with their respective policies for identifying and managing conflicts of interest.

19. Force Majeure

19.1 Neither Party shall be entitled to bring a claim for a breach of obligations under this Agreement by the other Party or incur any liability to the other Partner for any losses or damages incurred by that Party to the extent that a Force Majeure Event occurs and it is prevented from carrying out its obligations by that Force Majeure Event

19.2 On the occurrence of a Force Majeure Event, the affected Party shall notify the other Partner as soon as practicable. Such notification shall include details of the Force Majeure Event, including evidence of its effect on the obligations of the affected Party and any action proposed to mitigate its effect

19.3 As soon as practicable, following notification as detailed in Clause19.2,the Party shall consult with each other in good faith and use all best endeavours to agree appropriate terms to mitigate the effects of the Force Majeure Event and, subject to Clause 19.4, facilitate the continued performance of the Agreement.

19.4 If the Force Majeure Event continues for a period of more than [sixty (60) days], either Partner shall have the right to terminate the Agreement by giving [fourteen (14) days] written notice of termination to the other Partner. For the avoidance of doubt, no compensation shall be payable by either Partner as a direct consequence of this Agreement being terminated in accordance with this Clause 19.

20. Notices

20.1 Any notice to be given under this Agreement shall either be delivered personally or sent by facsimile or sent by first class post or electronic mail. The address for service of each Party shall be as set out in Clause 20.3 or such other address as each Partner may previously have notified to the other Partner in writing. A notice shall be deemed to have been served if:-

20.1.1 personally delivered, at the time of delivery;

20.1.2 sent by facsimile, at the time of transmission

20.1.3 posted, at the expiration of forty eight (48) hours after the envelope containing the same was delivered into the custody of the postal authorities; and

20.1.4 if sent by electronic mail, at the time of transmission and a telephone call must be made to the recipient warning the recipient that an electronic mail message has been sent to him (as evidenced by a contemporaneous note of the Partner sending the notice) and a hard copy of such notice is also sent by first class recorded delivery post (airmail if overseas) on the same day as that on which the electronic mail is sent

20.2 In proving such service, it shall be sufficient to prove that personal delivery was made, or that the envelope containing such notice was properly addressed and delivered into the custody of the postal authority as prepaid first class or airmail letter (as appropriate), or that the facsimile was transmitted on a tested line or that the correct transmission report was received from the facsimile machine sending the notice, or that the electronic mail was properly addressed and no message was received informing the sender that it had not been received by the recipient (as the case may be).

20.3 The address for service of notices as referred to in clause 20.1 shall be as follows unless otherwise notified to the other Partner in writing:-

20.3.1 if to the Council, addressed to the

Director of Adult Social Services
Halton Borough Council
Second Floor
Runcorn Town Hall
Heath Road
Runcorn
Cheshire, WA7 5TD
Tel: 0151 511 8825

and

20.3.2 if to the CCG, addressed to the

Chief Operating Officer
Halton CCG
First Floor
Runcorn Town Hall
Heath Road
Runcorn
Cheshire, WA7 5TD
Tel: 01928 593479

21. Variation

21.1 No variations to this Agreement will be valid unless they are recorded in writing and signed for and on behalf of each of the Partners.

22. Change in Law

22.1 The parties shall ascertain, observe, perform and comply with all relevant Laws, and shall do and execute or cause to be done and executed all acts required to be done under or by virtue of any Laws.

22.2 On the occurrence of any Change in Law, the Partners shall agree in good faith any amendment required to this Agreement as a result of the Change in Law subject to the Partners using all reasonable endeavours to mitigate the adverse effects of such Change in Law and taking all reasonable steps to minimise any increase in costs arising from such Change in Law

23. Waiver

23.1 No failure or delay by any Partner to exercise any right, power or remedy will operate as a waiver of it nor will any partial exercise preclude any further exercise of the same or of some other right to remedy

24. Severance

24.1 If any provision of this Agreement, not being of a fundamental nature, shall be held to be illegal or unenforceable, the enforceability of the remainder of this Agreement shall not thereby be affected

25. Assignment and Sub Contracting

25.1 A Party shall not sub contract, assign or transfer the whole or any part of this Agreement other than to a statutory successor of all or part of a Party's statutory functions

26. Exclusion of Partnership and Agency

26.1 Nothing in this Agreement shall create or be deemed to create a partnership under the Partnership Act 1890 or the Limited Partnership Act 1907, a joint venture or the relationship of employer and employee between the Partners or render either Partner directly liable to any third party for the debts, liabilities or obligations of the other

26.2 Except as expressly provided otherwise in this Agreement or where the context or any statutory provision otherwise necessarily requires, neither Partner will have authority to, or hold itself out as having authority to:-

26.2.1 act as an agent of the other;

26.2.2 make any representations or give any warranties to third parties on behalf of or in respect of the other; or

26.2.3 bind the other in any way

27. Governing Law and Jurisdiction

27.1 This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the laws of England and Wales

27.2 Subject to Clause 14 (Dispute Resolution), the Partners irrevocably agree that the courts of England and Wales shall have exclusive jurisdiction to hear and settle any action, suit, proceedings, dispute or claim, which may arises out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

28. Partnership Flexibilities

28.1 The Partners may during the Term of this agreement establish one or more of the following in the contracting of the Services:

28.1.1 Lead Commissioning Arrangements

28.1.2 Integrated Commissioning

28.1.3 Joint Commissioning

28.2 In developing these arrangements the Council may delegate to the CCG and the CCG agrees to exercise, on the Council's behalf, the Health Related Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the NHS and Council Related Functions

28.3 In developing these arrangements the CCG may delegate to the Council and the Council agrees to exercise on the CCG's behalf the NHS Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the Health Related Functions

28.4 Where the powers of a Party to delegate any of its statutory powers or functions are restricted, such limitations will automatically be deemed to apply to the relevant Service and the Parties shall agree arrangements designed to achieve the greatest degree of delegation to the other Party necessary for the purposes of this Agreement which is consistent with the statutory constraints

29. Commissioning Arrangements

The following shall apply to Integrated Commissioning:-

29.1 Where there are Integrated Commissioning arrangements in respect the commissioning of a Service, both Parties shall work in cooperation and shall endeavor to ensure that the NHS Functions and Health Related Functions are commissioned with all due skill, care and attention

29.2 Both Parties shall be responsible for compliance with and making payments of all sums due to a Provider pursuant to the terms of each Service Contract.

29.3 Both Partners shall work in cooperation and endeavor to ensure that the relevant Services are commissioned within each Parties financial contribution in respect of that particular Service in each Financial Year

30. Appointment of a Lead Commissioner

30.1 Where the Parties agree that there are to be Lead Commissioning Arrangements the Lead Commissioner shall:-

30.1.1 exercise the NHS Functions in conjunction with the Health Related Functions

30.1.2 endeavour to ensure that the NHS Functions and Health Related Functions are funded within the parameters of the financial contributions of each Party in relation to each particular Service in each Financial Year

30.2 Commission Services for individuals who meet the respective Eligibility Criteria

30.3 Contract with a Provider(s) for the provision of the Services on terms agreed with the other Party;

30.4 Comply with all relevant legal duties and guidance of both Parties in relation to the Services being commissioned;

30.5 Where Services are commissioned using the NHS Standard Form Contract, perform the obligations of the "Commissioner" and "Co-ordinating Commissioner" with all due skill, care and attention and where Services are commissioned using any other form of contract to perform its obligations with all due skill and attention;

30.6 Undertake performance management and contract monitoring of all Service Contracts;

30.7 Make payment of all sums due to a Provider pursuant to the terms of any Services Contract.

30.8 Keep the other Party regularly informed of the effectiveness of the arrangements including the Better Care Fund and any overspend or underspend in a Pooled Fund

SIGNATURES SHEET

SIGNED on behalf of

HALTON BOROUGH COUNCIL

(signature)

SUSAN WALLACE-BONNER **(print name)**

DIRECTOR OF ADULT SOCIAL SERVICES **(position)**

1.4.16 **(date)**

(duly authorised in that behalf)

SIGNED on behalf of

NHS HALTON CLINICAL COMMISSIONING GROUP

(signature)

SIMON BANKS **(print name)**

CHIEF OFFICER **(position)**

1.4.16 **(date)**

(duly authorised in that behalf)

Schedule 1: Assessment, Eligibility and Local Dispute Pathway

S1.1 **Eligible Services**

The Pooled Fund between the CCG and HBC will provide the main financial resource to be used for adults who are eligible for services. This pathway supports Practitioners and Managers within Health and Social Care Teams to ensure assessment of need and considerations of eligibility are undertaken in a transparent way, involving the person and their significant others in the associated processes. The pathway complies with and promotes the use of the national and local guidance, legislation i.e. Care Act 2014, policies and procedures in relation to National Eligibility Criteria for Continuing Health Care (CHC), Funded Nursing Care (FNC) and Jointly Commissioned Care.

S1.2 **Assessment Process**

Short Term Intervention/Intermediate Care Services

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

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

S1.4 **Long Term Provision (including provision of equipment)**

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

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

S1.6 **End of Life Fast Track Eligibility**

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

S1.7 **Quality Assurance**

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

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

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

S1.9 **Resource Allocation Authorisation**

Authorisation for the level and type of resource allocation to support an individual will be undertaken by appropriate Managers and Leads within HBC and the CCG, in line with the respective organisations financial standing orders and delegation limits and as agreed with the Pool Manager.

Schedule 2: Role, Function and Rules of the Executive Partnership Board

S2.1 In this Schedule, “member” or “members” shall be defined by reference to the bodies (as amended from time to time as hereinafter set out) as set out in this Schedule 2

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

S2.3 Any of Parties may from time to time replace or fill a vacancy of one or more of its appointees to serve on the Executive Partnership Board

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

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

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

S2.7 The Chair of the Executive Partnership Board will be HBC’s Executive Portfolio Holder (Health and Wellbeing).

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

S2.9 The Executive Partnership Board shall meet on a quarterly basis. The timing of the meeting may change in exceptional circumstances with the agreement of the Parties and the Chair. Reports and agendas shall be circulated, wherever possible, to the members at least five working days in advance of the said meeting. The agenda papers shall be sent to the members of the Better Care Board and to such other persons and agencies who would normally receive the papers had the Parties been reporting to their own respective boards in respect of the Pooled Fund Arrangements. Any items or matters, which are deemed to be exempt from discussion in public or before the press must be properly and clearly marked and endorsed with the reason thereof. For Exempt Information see definition 1.13 on Page 5 and for further information Appendix 1.

S2.10 The minutes of all meetings of the Executive Partnership Board shall be sent to the HWB its members and the Parties within 7 working days of the said meeting.

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

S2.12 The members of the Executive Partnership Board may be authorized by the Parties within the Service of Delegation (which is received through their respective organisation's own financial scheme of delegation) to agree Lead Commissioning, Integrated Commissioning or Joint Commissioning Arrangements for the purposes of the provision of the Services.

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

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

- Ensuring that the Partners strategic objectives for the delivery of the Services is met for those with identified care and support needs to improve quality, productivity and prevention.

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

- Review all budgets, including the Better Care Fund ensuring financial probity.

- Driving forward the continued implementation of achieving a whole system coordinated approach, including the strategic aims outlined in Halton's Better Care Plan by overseeing the associated work of Partner organisations, monitoring performance, reviewing and evaluating services and taking assertive action where performance is not satisfactory.

S2.15 The Executive Partnership Board will encourage the full use of the Health Act Flexibilities as defined within the NHS Act 2006.

S2.16 The Executive Partnership Board will take responsibility for the overseeing, monitoring and use of the Pooled Fund Arrangements for the Services, receive reports and information on the operation of the same from the Pool Manager and the OCC.

S2.17 Meetings of the Executive Partnership Board shall be quorate when at least two members from the CCG and two members from HBC are in attendance.

S2.19 **Membership**

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

- ***Halton Borough Council***
  - HBC Executive Board Portfolio Holder (Resources)
  - Director of Adult Social Services
  - Chief Accountant or representative

- ***NHS Halton Clinical Commissioning Group***
  - Director of Transformation
  - Chief Nurse (Vice Chair)
  - GP Clinical Lead
  - Chief Finance Officer

S2.20 The Executive Partnership Board will elect a Vice Chair from within its membership..

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

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

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

S2.24 The Executive Partnership Board will be accountable to the Parties.

S2.25 The minutes of all meetings shall be sent to the OCC within 7 working days of the said meeting.

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

S2.27 Any decisions of the Executive Partnership Board must have the approval of the respective Parties Boards or Governing Body unless otherwise delegated to the members of the Executive Partnership Board as set out in their respective Schemes of Delegation

Schedule 3: Role, Function and Rules of the Operational Commissioning Committee

S3.1 To develop and make recommendations to the Executive Partnership Board on the strategic, commissioning and operational direction of the Services in Halton.

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

S3.3 To be responsible for the monitoring contractual relationships with Providers financed by the Pooled Fund through the implementation of a performance management framework and for reporting to the Executive Partnership Board in all matters relating to such monitoring, including those associated with the Better Care Fund.

S3.4 To develop and prepare the performance management framework.

S3.5 To be responsible for the implementation of the decisions of the Executive Partnership Board relating to the strategic objectives for the commissioning of the Services and for the operational delivery of those Services including those outlined in the Better Care Fund Plan.

S3.6 To prepare detailed planning proposals for the Services and present to the Executive Partnership Board for discussion and approval.

S3.7 To consider bids for projects from the Executive Partnership Board, and to prepare reports with recommendations to the Executive Partnership Board.

S3.8 To analyse government policies, local and national research and audit and national information relating to care and support services and to present such information to the Executive Partnership Board for the purposes of the development and commissioning of Care and Support Services in Halton within the resources of available funding.

S3.9 Meetings of the OCC shall be held bi-monthly.

S3.10 The OCC will be accountable to the Parties. Its Minutes shall be provided to the Parties, the HWB and the OCC within 7 days of its meetings

S3.11 The members of the OCC may be authorized by the Parties within the Scheme of Delegation (which is received through their respective organisations own financial scheme of delegation) to authorise expenditure from the Pooled Fund where it is not within the delegated limits of the Pooled Fund Manager and the entering into Service Contracts with a Provider

S3.12 **Membership**

The OCC is chaired by HBC's Director of Adult Social Services and membership of the Board will consist of the following representatives:-

- Divisional Manager (Urgent Care), HBC
- Divisional Manager (Independent Living), HBC
- Divisional Manager (Care Management), HBC
- Finance Manager, HBC
- Public Health Consultant, HBC
- Development Manager Urgent and Integrated Care HBC
- Practice Manager Support Services HBC
- Director of Transformation, NHS Halton CCG (Vice Chair)
- Performance and Planning Manager, NHS Halton CCG
- Clinical Lead, Complex Care, NHS Halton CCG
- GP Clinical Lead, NHS Halton CCG
- Finance Manager, NHS Halton CCG
- 3 x Heads of Service, NHS Halton CCG

S3.12 The OCC may co-opt members for the purposes of providing expertise to the OCC in relevant matters.

Schedule 4: Finance

S4.1 Contributions – Financial Year 2016/17

S4.1.1 For the purposes of Paragraph 5 the contributions to be made to the Pooled Fund by the HBC and the CCG for the period 1st April 2016 to 31st March 2017 are set out below (subject to variation as agreed between the Parties):-

HBC:- £18,281,020

CCG:- £12,846,861

Better Care Fund - £9,490,960

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

S4.2 Contributions - Years 2016/17, 2017/18 and 2018/19

S4.2.1 The contributions for the financial years 2017/18 and 2018/19 will be determined by the respective Parties and agreed by 1st March of the respective preceding financial year.

S4.3 Additional Funds

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

S4.4 Variations of Contributions

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

S4.5 Overspends

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

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

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

S4.5.3.1 The OCC will be convened within 2 weeks of the report by the Pool Manager to produce a financial plan to address the budget insufficiencies within the existing Pool Fund allocation.

S4.5.3.2 The financial plan will be presented to the Parties for discussion and agreement within 4 weeks of the report by the Pool Manager.

S4.5.3.3 Where the Pool Fund is unlikely to be able to meet the agreed contractual duties of this Agreement then the Pool Manager may make proposals to the OCC including a reduction in service activity, and seek further action of the Parties as special conditions for the temporary support of the budget.

S4.5.3.4 Prior to the implementation of the financial plan referred to above at S4.5.3.2 any conditions which the Pool Manager shall seek to impose including amendments to this Agreement shall first be agreed with the Parties.

S4.6 Termination of this Agreement

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

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

S4.7 Debt

S4.7.1 Where charges to Clients for services funded by HBC within National Eligibility Criteria are made and debts are incurred, then HBC will use its Debt Recovery policy to recovery those debts. This will also apply to HBC funded elements of joint funded services between the CCG and HBC.

S4.8 S.151 Officer / Chief Finance Officer for the CCG

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

S4.9 CCG's and HBC's Financial Standing Orders and Finance Regulations

S4.9.1 The CCG's and HBC's Financial Standing Orders will apply to the operation of the Pooled Fund.

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

S4.10 Monitoring and Reporting Arrangements

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

S4.11 VAT

S4.11.1 The Parties shall agree the treatment of the Pooled Fund for VAT purposes in accordance with any relevant Guidance from HM Customs and Excise

S4.12 Expenses

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

S4.13 Payment Arrangements

S4.13.1 In the event of the CCG making its Revenue Payment to the Pooled Fund hosted by HBC such payment shall be by quarterly installments within 5 working days of the start of each quarter month commencing on April 2016 on production of an invoice from HBC with any relevant supporting documentation provided that such payment to the HBC will be dependent upon receipt of the Revenue Payments made into the Pooled Fund by the HBC.

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S4.13.2 In the event of the HBC making its Revenue Payment to the Pooled Fund hosted by the CCG such payments will be made in 12 equal monthly installments on receipt of an appropriate invoice and where necessary, with supporting documentation on 15th of each month commencing from 15th April 2016 provided that such payment to the CCG will be dependent upon receipt of the Revenue Payments made into the Pooled Fund by the CCG.

S4.14 Efficiency Savings

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

S4.15 Capital Expenditure

S4.15.1 Capital expenditure for the purchase of Capital Assets cannot be incurred without the prior written approval of the OCC and Section. 151 officer and the CCG's Chief Finance Officer.

S4.15.2 In the event of approval being given as in clause S.4.1.15.1 the Parties shall decide which of them shall purchase and own the Capital Assets on behalf of the Parties and thereafter be responsible for the maintenance, repair, renewal and insurance costs of the Capital Assets on behalf of the Parties.

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

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

S4.15.5 If the proposed cost of any of the Capital Assets shall exceed £5,000 (other than those purchased through the DFG) then such cost shall not be funded from the Pooled Fund but shall require the submission and preparation by a manager of an initial Business Case to be made to the OCC which shall, if it accepts the validity of the Business Case, then refer such request for making a formal bid or request whether by submission of a formal Business Case for approval or otherwise to the appropriate statutory funder for such monies and if approved such Party shall retain legal ownership of the Capital Assets.

S4.15.6 In the event of either Party receiving Capital Expenditure grant from the Government or other public department a protocol will be agreed by the OCC, taking advice from the S.151 officer of the HBC and the Chief Finance Officer of the CCG as to how such monies may be returned to the relevant party on termination of this Agreement howsoever accruing.

S4.16 Specific Grants

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

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

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

S4.17 Budget Timetable

S4.17.1 The annual HBC Budget for the whole Council will be set in accordance with the HBC's Corporate Budget Setting Process, identified below and which shall include those monies to be contributed by HBC to the Pooled Budget.

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S4.17.2 Subject to which party is holding the Pooled Fund either the Chief Finance Officer for the CCG or the Chief Accountant for the HBC will contact the budget managers for the relevant Services, including the Pooled Manager, to request any information required and arrange meetings with Budget / Pool Manager during September and October each year, in preparation of setting the budget for the forthcoming year. It is essential that the information be provided promptly so that the overall deadlines for budget preparation are to be achieved.

S4.17.3.1 The indicative budget timetable for HBC is as follows:

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

S4.17.3.2 The indicative budget timetable for the CCG is as follows:-

- Commences October through to January with review of spend and expected outturn including identification of next year's pressures
- Initially planning of budget presented to Governing Body during January
- January to February budget meetings are held across the CCG to agree on-going committed spend and identify new spend
- Final budgets are agreed with commissioning intentions and plans during March with further budget plan to Governing Body
- Regular reviews of budget planning are managed through Performance and finance committee reporting to Governing Body
- April at commencement of financial year final budgets are presented to Governing Body for approval

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

S.4.17.5 The Parties shall agree the budgets and their respective contributions to the Pooled Fund by the 1st March for the next financial year beginning on 1st April.

Schedule 5: Delegation Limits

S5.1 **Delegated Authority**

As stated in Governance 3.2, neither the Executive Partnership Board nor the OCC is an autonomous body and does not therefore have legal status. Any decisions of the OCC and/or the Pool Manager which are beyond their respective delegated authority/limits (as set out below) or are inconsistent with the terms of this agreement would require the prior approval and/or the ratification of the governing bodies of the Parties organisations in accordance with both Parties Standing Orders, Standing Financial Instructions and Schemes of Delegation.

S5.1.1 As stated in Schedule 4, paragraph 9.1 the Pooled Fund will (subject who is the Host Party) be operated under either the CCG's or the Council's Constitution, Standing Orders and Finance Regulations. Within paragraph 3.4 of the Council's Standing Orders relating to Finance there is provision for Delegated Authority to be granted to Officers of the Council for the certification of financial and personnel documents with the approval of the Strategic Director People & Economy and Head of Internal Audit.

S5.1.2 The List of Officers who have delegated powers to authorise expenditure from the Pooled Fund and enter into Services Contracts with Providers for the respective Parties together with the limits of their authorisation is set out in Appendix 3 for the CCG and in Appendix 4 for the HBC and the delegated limited for the Pool Fund Manager is set out in Appendix 5

S5.1.3 Authorised Certifying Officers shall be responsible for all financial arrangements delegated as per the list and shall maintain a sufficient record of all transactions to account to the Pool Manager for the Pooled Funds.

S5.1.4 The Pool Manager should ensure that certifying officers are familiar with the procedures and requirements set out in the Standing Orders Relating to Finance and Procurement and be satisfied that officers are aware of and comply with the correct procedures.

S5.1.5 Authorised Certifying Officers have a responsibility to assist the Internal Auditors acting on behalf of the Council when reviewing any internal or financial control system for which they are responsible.

S5.1.6 Delegated powers are restricted to individual areas of management control as stated within this Agreement. In particular the certification of financial documents requires responsibility for ensuring adequate budgetary provision is available and documents are processed strictly in accordance within the specific authorisation limits as detailed in the list.

S5.1.7 Any changes to the officers included in the list can only be authorised jointly by the Strategic Director, People & Economy and the Chief Internal Auditor.

S5.1.8 Specimen signatures have been obtained for all the certifying officers and copies provided to the relevant sections within People & Economy Directorate, and the Community and Resources Directorate.

Appendix 1: Exempt Information

1 The Executive Partnership Board may choose to discuss in private certain information which includes or is likely to involve discussion of Exempt Information for the purposes of Schedule 12A Local Government Act 1972. The categories of Exempt Information applicable as at 29 September 2004 are listed for illustrative purposes only below and references in Schedule 12A aforesaid to 'the authority' shall in the context of this Agreement be taken to refer to the OCC

2 The Executive Partnership Board shall discuss in private any item of business which includes or is likely to involve discussion of confidential information.

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

a) information furnished to the Executive Partnership Board of any member of the CSC or to the Council or to the CCG by a government department upon terms (however expressed) which forbid the disclosure of the information to the public; or

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

Appendix 2: Finance

NHS Halton Clinical Commissioning Group

	£
Adult Complex Health Care	9,141,797
Intermediate Care Services	2,762,517
Funded Nursing Care	876,266
Director of Transformation (50%)	66,281
TOTAL	12,846,861

Halton Borough Council

	£
Intermediate Care Services	1,893,250
Sub Acute Unit	349,880
Adult Community Care Services	16,019,500
TOTAL	18,262,630

Better Care Fund

	£
Intermediate Care Services	1,508,000
BCF Schemes	1,746,000
End of Life	192,000
Urgent Care Centre	815,000
Joint Equipment	601,000
Contracts & SLA's	987,000
Adult Health & Social Care	3,123,960
Capacity Contingency	518,000
TOTAL	9,490,960

Note: BCF includes S256 & Reablement Grant

Appendix 3: Delegated Authority – NHS Halton CCG

Operational Delegated Limits from 1st April 2015

Ref	Description	Governing Body	Service Development Committee	Chief Officer	Chairman	Chief Finance Officer	Head of Finance/Head of Contracts and Performance	Chief Nurse / Director of Transformation	Other CCG Officers (as specified by authorised signatory list)
A	**GIFTS & HOSPITALITY** Head of Corporate Services to maintain a register of declared gifts and hospitality received. **Declaration required if:**			<Items of over £20 or less, if of a repetitive nature>					
B	**LOSSES & SPECIAL PAYMENTS** Chief Finance Officer to maintain a register of losses and special payments (including bad debts to be written off). All to be reported to the Audit Committee.	Over £100,000		£50,001 - £100,000		£5,001 - £50,000	Up to £5,000	Up to £500	
C	**PETTY CASH FLOAT**								
C1	**Authorisation to set up float**	Over £200		<		Up to £200 float		>	
C2	**Replenish petty cash float**								Principle Accountant Up to maximum float
C3	**Issue petty cash**			£50 per ordinary transaction – to be approved by manager as per signatory list					
D	**REQUISTIONING GOODS & SERVICES: NON HEALTHCARE**								
D1	**Initial Decision to recruit Agency Staff / Management Consultants** (Based on total expected cost)	Over £100,000		Up to £100,000	Up to £100,000	Up to £50,000	Up to £50,000	Up to £25,000	
D2	**Services including IT, maintenance and support services** (over lifetime of contract) were not included within agreed annual budgets	Over £250,000		Up to £250,000	Up to £250,000	Up to £100,000	Up to £50,000	Up to £25,000	
D3	**Recharges from other public sector bodies** (not included within agreed annual budgets)	Over £250,000		Up to £250,000	Up to £250,000	Up to £100,000	Up to £50,000	Up to £25,000	Up to £20,000

Ref	Description	Governing Body	Service Development Committee	Chief Officer	Chairman	Chief Finance Officer	Head of Finance/Head of Contracts and Performance	Chief Nurse / Director of Transformation	Other CCG Officers (as specified by authorised signatory list)
D4	**Approval of all other requisitions**	Over £250,000		Up to £250,000	Up to £250,000	Up to £100,000	Up to £50,000	Up to £25,000	Up to £20,000
E	**RELOCATION EXPENSES**	Over £30,000		Up to £30,000	Up to £30,000	Up to £8,500 (In line with Policy Approved By HR Cttee)	Up to £8,500 (In line with Policy Approved By HR Committee		
F	**DECISION TO APPROVE HEALTHCARE INVESTMENT BUSINESS CASES** (Annual Contract Value)								
F1	**Business Case Included in Annual Commissioning Plan & Annual Budget**	Over £500,000	Up to £500,000	Up to £250,000	Up to £250,000	Up to £100,000	Up to £25,000	Up to £25,000	Up to £20,000 (only if in budgets)
F2	**Business Case <u>Not</u> Incl. in Annual Commissioning Plan & Annual Budget**	Over £250,000	Up to £250,000	Up to £100,000	Up to £100,000	Up to £50,000	Up to £25,000	Up to £25,000	
G	**HEALTHCARE CONTRACTS**								
G1	**Signing of Healthcare Contracts** (Annual Contract Value)			Over £150,000,000		Up to £150,000,000	Up to £25,000,000		
G2	**Approval of Healthcare Contract Payments** All healthcare contract payments must be supported by signed contract (see H1).			Unlimited (within budget)		Unlimited (within budget)	Up to £4,000,000	Up to £25,000	As per SBS Approvals Limit
G3	**Procurement Route Decision Whether to Put Healthcare Service Out to Tender** (Annual Contract Value)	Over £250,000		Up to £250,000		Up to £100,000	Up to £25,000	Up to £25,000	
H	**APPROVAL OF ADHOC HEALTHCARE PAYMENTS** (For non-contract activity or complex case placements)	Over £1,000,000		Up to £1,000,000		Up to £1,000,000	Up to £400,000	Up to £25,000	As per SBS Approvals Limit
I	**QUOTATIONS AND TENDERS:** Over lifetime of contract. Please refer to Tendering and Procurement Procedure, sect 13 of Prime Financial Policies.								

Ref	Description	Governing Body	Service Development Committee	Chief Officer	Chairman	Chief Finance Officer	Head of Finance/Head of Contracts and Performance	Chief Nurse / Director of Transformation	Other CCG Officers (as specified by authorised signatory list)
I1	**Tender Waiver Approval** (Total Contract Value – see detailed financial policy on tendering when permissible)	Over £100,000		Up to £100,000		Up to £50,000	Up to £50,000		
I2	**Formal Tender** In accordance with EU directives and timescales. (Pre-qualification to be obtained)		Threshold and above Thresholds are £111,676 for Part A Services and £172,514 for Part B Services						
I3	**Minimum of 3 written competitive tenders:** In compliance with EC procurement directive. (No Pre-qualification required)		£80,000 to Threshold Thresholds are £111,676 for Part A Services and £172,514 for Part B Services						
I4	**Minimum of 3 written quotes**		£20,000 to £79,999						
I5	**No requirement to obtain quotes:** Although no formal requirement, it is best practice & demonstrates value for money.		Up to £19,999						
I6	**Opening of Tenders (**at least 2 from list)			√		**√**	**√**	**√**	
J	**BUDGET VIREMENT** In accordance with the virement policy, a virement form must be completed and signed by both parties.	Over £1,000,000		Up to £1,000,000		Up to £500,000	Up to £250,000	Up to £250,000	
K	**DISPOSALS AND CONDEMNATION** All assets disposed at market value. Reported to Audit Committee.	Over £50,000		Up to £50,000		Up to £50,000	Up to £,1000	Up to £1,000	Up to £1,000
L	**CHARITABLE FUNDS** If charitable funds received in the future a Charitable Funds committee will be established.	The CCG does not currently hold any charitable funds							
M	**HUMAN RESOURCES ISSUES**								
M1	**Approve HR Decisions Not Covered By CCG HR Policies or Is Exceptional To Policies** (e.g. additional compassionate leave or exceptional carry forward of leave days)			**√**					
M2	**Decisions As Set Out Within HR Policies** (where there is some management discretion e.g. study leave authorisation)			**√**		**√**	**√**	**√**	

Ref	Description	Governing Body	Service Development Committee	Chief Officer	Chairman	Chief Finance Officer	Head of Finance/Head of Contracts and Performance	Chief Nurse / Director of Transformation	Other CCG Officers (as specified by authorised signatory list)
M3	**Approving Operational Structure** (re staffing and departments)			√					
M4	**Appointment to Posts Below Chief Nurse or Director of Transformation**			√		√	√	√	
M5	**Appointment to Chief Nurse or Above** (not covered in Constitution Appendix D)			√					
N	**EXTERNAL COMMUNICATIONS & REPORTING**								
N1	**Approve Complaints Responses and Letters to Politicians and Media Responses**			√	√				
N2	**Approve Public Consultation Material**			√					
N3	**Approve Public & Staff Engagement Material including Website Design**			√				√	
N4	**Approve FOI Responses**			√				√	
N5	**Approve Annual Engagement & Communication Plan**			√					

Appendix 4: Delegated Authority – Halton Borough Council

As outlined in the Financial Standing Orders (paragraph 3.4.1) contained in HBC's Council Constitution, approved by Council on 15th April 2015.

Strategic Directors shall draw up a list, with the agreement of the Head of Internal Audit, of those officers authorised to certify accounts, invoices, orders and expenditure vouchers on their behalf (Delegated Authority to Certify Financial and Personnel Documents) within the following limits:

	Limit (£)
Strategic Directors	5,000,000
Operational Directors	1,000,000
Divisional Managers, Group Solicitors	100,000
Other specific managers	10,000
Other nominated Officers	1,000

Accounts, invoices, orders and expenditure vouchers over £5,000,000 in value must be certified by any two Strategic Directors.

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Appendix 5: Delegated Authority – Pool Fund Manager

The Pool Manager is the Director of Adult Social Services for HBC, therefore the delegated limit relative to this pool is in line with those outlined in HBC's Financial Standing Orders, as outlined below:-

	Limit (£)
Operational Directors	1,000,000

REPORT TO: Health & Wellbeing Board

DATE: 6 July 2016

REPORTING OFFICER(s): Simon Banks**,** Chief Officer
Leigh Thompson**,** Director of Commissioning
NHS Halton Clinical
Commissioning Group

PORTFOLIO: Health & Wellbeing

SUBJECT: Well North Programme

WARDS: Borough-wide

1.0 PURPOSE OF THE REPORT

To provide an update on the Well North programme for Halton.

2.0 RECOMMENDED: That

1) **The contents of the report are noted;**
2) **Feedback is provided on the identified work streams;**
3) **The initial work programme for Well Halton is agreed, and;**
4) **The resources required to support Well Halton are agreed**

3.0 SUPPORTING INFORMATION

Well North is a Department of Health response to the Due North Report published in 2014 which highlighted the disparity in health outcomes between the north and the south of England.

Well North's goals are to :-

- address inequality by improving the health of the poorest, fastest;
- increase resilience at individual, household and community levels;
- and reduce levels of worklessness, a cause and effect of poor health.

Well North is the recognition that for health inequalities to be addressed effectively, interventions must be built on developing community based programmes, which enable empowerment, control, self-determination and the freedom to lead lives that people have reason to value. Designing such an environment will deliver healthy behaviours and match the emotional needs of people.

The resource allocation for Well North is £1M PHE resource per pathfinder, of which £400,000 funds hub activity and £600,000 cash for each pathfinder, matched locally £400,000 cash and £600,000 in-kind activity over 3 year period.

The programme must be delivered in wards in the top 10% of IMD, the approach is to develop, test and pilot a set of linked interventions to improve the health of the poorest, fastest, targeting the social life of the social gradient through communities of influence, which support people from some of the most deprived areas to improve their health, bring the health system and economic growth priorities into closer alignment and build a best practice framework which can be replicated and transplanted.

Well North is a collaborative programme which is developing, testing and piloting a set of linked interventions to improve the health of the poorest, fastest, in some of the most deprived areas of the North of England.
Well North seeks to make visible previously invisible at-risk people and attempt to solve, rather than manage, their illnesses and anxieties.

Specifically, the hubs of which Halton is one must seek to reach and engage with people and work with them to identify holistic solutions for them and their families. The programme aims to improve their health, bring the health system and economic growth priorities into closer alignment and build a best practice framework which can be replicated and transplanted.

A fundamental and critical cross-cutting, unifying philosophy underpinning Well North is the recognition that for health inequalities to be addressed effectively, interventions must be built on developing community based programmes, which enable empowerment, control, self-determination and the freedom to lead lives that people have reason to value. Designing such an environment will deliver healthy behaviours and match the emotional needs of people.

The development of the Well Halton programme under the auspices of Well North has been conducted in partnership between NHS Halton CCG (as the lead organisation) and Halton Borough Council. The Health and Wellbeing Board reviewed and approved the initial proposition and have received a progress report, with a further report due in July. Regular updates and opportunities for engagement in the development of the Well Halton proposition have also been offered across the two organisations and community partners.

4.0 PROGRESS

4.1 The initial phase of the Well North programme has been undertaken in the last few months as outlined in the report to the Health & Wellbeing Board in February 2016. This phase culminated in a collaborative two day workshop with a Halton cohort in attendance along with a number of representatives of the Well North team. The intention of the workshop was to refine and agree the work programme for Halton (hereafter referred to as Well Halton) building on the initial bid, the diagnostic stage and the potentials that have been identified from the Well North team whilst exploring Halton.

5.0 WELL HALTON

5.1 The two day workshop was held on 3rd & 4th May 2016 at Trafford Hall, Chester. Ahead of the workshop three areas of focus were agreed in principal by the Halton cohort which were; Windmill Hill, Halton Brook & Widnes. During the workshop the work streams were fleshed out further which resulted in three distinct schemes;

1. **Windmill Hill** – this is to build on the initial proposition outlining our intentions to extend the concept of One Halton, utilising our community assets to support a bottom up approach for an Intergenerational Family Centre with Multidisciplinary teams providing services to children, young people, families and older people. We can build upon the Big Local approach to address the lack of community hub and the integrated access to services including a long term solution of access to medical services.

   This approach will widen the Children's Centre offer to whole life cycle access to services at a neighbourhood level away from clinical settings. This strand will also consider the wider infrastructure requirements of the expanding area of east Runcorn exploring how the emerging needs may dovetail and compliment the provision of a community hub in Windmill Hill. There will be some focus on building relationships with the business sector at Sci-tech Daresbury to seek employment opportunities and develop aspirational programmes to inspire science, technology and innovation with Halton's school children.

2. **Halton Brook** – has a community sector that includes the Four Estates Charity, Runcorn Veterans Association and many others, there are multiple physical assets such as Halton Brook Community Centre, Holy Spirit Church, the Children's Centre and two schools. What the estate lacks is the expertise to capitalise on these assets in a way that will make them sustainable. With support from the Well Halton team we will look to address this. There are a number of long standing wicked issues on the estate these include poor health outcomes, criminality, drug/alcohol abuse, youth nuisance, worklessness and low levels of adult education. Part of the work will involve bringing in services to tackle these issues. We will foster a 'can do' spirit, offer people the opportunity to 'loiter with intent', create a space (or spaces) where people can harness their creative/entrepreneurial spirit and start to build projects, business and opportunities.

3. **Well Widnes (Virtual Community Health Hub)** - Opportunities to create "start up and support" business models in the wards of Kingsway and Ditton between the CCG, LA, Well North and the public, private and voluntary, community and social enterprise (VCSE) sector to design, implement and govern a potential community Hub to stimulate entrepreneurship to improve the health and wellbeing of our local population; as a catalyst for new innovations and strengthen the economy and collaborative working for the benefit of people living and working in the borough. Our shared aspiration is that this virtual community health hub will bring about opportunities so that everyone in Halton can realise their potential.

5.2 Each of the three work streams (schemes) have developed a plan on a page to provide an initial narrative, and each have yet to progress their ideas and thoughts into action. The next steps for the Well Halton programme is that each scheme will require a clearly identified governance structure, a project initiation document and clear leadership team to progress the schemes as follows:-

Windmill Hill – Lead Officer is Nicola Goodwin, leadership team members are Rob Trimble, CEO of Bromley by Bow, Irene Bramwell – Windmill Hill resident, Sarah Vickers – CCG lead for GP Services, Ian Hunter - Chair of Windmill Hill Big Local Partnership, Richard Jones – Homes & Communities Agency, Veronica Wright – Children's Services & Dr Cliff Richards – Chair of NHS Halton CCG.

Halton Brook – Lead Officer is Chris Carlin - VCA, leadership team members are Donald Findley – Well North, Veronica Wright – Children's Services, John Patton – Social Care in Practice.

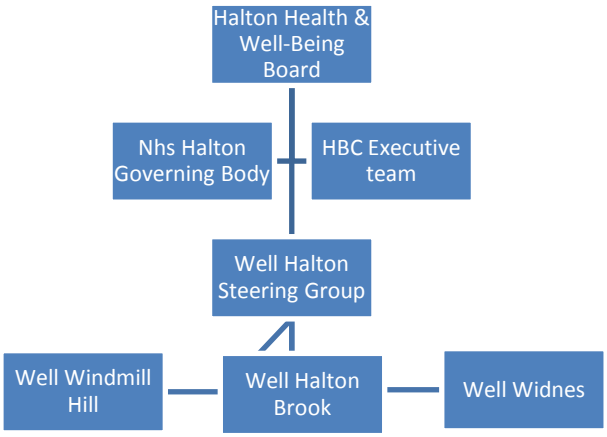
Well Widnes (Virtual Community Health Hub) – Lead Officer is Dave Sweeney – CCG, Tim Leather – HBC, Sally Yeoman – VCA, Paula Caine – Halton Chamber of Commerce, Richard Munson – Vikings, Mark Swift – Wellbeing Enterprises, Lisa Taylor – HBC, Mick Hanratty – Well North.

Each team will need to further scope their work streams providing detailed insight on the initiatives, the intended outcomes, stakeholders, opportunities & potentials, challenges, action plans, timescales etc. These should be completed in the next three months (by September 2016) to provide a tangible work programme and a further update on the Well Halton programme.

6. **Governance and Support**

Support to co-ordinate the programme to date has come from an integrated senior team providing strategic insight and support. A steering group has now been established chaired by the Chief Officer of NHS Halton CCG. It is imperative that both organisations maintain a key role to progress Well Halton and to deliver the innovative, strategic and operational place shaping role of the public sector.

The success of Well Halton will depend on not only maintaining the current level of strategic and operational support but providing it to the required future levels. Therefore, the CCG and the local authority need to consider and provide the appropriate level of resources moving forward.



7.0 POLICY IMPLICATIONS

7.1 The Well North programme provides the opportunity to be innovative and further develop our integrated approach to health and wellbeing in Halton.

8.0 FINANCIAL IMPLICATIONS

8.1 The initiative provides investment in the Borough.

9.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

9.1 **Children and Young People in Halton**
Improving the health of Children and Young People is a key priority in Halton, the Well North programme will contribute to this are of work.

9.2 **Employment, Learning and Skills in Halton**
The above priority is a key determinant of health, hence, improving outcomes in this area will have an impact on improving the health of Halton residents.

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

9.4 **A Safer Halton**
The Well North programme objectives connect with the Safer Halton agenda through supporting and building resilient communities.

9.5 **Halton's Urban Renewal**
The environment in which we live and the physical infrastructure of our communities has a direct impact on our health and wellbeing; Well North recognises the broad context of issues that impacts on residents health & wellbeing including the physical environment.

10.0 RISK ANALYSIS

On approval and development of scheme plans a risk analysis and risk register will collated for each scheme and presented to the Well Halton Steering group.

11.0 EQUALITY AND DIVERSITY ISSUES

The Well North programme will strive to engage with cohorts of Halton's community whom traditionally haven't accessed primary care services.

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

None under the meaning of the Act.

REPORT TO: Health and Wellbeing Board

DATE: 6th July 2016

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Wellbeing

SUBJECT: Health and Wellbeing Strategy

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 The purpose of this report is to provide the Health and Wellbeing Board with an update on the development of the new Halton Health and Wellbeing Strategy (2017-2022).

2.0 RECOMMENDED: That the Board provide leadership and oversight for the development of the new strategy and help inform its chosen priorities.

3.0 SUPPORTING INFORMATION

3.1 In Halton we have a good track record of partnership working on health and wellbeing issues. As a result of the Health and Social Care Act 2012, each local area was obliged to set up a new Health and Wellbeing Board. One of the key responsibilities of the Health and Wellbeing Board was to develop a Health and Wellbeing Strategy to meet the needs of the local population. Halton's first Health and Wellbeing Strategy covered the period 2013-2016 and set out the vision for Health and Wellbeing in Halton. The Strategy was the overarching document for the Health and Wellbeing Board outlining the key priorities the Board has focussed on over the past three years. As the current strategy finishes in 2016 we need to develop a new Health and Wellbeing Strategy to build on successes and make further improvements.

3.2 The development of the current strategy was an excellent example of the synthesis of evidence (using the JSNA), stakeholder and public engagement to identify issues of particular significance for the borough. Since its development it has provided a focus for the development and/or strengthening of local action, bringing together partnerships focused on prevention, treatment and care across the lifecourse. The overarching health and wellbeing strategy not only explained why and how priorities were chosen but also laid down a set of principles which each partnership has integrated into priority-focused strategies and action plans. The strategy has been well

received locally and nationally – its style told a clear story about why and how we would approach our priorities - and we need to build on this experience for the next one.

3.3 It will be vital that the new Strategy is aligned with developing system level plans across Local Authorities and the NHS. Since 2013 when first strategy was published there have been significant developments within the policy landscape.

Of particular importance is the agreement between the government and the leaders of the Liverpool City Region to devolve a range of powers and responsibilities to the Liverpool City Region Combined Authority and the NHS Five Year Forward View and ask to produce a five year Sustainability and Transformational Plan (STP).

All of the CCGs, Local Authorities and Provider Trusts within Cheshire and Merseyside have agreed to work collaboratively on the STP, to develop a governance structure and to manage any allocations received from the national transformation fund. Although NHS England want a single STP across an economy footprint, they still require every organisation to provide a local plan. NHS Halton CCG has adopted an integrated Borough wide approach to planning with Halton Borough Council and a series of stakeholders, called “One Halton”.

3.3 The new Health and Wellbeing Strategy needs to reflect current priorities from elsewhere in the system (Devolution and STP) whilst maintaining a local focus that is evidence based and reflects local people’s views.

3.4 Priorities identified within the new strategy will be aligned with LCR Devolution and “One Halton” areas of focus. The priorities must be backed by a strong evidence base considering the local JSNA, Right Care benchmarks and performance against the range of national and local targets. They are currently being discussed but include:

- Child development
- Community mobilisation, healthy eating and exercise
- Long term conditions including CVD and cancer
- Mental health
- Disabilities

3.5 The new strategy will include an updated health and wellbeing profile for Halton, outline the progress made since 2013 and the challenges that remain, provide an overview of priorities and how and why these were chosen, outline

what we will do as a system at scale to make a difference, and outline how we will measure success.

3.6 We believe that success in delivering against the strategy can only be achieved by working in partnership with local people. Therefore, in developing the new Strategy we will consult with a wide range of Halton residents to ensure that the principles and priorities are reflective of the experience and needs of our local communities. Consultation will be undertaken by One Halton portfolio directors using pre-existing networks and forums for engagement e.g. Halton Peoples Health Forum.

3.7 After considerable consultation with the public and key stake holders a draft of the new strategy will be presented to the Health and Wellbeing Board for comment in October. And the Final version presented to board for approval in January 2017. The final approved version will be made available in hard copy and online.

4.0 POLICY IMPLICATIONS

4.1 The Health and Wellbeing Strategy will inform collaborative action for the Council, NHS, Social Care, Public Health and other key partners as appropriate.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 No additional funding required. However the strategy will inform future activity and spending across the system.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

Improving the Health and Wellbeing of Children and Young People is a key priority in Halton. The Health and Wellbeing Strategy will include child development as a priority.

6.2 Employment, Learning & Skills in Halton

The above priority is a key determinant of health. Therefore improving outcomes in this area will have an impact on improving the health of Halton residents

6.3 A Healthy Halton

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

6.4 A Safer Halton

Reducing the incidence of crime, improving Community Safety and reducing

the fear of crime have an impact on health outcomes particularly on mental health.

6.5 **Halton's Urban Renewal**

The environment in which we live and the physical infrastructure of our communities has a direct impact on our health and wellbeing.

7.0 RISK ANALYSIS

7.1 Developing the Health and Wellbeing Board Strategy does not present any obvious risk however, there may be risks associated with the resultant recommendations. These will be assessed as appropriate.

8.0 EQUALITY AND DIVERSITY ISSUES

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

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

None

REPORT TO: Health and Wellbeing Board

DATE: 6th July 2016

REPORTING OFFICER: Councillor Marie Wright

PORTFOLIO: Health and Wellbeing

SUBJECT: Discussion paper on the Management of Lettings within the Borough and the impact on Older People

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To highlight to the Board the impact that some housing lettings can have on the health and wellbeing of older people within the Borough, and to create a discussion to move this agenda forward with a system-wide solution.

2.0 RECOMMENDATION: That:

i) The Board note the report.

ii) The Board discuss the issues under *3.5 Options for Change* and develop a system-wide solution.

iii) The Board adopt the National Pensioners Convention Dignity Code.

3.0 INTRODUCTION

This report focusses on some of the potential issues that older people can face that impact on their health and wellbeing when in housing association properties. As way of introduction, the following are potential issues faced by older people:

- The older person's surroundings being changed without their prior knowledge;
- Experiencing anti-social behaviour and/or perceived anti-social behaviour, such as noisy children;
- Older people feeling frightened within their own surroundings and feeling that no-one respects their home/living space due to the above;
- The older person becoming isolated and lonely because of the above; and
- not feeling able to complain against fear of retribution.

4.0 **SUPPORTING INFORMATION**

4.1 **Sub-Regional Choice Based Lettings Allocations Scheme**
Halton Borough Council are members of a Sub-Regional Choice Based Letting Scheme, known as Property Pool Plus, and have adopted a common allocations scheme which is a requirement of the Housing Act 1996 as amended by the Homelessness Act 2002 and the Localism Act 2011. Five Councils in total are part of the Scheme, including Knowsley Metropolitan Borough Council, Liverpool City Council, Sefton Metropolitan Borough Council and Wirral Council. 29 Housing Associations have agreed to participate in this Scheme, and are known as Scheme Landlords.

4.1.1 Under Unacceptable Behaviour, point 3.2.3 of the Property Pool Plus, it states that "……partners of the scheme are committed to achieving stable, balanced and sustainable neighbourhoods and to tackling crime and anti-social behaviour and promoting good tenancy conduct".

4.1.2 The Property Pool Plus mentions equality of opportunity within the housing allocation process and delivering a quality service without prejudice and discrimination. There is no specific mention of dignity.

4.1.3 Section 2.4 Sheltered Accommodation focusses on older applicants for housing, but again, there is no mention of dignity.

4.2 Dignity

4.2.1 The National Pensioners Convention has recently developed a national Dignity Code (attached at Appendix 1). Their Dignity Code is similar to the Dignity in Care principles (Appendix 2) that the Council is already signed up to, and therefore, the Council supports the values and principles of this Dignity Code, in line with Dignity in Care. This was taken to the Safeguarding Champions Group on 3rd May and has been shared with social care providers. The code recognises that certain practices and actions are unacceptable to older people. The actions that relate to this paper include:

- Treating older people as objects or speaking about them in their presence as if they were not there.
- Not informing older people of what is happening in a way that they can understand.
- Changing the older person's environment without their permission.

The code calls for positive action, including:

- Respect for an individual's habits, values, particular cultural background and any needs, linguistic or otherwise.
- Comfort, consideration, inclusion, participation, stimulation

and a sense of purpose in all aspects of care.
- Respect for people's homes, living space and privacy.
- Concerns to be dealt with thoroughly and the right to complain without fear of retribution.

4.3 Options for Change

4.3.1 In order to ensure that the health and wellbeing of older people in housing lettings is improved and maintained, the following options need to be considered by the Board:

i) The Board adopt the National Pensioner's Convention (NPC) Dignity Code.

ii) The Property Pool Plus Sub Regional Choice Based Lettings Allocation Scheme focusses on the fair and equitable letting of houses/flats to new customers following certain criteria, but does not mention the dignity of current lettings, or older people specifically. The Board are asked to consider putting forward a recommendation to the Property Pool Plus to adopt the NPC's Dignity Code.

iii) The Board discuss how the health and wellbeing of older people within housing lettings can be brought to the fore and drawn attention to so that other older people do not have their lives affected by inappropriate lettings.

5.0 POLICY IMPLICATIONS

5.1 The adoption of the NPC's Dignity Code by the Health and Wellbeing Board, and potentially, the Sub-Regional Property Pool Plus.

6.0 OTHER/FINANCIAL IMPLICATIONS

6.1 None identified.

7.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

7.1 **Children & Young People in Halton**
N/A

7.2 **Employment, Learning & Skills in Halton**
N/A

7.3 **A Healthy Halton**

The strategic theme under a Healthy Halton is “To improve the health and wellbeing of Halton people so they live longer, healthier and happier lives”.

7.4 **A Safer Halton**

The strategic theme under a Safer Halton is “To ensure safe and secure neighbourhood environments, with attractive, safe surroundings, good quality local amenities, and the ability of people ***to enjoy life where they live***”.

7.5 **Halton’s Urban Renewal**

N/A

8.0 **RISK ANALYSIS**

8.1 Older People within our housing lettings across the borough could be at risk to their health and wellbeing if this matter is not addressed soon. All agencies involved with housing lettings should work together to protect the health and wellbeing of vulnerable older people so that they can all enjoy life where they live.

9.0 **EQUALITY AND DIVERSITY ISSUES**

9.1 Whilst equality and diversity issues need to be considered by scheme landlords when approving housing letting applications, dignity for current residents also needs to be taken into consideration to ensure that new residents do not have a negative effect on current older residents.

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

Document	**Place of Inspection**	**Contact Officer**
Property Pool Plus		Emma Sutton-Thompson

Dignity Code

The purpose of this Dignity Code is to uphold the rights and maintain the personal dignity of older people, within the context of ensuring the health, safety and well being of those who are increasingly less able to care for themselves or to properly conduct their affairs.

This Code recognises that certain practices and actions are unacceptable to older people, such as:

- Being abusive or disrespectful in any way, ignoring people or assuming they cannot do things for themselves
- Treating older people as objects or speaking about them in their presence as if they were not there
- Not respecting the need for privacy
- Not informing older people of what is happening in a way that they can understand
- Changing the older person's environment without their permission
- Intervening or performing care without consent
- Using unnecessary medication or restraints
- Failing to take care of an older person's personal appearance
- Not allowing older people to speak for themselves, either directly or through the use of a friend, relative or advocate
- Refusing treatment on the grounds of age

This Code therefore calls for:

- Respect for individuals to make up their own minds, and for their personal wishes as expressed in 'living wills', for implementation when they can no longer express themselves clearly
- Respect for an individual's habits, values, particular cultural background and any needs, linguistic or otherwise
- The use of formal spoken terms of address, unless invited to do otherwise
- Comfort, consideration, inclusion, participation, stimulation and a sense of purpose in all aspects of care
- Care to be adapted to the needs of the individual
- Support for the individual to maintain their hygiene and personal appearance
- Respect for people's homes, living space and privacy
- Concerns to be dealt with thoroughly and the right to complain without fear of retribution
- The provision of advocacy services where appropriate

NPC
Walkden House, 10 Melton Street, London NW1 2EJ
www.npcuk.org

NPC
NATIONAL PENSIONERS CONVENTION