NHS

Halton Clinical Commissioning Group

Integrated Commissioning Strategy 2013-15

March 2013

Halton Clinical Commissioning Group

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Foreword

On 1st April 2013, under the NHS reforms set out in the Health and Social Care Act 2012, the responsibility for the commissioning of health care services for the people of Halton will be legally passed to three organisations. These organisations are the NHS Commissioning Board (NHS CB), Halton Borough Council and NHS Halton Clinical Commissioning Group (CCG).

This *Integrated Commissioning Strategy* sets out how NHS Halton CCG will deliver the commissioning responsibilities we have been given following the NHS reforms. It is integrated as it sets outs how we will deliver these responsibilities with local people, our member general practices, providers of NHS services and, of course, the NHS CB and Halton Borough Council.

The *Integrated Commissioning Strategy* is the product of over twelve months of engagement with people who live and work in the borough. This engagement has shaped our vision, purpose, values and strategic objectives as a CCG. The *Strategy* therefore demonstrates how, through engagement, our CCG and our member practices are becoming integrated with the local population.

The *Strategy* brings together the 'must dos' for the NHS that are set out in the NHS Constitution, the NHS Mandate and *Everyone Counts: Planning for Patients 2013/14.* The document also sets out the local priorities for Halton that have come from the Joint Strategic Needs Assessment and Health and Well Being Strategy and how the CCG will contribute to delivering these. The *Strategy* therefore integrates national and local priorities in one place and provides clarity as to the outcomes that are to be achieved.

We believe that this *Integrated Commissioning Strategy* paints a rich picture of Halton, of the needs of our population, the challenges we face and what we are going to do to improve access, quality and the experience of the people who use those services. We hope that the *Strategy* becomes a road map for us to deliver our vision of involving everybody in improving the health and well-being of the people of Halton.

Dr Cliff Richards
Chair

Simon Banks
Chief Officer

Executive Summary

- The *Integrated Commissioning Strategy* for 2013-15 describes how NHS Halton CCG developed its plans for conducting business during its first two years as a statutory organisation. It should be read in conjunction with the *Operational Delivery Plan and Commissioning Intentions 2013-14*, which provides more detail about the projects which will underpin organisational development and the commissioning of services in the first year.

- NHS Halton CCG received authorisation from the NHS Commissioning Board (NHS CB) in February 2013 in the third wave of such authorisations, following a rigorous assessment process. This included a review of the CCG's policies, a site visit, assessments of clinical and managerial leadership and work with stakeholders and patients. The *Strategy* forms part of the authorisation process. Its implementation and the delivery of the commissioning intentions will be monitored by the NHS CB.

- This document provides background information about the local area, health priorities, the development of the coming year's commissioning intentions and the achievements of 2012/13. It also details the resources available to the CCG to enable the delivery of its responsibilities, including its budget.

- Early versions of the document have been shared with local authority colleagues by discussion at meetings of the Governing Body (17th January, 21st February, 21st March, 18th April 2013) and the Halton Shadow Health and Wellbeing Board (13th March 2013).

- In accordance with the Constitution of the CCG, the commissioning intentions were approved by the membership (8th February 2013).

- The *Operational Delivery Plan and Commissioning Intentions* sets out our projects in five work programmes.

    - The **corporate development** workstream describes the projects to support the development of the fledgling organisation. These are enabling initiatives which will underpin the delivery of the commissioned services.

    - The engagement process with the general public demonstrated the importance of the **mental health and unplanned care** workstream to our local population. Projects in these areas range from increasing access to psychological therapies to the introduction of rapid assessments for mental health conditions for people presenting at A&E departments.

    - A number of initiatives in **primary, community and integrated care services** provide opportunities for the further development of partnership working with the local authority, such as the redesign of working teams to give a higher quality of support to people discharged from hospital with several different needs. The programme also includes the ongoing development of the 'community wellbeing practices' model, a flagship project for the CCG, which aims to increase the resilience of local communities by harnessing local assets to support wellbeing.

    - The **planned care** work programme contains several initiatives to support people with long-term conditions such as diabetes and respiratory disorders. A number of projects aim to improve the experience of care for people at the end of life.

    - **Women, children and families services** offer a further opportunity to enhance partnership working with the local authority. Plans include a redesign of the care pathway for children experiencing mental health and emotional wellbeing issues and a full review of the community midwifery services.

1. VISION

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

Our **purposes** are:

- To improve the health and wellbeing of the population of Halton, 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.

- 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.

- To work with local people and with partner organisations including Halton Borough Council, 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.

a) 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 as a commissioning organisation.
Leadership	We will be role models and champions for health 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.

2. CONTEXT

a) Who we are

NHS Halton Clinical Commissioning Group (CCG) is responsible for commissioning health services for its 125,700 residents and others who need emergency care whilst in the area.[1]

Halton has two main towns, Runcorn and Widnes, as well as a number of parishes and villages. The geographical area covered by the CCG is coterminous with the local authority boundary of Halton Borough Council.

The CCG is clinically-led by GPs and other healthcare professionals. We are formed and built on a membership model, drawn from the 17 general practices located within Halton, with the aim of ensuring high quality, cost-effective services within a sustainable system.

Each practice has nominated a GP as its lead for liaison with the CCG and this group meets regularly. Additionally, each clinical workstream has a nominated GP lead. There are also regular meetings of practice managers and we are in the process of developing a nurses' forum.

The CCG has existed in shadow form since November 2011, and was established as a sub-committee of the Board of NHS Merseyside in January 2012. It was formed from practices previously governed by NHS Halton and St Helens Primary Care Trust.

Dr Cliff Richards, a local GP, is the Chair of the CCG. Senior officers are Simon Banks, Chief Officer; Jan Snoddon, Chief Nurse; and Paul Brickwood, Chief Finance Officer.[2] Dave Sweeney, Operational Director – Integrated Commissioning, is a joint appointment with the CCG and Halton Borough Council.

[1] This figure is from the 2011 Census
[2] Paul Brickwood is also Chief Finance Officer of NHS Knowsley CCG and NHS St Helens CCG

Fig. 1: Member practices of Halton CCG

Member practices

Practice name	Address
Appleton Village Surgery	2-6 Appleton Village, Widnes WA8 6DZ
Beaconsfield Surgery	Bevan Way, Widnes WA8 6TR
Beeches Medical Centre	20 Ditchfield Road, Widnes WA8 8QS
Brookvale Practice	Hallwood Health Centre, Hospital Way, Runcorn WA7 2UT
Castlefields Health Centre	Village Square, Castlefields, Runcorn WA7 2HY
Grove House Practice	St Paul's Health Centre, High Street, Runcorn WA7 1AB
Heath Road	Heath Road, Runcorn WA7 5TJ
Murdishaw Health Centre	Gorsewood Road, Murdishaw, Runcorn WA7 6ES
Newtown Health Care Centre	Widnes Health Care Resource Centre, Oaks Place, Caldwell Rd, Widnes WA8 7GD
Oaks Place Surgery	Widnes Health Care Resource Centre, Oaks Place, Caldwell Rd, Widnes WA8 7GD
Peelhouse Medical Plaza	Peelhouse Lane, Widnes WA8 6TN
Tower House Practice	St Paul's Health Centre, High Street, Runcorn WA7 1AB
Hough Green Health Park	Hough Green Road, Widnes WA8 4NJ
Upton Rocks Primary Care	Widnes Rugby Union Football Club Car Park, Heath Road, Widnes WA8 7NU
Weavervale Practice	Hallwood Health Centre, Hospital Way, Runcorn, WA7 2UT
West Bank Medical Centre	2 Lower Church Street, West Bank, Widnes WA8 ONG
Windmill Hill Medical Centre	Norton Hill, Windmill Hill

b) How we are governed

Our governance structure, developed in consultation with member practices, is designed to deliver

- clinical engagement,
- clinical governance, and
- clinically-led commissioning.

It provides a supporting structure which promotes strong governance, proper stewardship of public resources and high quality services.

Our comprehensive Constitution sets out our responsibilities and the procedures by which we operate. These are designed to ensure decisions are taken in an open and transparent manner, so that the interests of patients and the public remain central to our goals.

All the members of every general practice are invited to attend the quarterly meetings of the **Members' Forum**. This group makes the final decision on commissioning intentions, the financial plan and the annual report. Decision-making on other matters is delegated to the **Governing Body**, which is charged with the effective, efficient and economical delivery of the CCG's functions in accordance with the principles of good governance.

Dr Cliff Richards chairs the CCG and the monthly meetings of the Governing Body, the membership of which consists of the CCG's Chief Officer, Chief Finance Officer and Chief Nurse; four GPs/other health care professionals; a secondary care doctor; a registered nurse; a practice manager; and four lay members.

The Governing Body is supported by a number of sub-committees and other groups set up to provide assurances and appropriate member practice engagement.

The **Audit Committee** meets quarterly and its function is to provide an independent and objective view of risk management, governance and internal control systems. To enable this, no CCG staff sit on the committee and representatives from Mersey Internal Audit Agency and the external auditors are in attendance.

The **Quality and Integrated Governance Committee** is responsible for the development, implementation and monitoring of patient safety; patient experience; risk management; information governance; complaints; claims; serious incidents; and statutory responsibilities. This committee is supported by a **Service Improvement Group**, which develops, monitors and reviews a service improvement plan. Additional support comes from the **Practice Leads Group,** which enables the ongoing involvement of member practices in setting the commissioning agenda and the development of plans to make our intentions operational.

Discharge of statutory functions in line with the Standing Financial Instructions is the responsibility of the **Finance and Performance Committee**. This committee also monitors the performance of commissioned services.

The **Human Resources, Remuneration and Organisational Development Committee** has delegated responsibility for all matters relating to staffing, salaries and organisational development of the CCG.

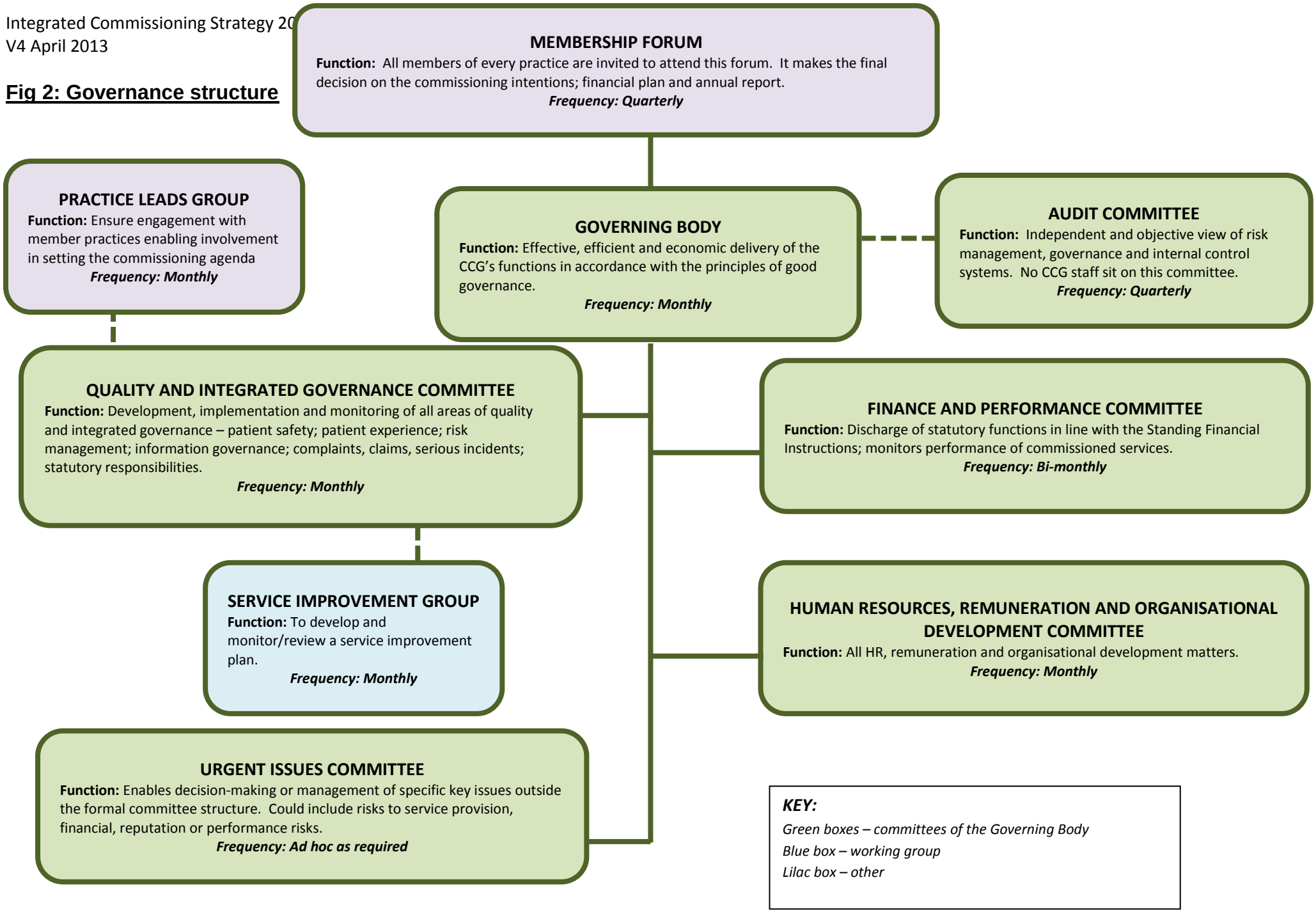
The **Urgent Issues Committee** meets as required to enable speedy decision-making or management of specific issues outside the formal committee structure. These could include risks to service provision and financial, reputation or performance risks.

Fig. 2 on p.10 illustrates this structure.

Conflicts of interest

The CCG has a policy, approved by the Governing Body, for Standards of Business Conduct. This outlines the responsibility of all members of the Governing Body and all employees to adhere to the standards, which include the declaration of conflicts of interest. This policy also applies to GPs and practice staff and there is an implementation plan to ensure its delivery. The Register of Interests and delivery of the implementation plan are monitored by the Audit Committee and MIAA will audit compliance with the policy.

Fig 2: Governance structure



Safeguarding

It is a requirement of all CCG staff that they undertake training in mandatory and statutory areas. These include safeguarding of both adults and children and an introduction to information governance.
All NHS service providers are required to show evidence of their compliance with the safeguarding arrangements against related Care Quality Commission standards. This evidence must be demonstrated as part of the annual regulatory framework.

The Quality and Integrated Governance Committee is responsible for oversight of the effectiveness of safeguarding arrangements.

The Merseyside CCGs have agreed a structure for safeguarding services for both children and adults which is designed to increase resilience across the area. It will improve capability, capacity and quality of service; and ensure statutory duties are fulfilled. From April 2013, Halton CCG will host both the Adult Safeguarding Service and the Children's Safeguarding Service on behalf of the Merseyside CCGs.

Local arrangements for safeguarding are managed by a fully integrated local authority/NHS team.

Complaints and Serious Untoward Incidents

The Quality and Integrated Governance Committee is responsible for ensuring that complaints and serious incidents have been investigated and responded to appropriately. There is ongoing work to raise awareness of identification of serious incidents and to develop a culture of systematic recognition and reporting of complaints and serious incidents. Although it is always regrettable when people are not satisfied with our services, we are working to develop systems which allow us to integrate the learning from such experiences into service improvement and development. We are working within our local health economy to further develop an existing system for the hospitals to raise any concerns they may have about any of our member practices; and for GPs to raise their concerns about any problems they or their patients are experiencing with hospital services.

We are striving for a 'no blame' culture where the investigation of concerns is seen as an opportunity for service development.

Complaints are managed by the Cheshire and Merseyside Commissioning Support Unit (CMCSU). The customer service team operationally manages any complaints received, ensuring investigation and production of a response for the complainant, which is first approved by the chief officer or chief nurse. Most complaints received by the unit relate to primary care but NHS Halton CCG generally has a low number. The team produces monthly reports for the CCG, outlining new complaints; those which are closed; their progress through the system to ensure they are dealt with in the appropriate time frame; and short overviews of the complaint and response. These are reported via the Quality and Integrated Governance Committee.

Responsibility for managing serious incidents will transfer to the CCG, supported by the CMCSU, in April 2013. The process requires reporting of an incident within 48 hours of declaration, via the strategic executive information software system (STEIS). Reports are produced for the CCG on incidents reported by providers. The CMCSU will manage the reporting and performance against timelines and the CCG will form a small internal group to review reports relating to its patients.

c) Our strategic objectives

Our strategic objectives are:

1. Continuous improvement of the health and wellbeing of the people of Halton.
2. Meaningful engagement with local people and communities.
3. Clear and credible plans which continue to deliver improvements in local health services and the **Quality, Innovation, Productivity and Prevention** (**QIPP**) challenge within financial resources, in line with national outcome standards and the local **Joint Health and Wellbeing Strategy (JHWS).**
4. Ensure robust constitutional and governance arrangements, with the capacity and capability to deliver all our duties and responsibilities, including financial control, as well as effectively commissioning all the services for which we are responsible.
5. Establish and sustain collaborative arrangements for commissioning with **other CCGs, Halton Borough Council** and the **NHS Commissioning Board (NHS CB).**
6. Appropriate, affordable and effective external commissioning support.
7. Achieve and maintain authorisation without conditions from the NHS CB.

Achievement of these strategic objectives will be measured via the five domains of the *NHS Outcomes Framework (NHS OF),* which are:

1. Preventing people from dying prematurely.
2. Enhancing quality of life for people with long-term conditions.
3. Helping people to recover from episodes of ill health or following injury.
4. Ensuring people have a positive experience of care.
5. Treating and caring for people in a safe environment and protecting them from avoidable harm.

d) Our locality

Halton's population, at around 125,700, has increased by approx. 6% in the decade to 2011. The most significant increases were in the 0-4; 45-64 and 75+ age groups. The 5-14 age group has declined.

Ten things you need to know about Halton …

1. **The older people age group (65+) is projected to grow from 18,600 in 2011 to 24,700 in 2021.**
2. **Halton's population is largely white (97.5%).**
3. **Unemployment and worklessness are key challenges in Halton, with variation between wards. Around one-third of adults in Windmill Hill claim an out-of-work benefit.**
4. **The average household income in Halton is £33,800.**
5. **GCSE attainment in Halton is in line with the national average. The range is 30% (Windmill Hill) to 90% (Hale).**
6. **House prices in Halton are low. This means that Halton is a relatively affordable place to live, with house prices around four times average earnings.**
7. **Around a quarter of Halton's population rent homes from registered providers. This is around twice as much as regional and national figures.**
8. **Deprivation is a major issue in Halton. Of the 70 'super output areas', 21 fall in the 10% most deprived areas in England. Over a quarter of children – 6,950 – live in poverty.**
9. **Life expectancy in Halton is low. Female life expectancy is the fourth lowest in the country.**
10. **Halton has been identified as the eighth worst local authority area in England for alcohol-related harm and the 50th worst area for binge drinking.**

Health has improved over the last decade. People in Halton are living an average of two years longer than they were a decade ago. However, they still do not live as long as the national average.

Factors contributing to the overall improvements in health include:

Reductions in:

- Deaths from heart disease and cancers.
- The number of adults who smoke.
- The number of adults and children killed and seriously injured in road traffic accidents.

Improvements in:

- Diagnosis and management of common health conditions such as heart disease and diabetes.
- Detection and treatment of cancers .
- The percentage of children participating in at least three hours of sport/ physical activity. This is above the national average.

Increases in:

- The percentage of children and older people having their vaccinations and immunisations.

The table below shows a baseline view of the population dynamics, assuming recent demographic trends continue.

HALTON'S BASELINE POPULATION DYNAMICS		
Short term 2011-14	**Medium term 2011-17**	**Long term 2011-21**
+ 1%	+ 2%	+ 3%*
Long term (2011-21) projections		
Younger people (0-15 year olds)		+ 10%
Working age (16-64 year olds)		- 5%
Older people (65+)		+ 33%

**This is lower than both North West regional and the national anticipated population growth, projected at 4% and 9% respectively.*

It is evident that prevention and early intervention strategies will be necessary for health and social care services to cope with the expected increased demand from this changing population.

The provider landscape

Healthcare services are commissioned from a wide range of providers. In the Halton area there are

17 general practices
12 dentistry practices
11 optometry practices
31 community pharmacies

contracted to provide NHS services. From 1st April 2013 these contracts will be held by the NHS CB.

In Merseyside, the CCGs have agreed that one CCG will act as co-ordinating commissioner for each of the NHS provider trusts; this is normally the CCG which accounts for the largest proportion of commissioned activity from that trust. The main NHS provider trusts offering services to Halton residents are listed below, with the co-ordinating commissioner shown in brackets.

Community services

Bridgewater Community Healthcare NHS Trust *(NHS Halton CCG)*

Hospital services

Warrington and Halton Hospitals NHS Foundation Trust *(NHS Warrington CCG)*
St Helens and Knowsley Teaching Hospitals NHS Trust *(NHS St Helens CCG)*, also known locally as Whiston hospital and St Helens hospital.

Mental health services

5 Boroughs Partnership NHS Foundation Trust *(NHS Knowsley CCG)*
Child and Adolescent Mental Health Service (CAMHS) for children and young people up to age 18

Ambulance services

The North West Ambulance Service (NWAS) provides emergency services *(NHS Blackpool CCG)*

Specialised services

Specialised services are commissioned nationally by the NHS CB. Generally speaking, these are services or procedures which affect fewer than 500 people across England in any year. The Merseyside area has four specialist hospitals (including one children's specialist hospital).

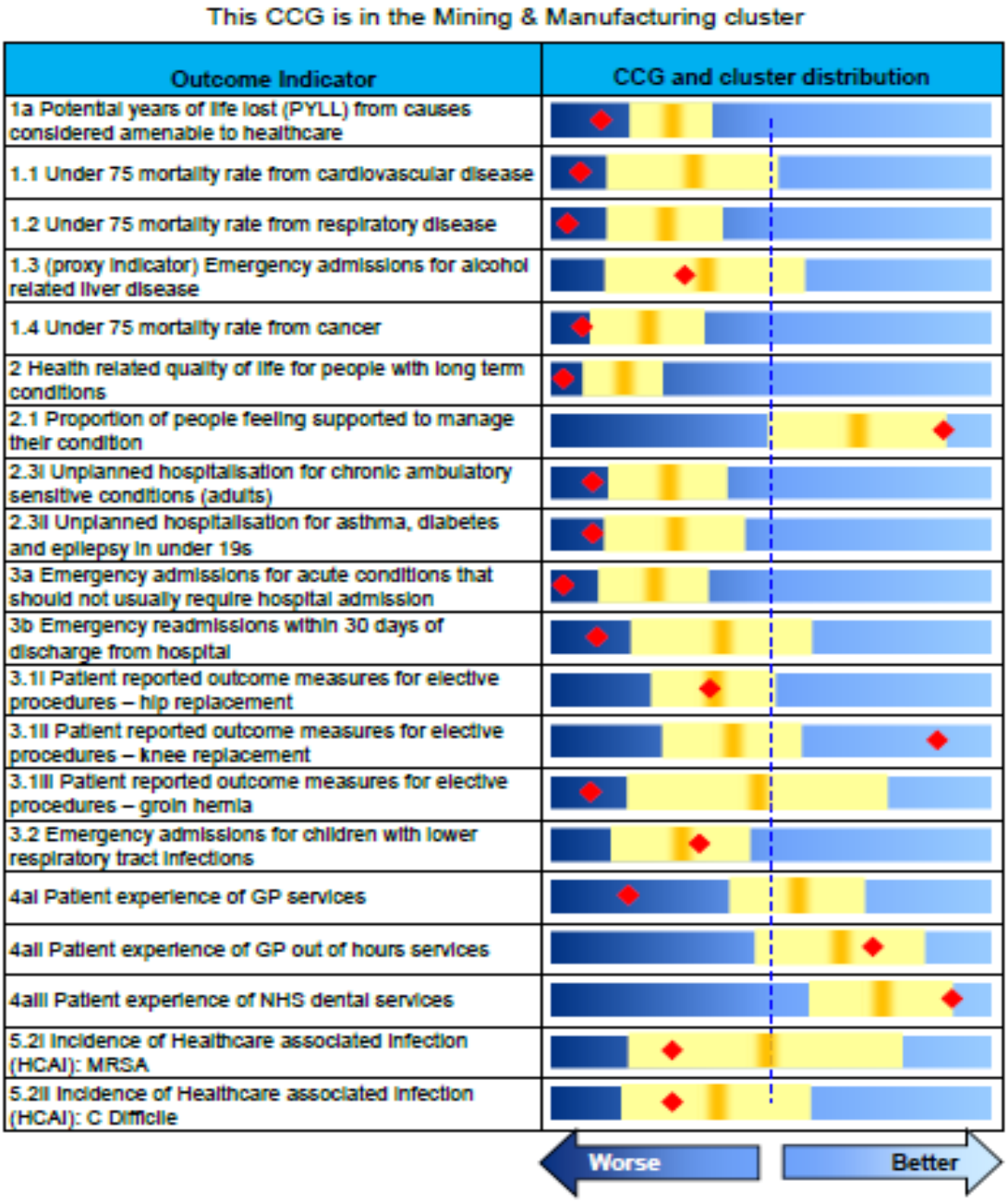
Third sector and commercial providers

Some services are provided by third sector and commercial providers. A diverse and competitive supplier base will give patients more choice. The network of CCGs on Merseyside has this year undertaken 'Any Qualified Provider' (AQP) procurements of musculoskeletal (neck and back pain) services; hearing aids for adults; and core podiatry.

Halton General Hospital, part of Warrington and Halton Hospitals NHS Foundation Trust

NHS Halton CCG's position on the indicators in the NHS Outcomes Framework

The chart below shows the distribution of CCGs on each indicator. NHS Halton CCG is shown as a red diamond. The yellow box shows the interquartile range and median of CCGs in the same cluster (as defined by the Office for National Statistics) as this CCG. The dotted blue line is the England median. Better outcomes are towards the right of thepage (lighter blue). This illustrates the disease areas where health inequality is greatest.



e) Working Collaboratively With Our Partners

The Halton area has a longstanding practice of close partnership working between public sector colleagues. We will continue to strengthen the existing working partnerships to maximise benefits for our local population.

This could include collaborative working with the council, schools, colleges, job centres, housing associations, the police and criminal justice agencies. It will also involve working with **other CCGs, health care providers,** the **NHS CB**, the **Department of Health** and **Public Health England**, **Healthwatch, patients** and the **public.**

Section 25 of the NHS Act enables local authorities and CCGs to pool resources in order to work together. We have worked with **Halton Borough Council** to produce a *Framework for Integrated Commissioning in Halton.* This explores national good practice, with an action plan aimed at improving the flexibility of both organisations in the use of resources, responsiveness and innovation. In support of the principles outlined within the framework we are developing a partnership agreement with the council to enable maximum levels of integration in the commissioning of health and social care services. This agreement includes urgent care; long-term conditions and complex care. One piece of work already undertaken is *Halton's Urgent Care Partnership's Response Plan*, which was approved by the CCG's Governing Body in September 2012. This sets out a 'whole system' vision for urgent care services in Halton, for which there is an increasing demand; and a strategy for achieving that vision.

At local level, the Health and Social Care Bill 2012 transfers primary responsibility for **public health** from the NHS to the local authority. There is a formal agreement (memo of understanding) between the authority and the CCG about how the public health department and the CCG will work together. Public health will provide specialist advice to the CCG, including the development of a defined specification for comprehensive public health support. Additionally, for agreed topics, public health will assess the health needs of the local population and how they can best be met using evidence-based interventions. The CCG will ensure it incorporates

specialist public health advice into its decision-making processes, in order that this expertise can inform key commissioning decisions. It will also utilise specialist public health skills to target services at the greatest population need and towards a reduction of health inequalities; and contribute intelligence and capacity to the production of the JNSA.

The **network of Merseyside CCGs** has agreed a high-level strategy until 2014-15, taking into account the need to focus on quality, reform and maximised use of resources. A number of pieces of work are undertaken across the whole network area. These include the ongoing QIPP projects, which are co-ordinated and monitored from a central programme office. In addition to the pan-Merseyside schemes, there are other projects undertaken with one or several local partners. For example, we are currently working with **NHS Warrington CCG, NHS St Helens CCG** and **Bridgewater Community Healthcare NHS Trust** to review intravenous therapies.

f) Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS)

We and our local authority colleagues are jointly responsible for assessing and prioritising key health and wellbeing needs. The JSNA provided evidence of local need. In conjunction with the outcomes frameworks for public health, the NHS, adult social care and children and families, it was used to inform an extensive consultation with local people (including children and young people).

The Halton Shadow Health and Wellbeing Board collated and analysed the information from all of those sources, using a prioritisation method which enabled the scoring of the emerging results. This meant that the decisions about the priorities focused on in the JHWS were made from a strong evidence-base.

The five priority areas identified in the JHWS, and the organisation with the lead commissioning responsibility for that priority, are:

- Prevention and early detection of **cancer** – Local Authority (Public Health)
- Improved **child development** – Local Authority and NCB
- Reduction in the number of **falls** in adults – Local Authority (Public Health)
- Reduction in the harm from **alcohol** – Local Authority (Public Health)
- Prevention and early detection of **mental health** conditions – Local Authority (Public Health)

In order to address these priorities, a series of co-ordinated interventions are needed and these are outlined in a multi-agency implementation plan. This commissioning strategy forms part of that plan.

Challenges

Significant progress has been made in increasing life expectancy and reducing health inequalities. However, there remains a range of challenges.

Cancer

- The proportion of women who die from cancer is higher in Halton than anywhere else in the country. Much of this is due to lung cancer caused by smoking.

Child development

- A range of child health indicators remain poor. Child obesity levels at both reception and year 5 remain above the national average. A greater percentage of women continue to smoke during pregnancy and fewer women start breast feeding compared with national rates.

Falls

- The rates of hospital admissions due to falls are higher in Halton than for England and the north west. Rates are especially high in the over 65 age group. Falls in Halton's population in this age group which resulted in a recorded injury were the highest in England in 2010-11.

Alcohol

- Alcohol and substance misuse continue to create challenges for the health service and wider society, in particular crime and community safety. Admissions to hospital due to alcohol-related conditions continue to rise each year.
- Hospital admissions due to alcohol for those under the age of 18 are amongst the highest in the country (2007-2010 figures). Admissions due to substance misuse (age 15-24 years) were the highest in England (2008-11 figures).

Mental health

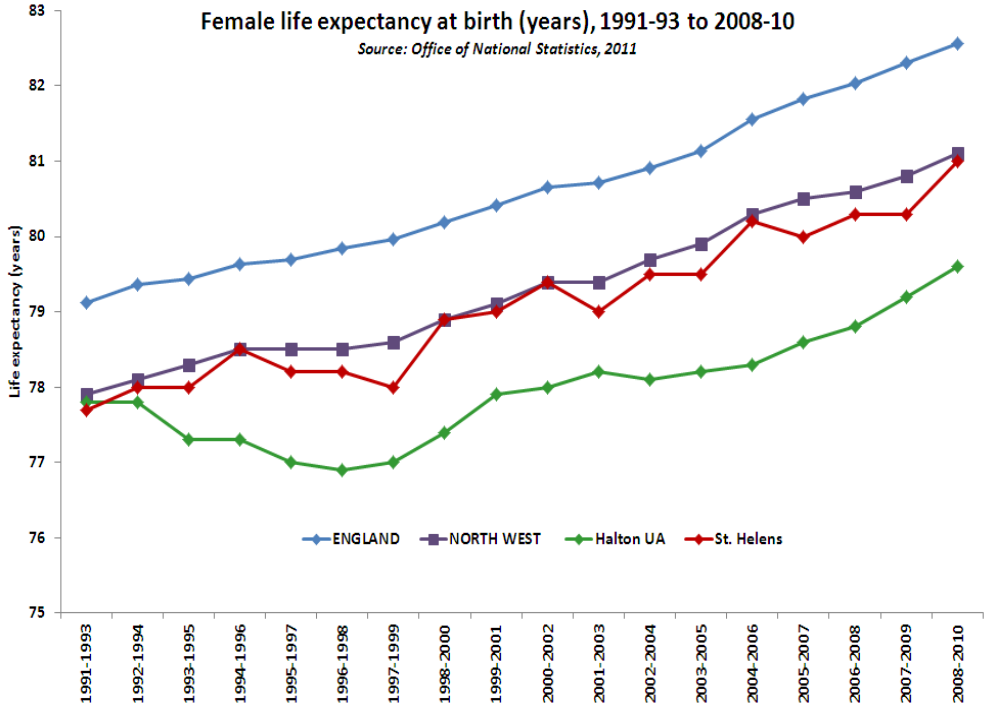
- The ageing population means more people will be living with dementia.

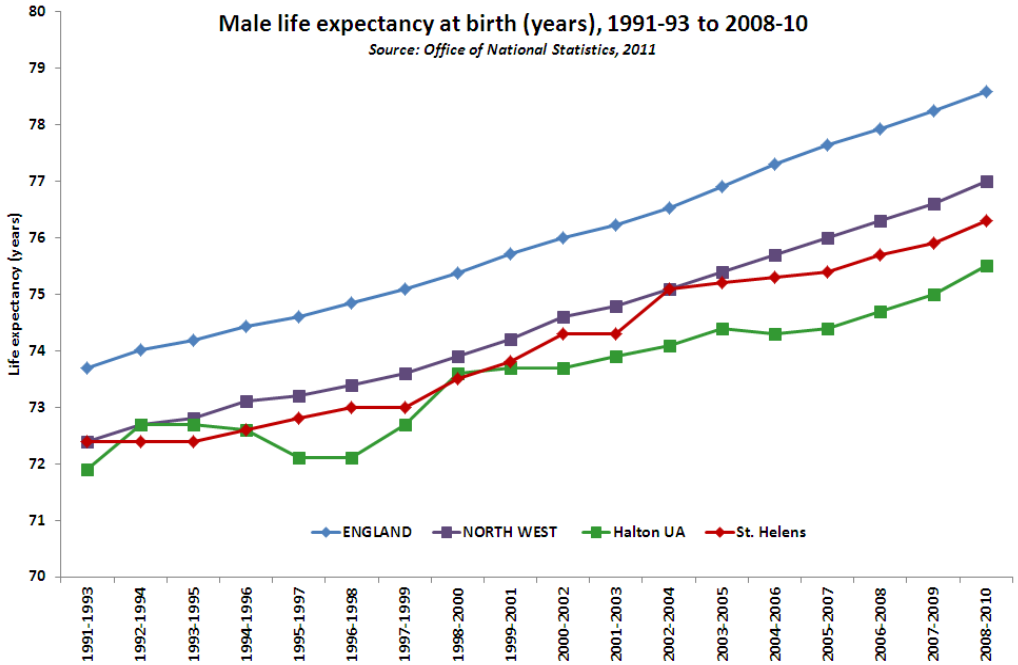
- Significant numbers of people suffer mental health problems, such as depression. One in every four people will develop depression during their life. Mental health problems account for the single largest cause of ill health and disability in the borough.

General

- There are significant inequalities in how long people live across the borough.
- People in Halton live a greater proportion of their lives with an illness or health problem that limits their daily activity than in the country as a whole.
- As Halton's population ages, it is predicted there will be more people with diabetes; this is linked to obesity.
- It is predicted that more people will develop bronchitis and emphysema because of previously high levels of smoking.
- Halton has high levels of people admitted to hospital as emergency cases compared with the country as a whole and many other boroughs. The less wealthy parts of the borough have higher emergency admission rates than those area which are wealthier.
- Teenage pregnancy rates remain high. Having a child before the age of 18 can negatively affect the life chances and health of both the parent and the child.

Life expectancy




Male life expectancy at birth (years), 1991-93 to 2008-10
Source: Office of National Statistics, 2011
Life expectancy (years)
80
79
78
77
76
75
74
73
72
71
70
ENGLAND
NORTH WEST
Halton UA
St. Helens
1991-1993
1992-1994
1993-1995
1994-1996
1995-1997
1996-1998
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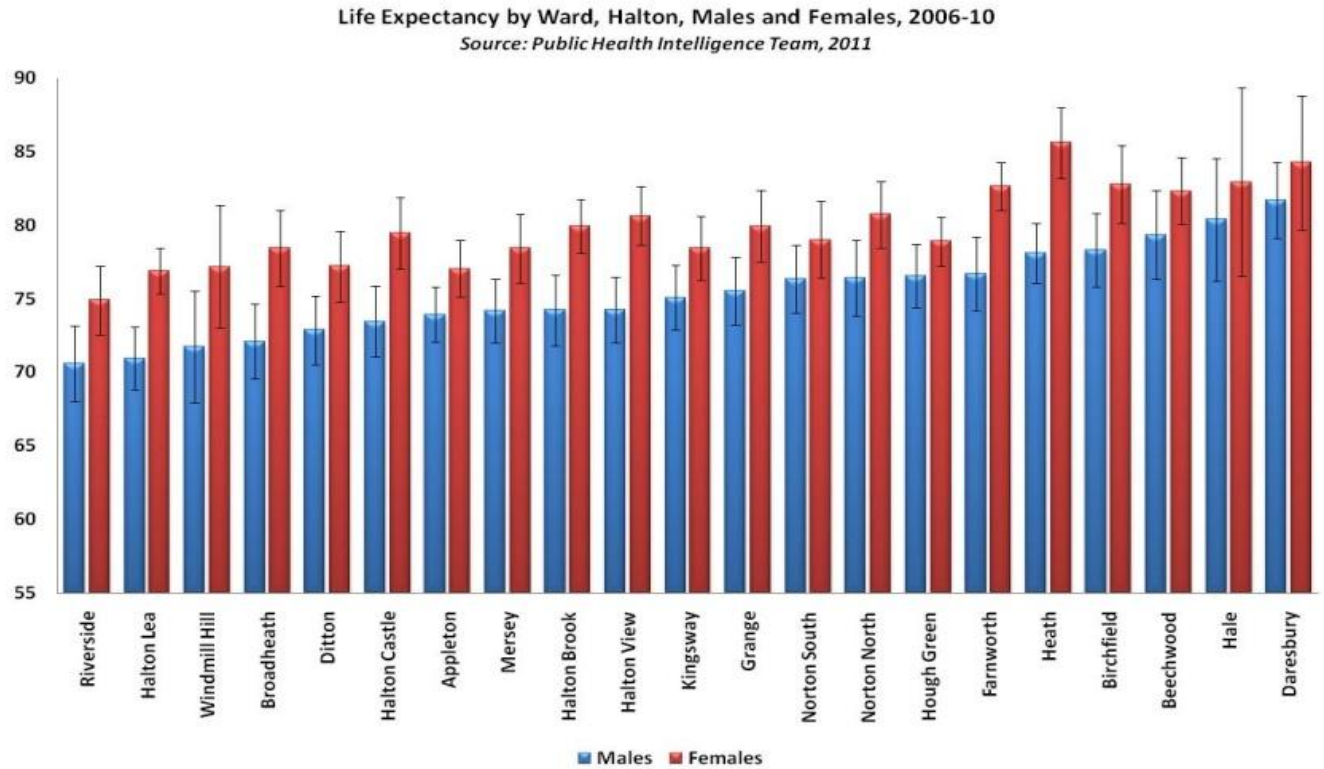
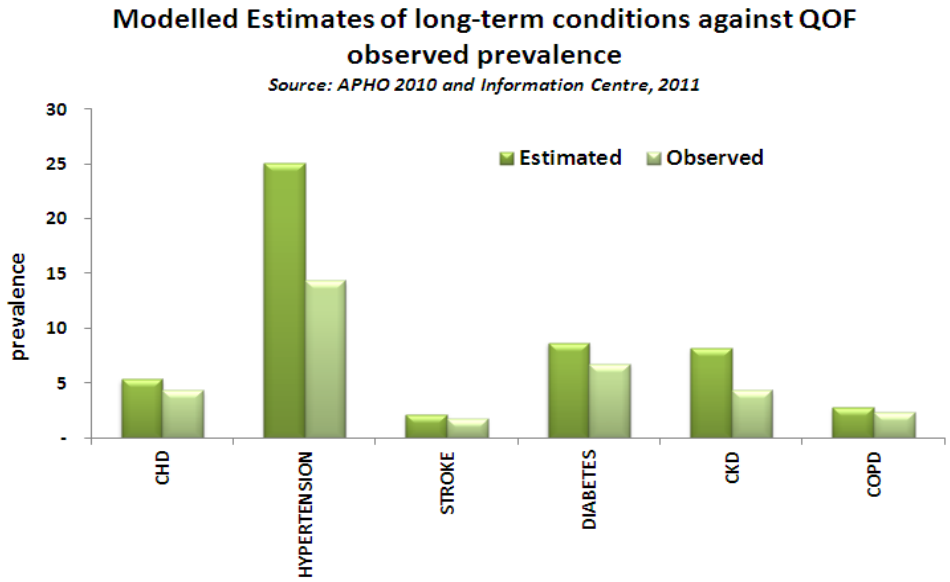

Life Expectancy by Ward, Halton, Males and Females, 2006-10
Source: Public Health Intelligence Team, 2011
90
85
80
75
70
65
60
55
Riverside
Halton Lea
Windmill Hill
Broadheath
Ditton
Halton Castle
Appleton
Mersey
Halton Brook
Halton View
Kingsway
Grange
Norton South
Norton North
Hough Green
Farnworth
Heath
Birchfield
Beechwood
Hale
Daresbury
Males
Females

Disease prevalence: expected against observed rates



LONG TERM CONDITION	MODELLED		OBSERVED	
	Number	Prevalence	Number	Prevalence
CHD	6928	5.40	5,665	4.4
HYPERTENSION	32141	25.10	18,411	14.4
STROKE	2866	2.20	2,362	1.8
DIABETES	8321	8.70	6,901	6.8
CKD	7,474	8.2	4,421	4.4
COPD	3633	2.80	3,048	2.4

g) How our performance will be measured and other key influences

The NHS is going through a time of unprecedented transformational change. The economic situation means that resources are likely to be limited for some time. This, along with an ageing population and increasing demand on services, means that we must find better ways of delivering services.

The **Health and Social Care Act 2012** is the largest piece of health legislation since the creation of the NHS. It legislates for the reform of the NHS first set out in the White Paper *Equity and Excellence: Liberating the NHS.'* The Act legislates for the key principles of:

- Placing patients at the centre of the NHS.
- Changing the emphasis of measurement to clinical outcomes.
- Empowerment of health professionals, in particular GPs.

The **NHS Commissioning Board** is responsible for directly commissioning some health services at a national level. These services are:

- Primary medical, pharmacy, optical and all dental services.
- Specialised services.
- Some specific public health screening and immunisation services.
- Services for members of the armed forces.
- Services for offenders in institutional settings.

The NHS CB is also responsible for the authorisation of CCGs and for carrying out annual assessments of CCGs. The criteria for assessment will be published by March 2013 and will be based on the domains used for authorisation:

- Improving the quality of services.
- Reducing inequalities.
- Obtaining appropriate professional advice.
- Public involvement.
- Meeting financial duties .
- Taking account of the local Joint Health and Wellbeing Strategy.

The Department of Health's (DH) Mandate to the NHS CB sets out the strategic direction for the NHS and objectives that the Board is legally obliged to pursue to March 2015. The Mandate has five improvement areas which correspond to the five domains with the *NHS Outcomes Framework* and indicators from the framework will be used to measure progress.

In December 2012 the NHS CB published *Everyone Counts: Planning for Patients 2013/14.* This document describes which areas CCGs must focus on in 2013/14 and the outcomes which will be used to track progress.

Four measures have been selected as national priorities and the NHS CB will monitor the CCG's progress against them. These are:

1. Potential years of life lost (PYLL) from causes considered amenable to healthcare.
2. Emergency readmissions within 30 days of discharge.
3. Friends and family test.
4. Incidence of healthcare associated infections (HCAI) – (i) MRSA and (ii) *C. difficile*

Additionally, the CCG will agree with the NHS CB three local measures, which take account of the priorities in the Health and Wellbeing Strategy, against which performance will be measured. These are:

- Increased number of physical health checks for people with learning disabilities
- Increased diagnosis/treatment of atrial fibrillation in people over 65
- Increased diagnosis/treatment of impaired glucose response

At the time of writing these priorities are subject to confirmation by the NHS Commissioning Board.

The CCG will also be monitored by the NHS CB on:

- Estimated diagnosis rates for people with dementia.
- Completion of the full roll-out of the access to psychological therapies (IAPT) programme by 2014/15 and recovery rate to reach 50%.

h) Our achievements 2012-13

Commissioning is divided into four workstreams, under the leadership of the Operational Director – Integrated Commissioning. The workplan for the year 2012-13, when the CCG was in shadow form, included ongoing projects from the former NHS Halton and St Helens PCT; the priorities set out by NHS Merseyside and the setting up of the shadow CCG.

Urgent and Unplanned Care

Urgent Care Review

This piece of work is undertaken in partnership with Halton Borough Council. A range of factors are causing an increase in the demand for urgent care services. These include a complex range of access points into the health system, which are not understood by the public, often leading to default to accident and emergency (A&E) departments. There is an increase in the number of A&E attendances which is in part due to people attending with minor ailments. An audit of A&E attendances has been undertaken. This was a two-week, 24/7 'snapshot' of all attendances and the results have been assimilated and analysed. A full options appraisal will follow.

Paramedic Pathfinders

Work has been undertaken with the North West Ambulance Service NHS Trust to agree care pathways for patients who are terminally ill and at the end of
life who may suffer a fall. When called to such patients, the paramedics will follow that individual's care plan, only taking them to a hospital if it is necessary. This scheme is being piloted and if successful will be introduced in other care pathways.

Reablement and Rehabilitation Team

This multi-disciplinary team, which includes social workers and therapists, has been formed jointly with Bridgewater Community Healthcare NHS Trust, Warrington and Halton Hospitals NHS Foundation Trust and the local authority. GPs can refer patients for assessment, including blood and other tests, and the most appropriate care will be arranged, avoiding hospital admission unless this is necessary.

Improving Access to Psychological Therapies (IAPT)

The service has been reviewed and redesigned. The service specification was approved by the Governing Body in December and the service will be procured in the current financial year. Benefits of the redesigned service include improved access; reduced waiting times; skills development of existing staff; and financial savings.

Primary, Community and Integrated Care

Tailored care/multi-disciplinary teamworking

This project redesigned integrated discharge teams as part of a bigger piece of work around the ongoing development of community nursing, in partnership with the local authority and a number of nursing homes. There are two general practices piloting the model of multi-disciplinary neighbourhood district nursing teams, which aim to ensure that care is delivered in the most appropriate place at the appropriate time for the individual patient.

Wellbeing practices

Funding was secured to pay for community development workers to engage with practices to develop a Wellbeing Practice scheme. Practices were invited to express interest in participation in the development of a growth model of increasing wellbeing by harnessing community resources. There was much enthusiasm, with eight practices showing keen interest. The aim of this is to develop community resilience, ultimately improving health. The development workers are helping practices to deliver action plans for a diverse range of activities where the practice acts as a hub to signpost people to other services – for example, fruit on prescription scheme; allotment scheme; exercise/parks/waterways; dementia. The learning from this project will be shared both locally and nationally.

Medicines management

As part of the Merseyside-wide QIPP plan, £2m savings were identified from Halton.

Carers

In conjunction with Halton Borough Council, funding for carers' breaks was mapped. Work was undertaken to use additional funding to enhance support for carers in joint CCG/local authority priority areas including hospital liaison, autism and mental health.

GP Portal

A health intelligence tool was implemented in each practice which gave access to that practice's activity. This can be tracked to individual patient level and allows practices to identify areas for development and improvement.

Planned Care

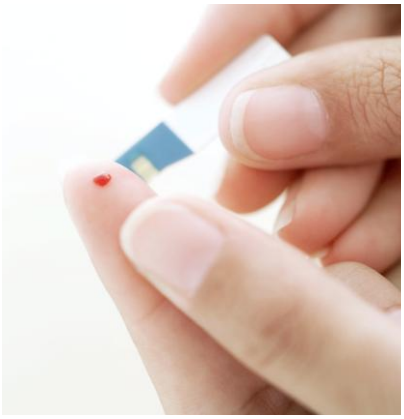
Diabetes

Several projects have been co-ordinated across the NHS Merseyside geographical area and are now complete. These include:

Insulin passports. Patients who take insulin to control their diabetes have been issued with 'insulin passports' in accordance with National Patient Safety Agency guidance. These documents are kept by the patient and record their current insulin products.

Insulin pumps. A specification for the consistent authorisation of these in accordance with patient need has been agreed and is in the process of being incorporated into provider contracts.

Impaired glucose reaction (IGR). A standard pathway was agreed across Merseyside, which has informed the development of NICE guidance. This will be introduced in primary care. For the Halton area, the capacity of the lifestyle service is to be verified.



24/7 Telephone Advice Service, Specialist Palliative Care. This service previously operated in standard business hours only. It was first extended to standard hours, all week availability and then further extended so that it is now available 24 hours, every day. Benefits include increased access to specialist palliative care advice and support for patients, families and professionals; ensuring the patient's preferred place of care is identified and their choice supported; delivery of NICE Improving Outcomes Guidance; and a reduction in unnecessary hospital admissions.

Any Qualified Provider (AQP) procurements. This work was co-ordinated by the Commissioning Support Unit and specifications were drawn up on a Merseyside-wide basis. There was a national requirement for all CCGs to participate in three AQP procurements, with the aim of extending patient choice. The areas chosen in Merseyside were musculoskeletal services; podiatry and adult hearing aid provision.

Women, Children and Families

Children's trusts were set up as local partnerships which brought together all the organisations responsible for children's services, led by local authority directors and lead members of children's services. Each partner organisation retained its individual responsibilities but worked with other organisations to ensure services worked together. Children's trusts are no longer a legal requirement; however, Halton has chosen to retain this model as it has worked well in the local area. A key priority for Halton Children's Trust is the commitment by all partners to improved outcomes for children and young people through the delivery of integrated early help and support. Recent examples of the success of this approach include an 18% fall in the rate of teenage pregnancy.

The CCG's women, children and families commissioning staff were appointed in January 2013 and work closely with the local authority team. Early pieces of work include:

- The development of a service specification for the coordination of diagnostic panels for autism spectrum disorder; the aim of this is to reduce waiting times for diagnosis.
- Health assessments for looked-after children. Halton has more children in care from other parts of the country than from the borough. This puts pressure on local services.
- Collaboration with primary care to develop scheme for reduction of hospital admissions for asthma.

3. COMMISSIONING INTENTIONS 2013-15

We have actively sought to ensure robust clinical and public engagement in the development of our commissioning plans for 2013-15. Stakeholder events were arranged for member practices and also for patients, community groups, partner organisations and the general public. This approach demonstrates our commitment to the need to reduce inequalities in line with local requirements and to give mental health the same priority as physical health, which are important aspects of the NHS CB's mandate.

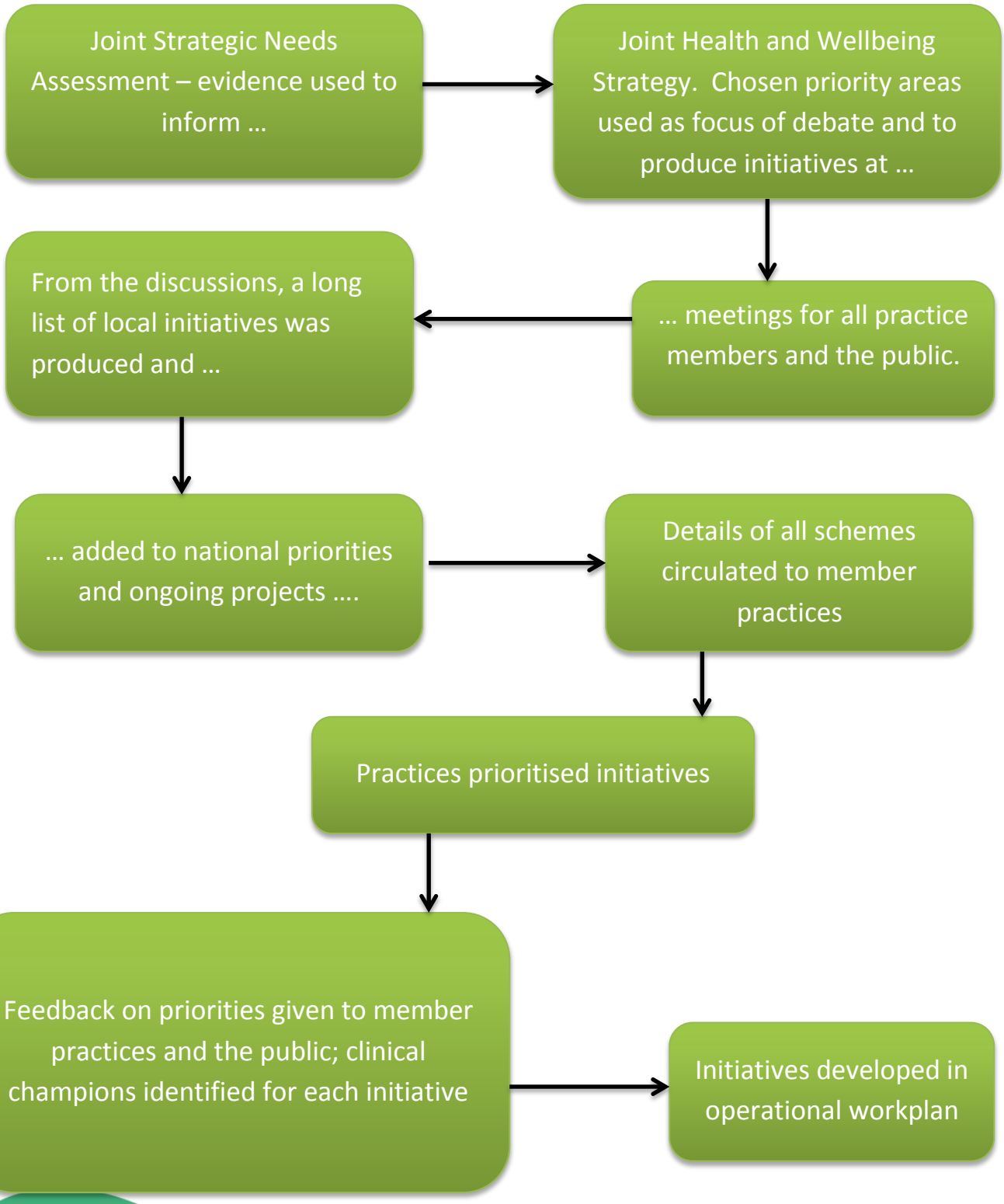
The five areas identified in the **JHWS – cancer, child development, falls, alcohol, mental health** – were used as topic areas for discussion. Each of these areas is compatible with at least one of the five domains in the *NHS Outcomes Framework.*

Attendees were invited to put forward their ideas for improvements in these areas. The resulting feedback was used to formulate a long list of potential topics for commissioning. These were added to outstanding projects from the previous year's commissioning intentions and the details fed into an IT system. The link to this system was then sent to every GP practice, enabling the practice team to allocate voting points to each initiative based on set criteria. Votes were analysed to produce a ranking order for the initiatives.

This process has enabled strong clinical engagement in the development of the commissioning intentions. It has also identified the areas of most concern to the public. These were mental health services, alcohol misuse and access to services at evenings and weekends. There is ongoing work on all these issues, including work led by the public health and local authority teams, which complements the projects led by the CCG.

The Halton commissioning plan has been developed to include the consideration of QIPP impact across all schemes. A companion document, *Operational Delivery Plan and Commissioning Intentions 2013-14* provides descriptions of each of the projects. It also details the plans for ongoing corporate development. The CCG's membership approved the commissioning intentions at its meeting on 8th February 2013.

Fig. 3 Flowchart illustrating the formation of the commissioning intentions.



Managing performance against our commissioning and financial plans

During 2012/13 NHS Merseyside developed an early warning dashboard (EWD) for each NHS Trust provider, similar to the approach adopted by the NHS CB on a national basis.

The EWD gives an at-a-glance view of performance of that provider against 48 indicators, which include infection control, quality risk profiles and safety measures. The indicators currently in the dashboard are those agreed nationally and locally as effective early markers of possible provider problems or service failure and more can be added when appropriate.

Regular review of the dashboard, which will take into account any additional local knowledge around particular issues, will allow effective and timely responses to manage situations as they arise.

The CMCSU will update the dashboard weekly and send to the Chief Nurse for review. Any concerns will be discussed by the senior management team and, when appropriate, escalated to the Governing Body. This process was agreed by the Quality and Integrated Governance Committee in February 2013, which also agreed to review the dashboard at its monthly meetings.

Internal performance management

We are working with the CMCSU and performance management teams in other CCGs to further develop the business intelligence portal. The aim is to enable us effectively to monitor performance against the requirements set out in *Everyone Counts*, some key information for use in general practices and other issues of importance locally.

Additionally, and in response to feedback received during the CCG's authorisation process, we are developing a programme management office. This function will monitor progress of projects in the commissioning workplan and, when appropriate, escalate issues for the attention of the senior management team; it will also be responsible for delivery of the corporate workstream detailed within the workplan for 2013/14.

Key milestones for each project are set out in the workplan. The early stages of development in each piece of work will include the identification of key performance indicators. We are working with colleagues in the CMCSU to identify a web-based project management system which will enable performance monitoring against plans.

Commissioning intentions

WORKSTREAM: Mental health and unplanned care

COMMISSIONING INTENTION	DESIRED OUTCOMES
MHUC1. Update oservice specifications.	Ensure current service is reflected; support performance monitoring.
MHUC2. Dementia screening in care homes.	Early identification and treatment aided by use of technology.
MHUC3. Redesign of A&E liaison psychiatry service.	Reduced waiting times; improved patient experience and support for families and carers.
MHUC4. Implement procurement of increased access to psychological therapies (IAPT).	Improved access; reduced waiting times; financial savings.
MHUC5. Urgent care redesign.	Reduce A&E attendance and readmissions.
MHUC6. Roll out of NHS 111/Directory of services .	Smooth transition between existing and new services.
MHUC7. Alzheimer's Admiral nurses.	Improved experience of care and quality of life for people with dementia, their families and carers.
MHUC8. Wellbeing care pathway redesign to ensure all patients on the seriously mentally ill register have access to yearly physical health checks.	Improve physical health care for people with severe mental illness..
MHUC9. Implement action plan for learning disabilities services.	Improved care for people with learning disabilities.
MHUC10. DVT pathway – community-based anti-coagulation clinic.	Improved access.

WORKSTREAM: Primary, community and integrated care

COMMISSIONING INTENTION	DESIRED OUTCOMES
PCI 1. Update service specifications.	Ensure current service is reflected; support performance monitoring.
PCI 2. Complex care – pooling of resources and alignment of systems.	Improve patient experience; improve discharge pathways; increase positive outcomes; reduce inappropriate hospital admissions
PCI 3. Mobilisation of new out of hours contract.	Smooth transition between existing and new services.
PCI 4. Redesign of integrated discharge teams.	Reduction in unplanned admissions; improvement management of healthcare-acquired infections.
PCI 5. Develop wellbeing practice model and extend to all practices.	Reductions in inappropriate referrals; integration of community and third sector provision with general practice; increase social cohesion; enhance wellbeing and community resilience.
PCI 6. Modernise six clinical pathways	Avoid inappropriate referrals, emergency attendances and admissions. Increased practice engagement in commissioning cycle.
PCI 7. Electrocardiogram in primary care	Reduce avoidable hospital referrals and admissions; reduce waiting times; improve patient experience.
PCI 8. Atrial fibrillation – routine screening for people aged over 65	Reduce variation in identification rates and significantly increase diagnoses; reduce incidence of stroke and its human, social and financial costs.

WORKSTREAM: Planned care

COMMISSIONING INTENTION	DESIRED OUTCOMES
PC 1. Update service specifications.	Ensure current service is reflected; support performance monitoring.
PC 2. End of life service improvement programme. a) Breathlessness; psychological support. b) QOF end of life (nursing homes) c) Med in Sheds d) Implement electornic palliative care co-ordination e) Local implementation of 'do not attempt cardiopulmonary resuscitation	Improved quality of care at end of life and increased support for patients; reduced inappropriate admissions.
PC 3. Gold standard framework for proactive palliative care	Improved consistency and reliability of care at end of life.
PC 4. Hypoglycaemic pathway.	Introduction of care pathway for people with diabetes who have a hypoglycaemic episode requiring hospital attention.
PC 5. Nebuliser modernisation.	Ensure ongoing provision of service.
PC 6. Procurement of ENT community assessment and treatment services.	Reduced follow-up appointments and reduced number of appointments cancelled by patients. Financial savings.
PC 7. Ophthalmic primary eye care assessment and referral.	Early access to specialist assessment, diagnosis and treatment.
PC 8. Musculoskeletal service.	Ensure ongoing provision of service.
PC 9. Diabetes patient education.	Secure provision of service at end of current contract.
PC 10. Review pathology provision.	Ensure provision of appropriate service.
PC 11. Multi-faceted respiratory education service.	Education programme for healthcare professionals to cover management of asthma; COPD; spirometry performance and interpretation; self-management plans; end of life care; oxygen management and pulmonary rehabilitation.

PC 12. Dedicated respiratory review service for Halton community.	Provision of fast-track consultant-led respiratory service to diagnose, review and optimise patient treatment.
PC 13. Direct access to gastrointestinal diagnostic services.	Reduction in inappropriate outpatient appointments.
PC 14. Modernise spirometry service.	Ensure correct diagnosis of COPD; and appropriate medicines management.
PC 15. Community dermatology service.	Improved patient experience; care closer to home; speedier treatment; improved value for money; reduced referrals to secondary care.
PC 16. Community gynaecology service.	Improved patient experience; care closer to home; speedier treatment; improved value for money; reduced referrals to secondary care.
PC 17. Seven-day TIA service	Reduce delays in diagnosis and risk of re-occurrence of TIA and occurrence of stroke; increase percentage of appropriate patients receiving thrombolysis which improves clinical outcomes.
PC 18. Termination of pregnancy service (TOPS)	Ensure provision of high-quality, cost-effective service.
PC 19. Impaired glucose tolerance pathway.	Increase ability for self-care; reduce risks of complications arising from development of the illness.

WORKSTREAM: Women, children and families

COMMISSIONING INTENTION	DESIRED OUTCOMES
WCF 1. Update service specifications.	Ensure current service is reflected; support performance monitoring.
WCF 2. Maternity services review.	Integrated high-quality community service which is financially viable and meets NICE guidance.
WCF 3. Orthoptic provision in special schools.	Provide service (no current provision); supports implementation of 'Healthy Child' policy.
WCF 4. Redesign of children's mental health and emotional wellbeing services.	Holistic approach to care for under 18s experiencing emotional/mental health issues.
WCF 5. Nasal pharyngeal services for children with complex needs.	Improved quality of service and reduced costs. Delivery of sustainable model for the future.
WCF 6. Update assisted conception/sub-fertility guidance.	Guidance to take account of revised NICE reocmmendations.

4. RESOURCES

a) People

We aspire to be a high-performance commissioning organisation. This means we need to develop leaders of change throughout the organisation in order to deliver our commissioning plans, incorporating quality, innovation, productivity and prevention. We are committed to ensuring that our approach to leadership development involves all within the organisation. We have adopted the NHS Change Model as our methodology and will endeavour to train all staff in the application of the model. This model was developed by the Department of Health and the NHS Institute for Innovation and Improvement. The aim is to create an environment and culture in which everyone can contribute.

Leadership and Organisational Development

A baseline self-assessment was undertaken, using the Diagnostic Tool for Emerging Clinical Commissioning Groups. The tool was established to allow CCGs to assess themselves against the clinical commissioning domains, reflecting upon the values, culture, behaviour and wider organisational health. This work involved members of the shadow board, management team, partners and other stakeholders. From it we identified five organisational development priorities, established a baseline position, identified agreed development needs and timescales for delivery; and produced an action plan to ensure delivery of those priorities.

The action plan is being implemented and is currently on schedule; it is attached as Appendix C.

The priorities and key development areas we have identified are:

i) **Values and behaviours** – These are built into staff induction and personal development review (PDR) processes.

ii) **Developing leadership capacity and capability** – All staff will have an annual PDR. A strategy to support continuous improvement will be developed at both practice and borough level. Training for all clinical and managerial leaders in the NHS Change Model will be provided by the CMCSU. The NHS Leadership Academy Governing Body Framework, AQuA Board to Board and CCG programmes will also be used.

iii) **Developing the workforce** – The composition of the workforce in the CCG is very different from that in the predecessor primary care trust. There is a mixture of directly employed staff, contracted commissioning support staff, Governing Body members and clinicians and practice staff from member practices who will contribute to our development. References to 'our workforce' embrace all of these people as we recognise the importance of the contribution they will make. Engaging the people who work for us in our vision and purpose will make it more likely that they will maintain performance through change and challenge. They are also more likely to contribute to innovation, business improvement and provide higher rates of discretionary effort. An analysis of skills, knowledge and expertise has been undertaken. A learning and development plan will be outlined including formal training, core skills, e-learning, team development sessions and the NHS Change Model. We will ensure our workforce is compliant with the mandatory and statutory skills required of NHS staff. This will be achieved through a core skills programme encompassing nine programmes of learning essential for all staff, including fire safety; manual handling; safeguarding of adults; safeguarding of children; equality and diversity; and an introduction to information governance.

iv) **Engagement and involvement** – The Communications and Engagement Strategy will be regularly reviewed to ensure effective internal communications. Empirical evidence demonstrates the importance of a culture of engagement and involvement in the development of new organisations. There will be a focus on the continued development of effective relationships with the local authority, councillors, and key committees (Social Care, Health and Wellbeing Board); Members of Parliament, providers, patients and the general public.

Those in leadership roles have a specific requirement in their job descriptions to undertake communications with internal and external stakeholders to ensure that true and meaningful engagement takes place. We will work to ensure that member practice development in clinical commissioning is inextricably linked

with our vision and values. Commissioning will become an integral part of practice education and will be multi-professional in its approach.

We will use the Members' Forum to provide protected learning opportunities in regard to clinical commissioning for clinical and non-clinical staff working in member practices. Each practice has a clinical lead for commissioning; this role is the key link between the CCG and the member practices with the lead expected to participate in bi-monthly CCG 'whole team' meetings. This will ensure practices are kept up to date with progress in the CCG. We will also use our website as an essential communications tool with internal and external audiences.

'Liberating the NHS' detailed at the very heart of the strategy the importance of public involvement. Our local strategy reflects this. We intend to work collaboratively with provider organisations and put in place systems to capture patient experience data, analyse this information and use it to inform the commissioning decisions of the CCG.

The established *'Talk To Us´* patient experience programme gives people an opportunity to provide feedback through a variety of channels.

We intend to work towards the development of patient participation groups in each of the 17 practices. It is our intention to form a reference group which will include representation from those groups, along with Halton LINk (local involvement network) and subsequently Healthwatch. There are established links with the voluntary and charitable sectors, local faith groups and other community forums. We will continue to work with these groups to develop an ongoing dialogue.

v) **Governing Body development** – Our Governing Body is acutely aware of its collective leadership responsibilities in shaping a new organisation to serve the people of Halton. It is cognisant of the growing evidence of the causal link between board level effectiveness and organisational performance in the NHS. An implementation plan has been developed to enable us to create a

high-performing Governing Body, providing strong leadership, ensuring all statutory functions are met, including information governance and equality and diversity leadership requirements. Tools from the AQuA Board to Board Programme and NHS Leadership Academy, observations/feedback based on high-performing board indicators and 360° feedback with stakeholders, partners and patients will be used.

b) Supporting Services

Our core team of staff is supported by services provided on a contractual arrangement from the CMCSU. The agreement provides us with resources for core corporate and business functions – strategic and business planning; HR and organisational development; contracting and procurement; and communications. We share a financial team with NHS Knowsley and St Helens CCGs. These arrangements allow us to function efficiently with a small team of core staff, drawing on additional support when necessary to meet business needs.

c) Financial Plan

The first budget plan for the CCG is intended to strike the balance between meeting the financial requirements set by the NHS CB and ensuring funds are available to deliver the commissioning intentions within its commissioning/QIPP plans for 2013/14. It is the foundation on which to build sustainable services for the benefit of people in the borough.

The budget plan takes into account the financial duties on CCGs and the financial planning assumptions provided by the NHS CB in *Everyone Counts* (December 2012). It was approved by the Governing Body on 21 March 2013.

In line with NHS CB guidance published in *Everyone Counts* (December 2012) the following financial planning assumptions are made.

- Income is allocated separately for programme and administrative costs. Administrative costs should not be overspent; but underspends on administrative costs can be spent on programme costs.

- A cumulative surplus at the end of 2013/14 of at least 1% of revenue is planned for, including any historic surplus not drawn down. This will be carried forward into 2014/15.

- In 2012/13, 2% of non-recurrent funding is ring-fenced. Expenditure cannot be made against all or part of these funds without approval from the NHS CB. Additionally, a minimum 0.5 contingency of revenue is ring-fenced to mitigate risk within the local health economy.

- An underlying growth in demand based on demographic and other changes is assumed.

- Running cost allowances for CCGs are £25 per head of population.

- The national provider efficiency requirement for 2013/14 tariff setting is 4%.

- Local authorities will assume responsibility for the management and administration of the funding for reablement provision.

NHS Halton CCG			
Summary of Allocations & Expenditure	**2013-14 Budgets**		
	Recurring £000	**Non-Recurring £000**	**Total £000**
Allocations			
Base Allocation	172,686	-	172,686
Growth	3,972		3,972
Other Anticipated Allocations	370	- 114	256
Total Programme Resources Available	177,028	- 114	176,914
Programme Expenditure			
Acute Services	83,992	2,152	86,144
Mental Health Services	13,505	325	13,830
Community Health Services	22,065	456	22,521
Continuing Care Services (Childrens)	15,383	-	15,383
Primary Care Services	23,963	-	23,963
Other Programme Services	747	-	747
Other Corporate Costs (Non-Running Costs)	811	-	811
Operating Plan Requirements & Reserves	7,429	4,336	11,765
Total Application of Funds-(Programme)	167,895	7,269	175,164
Planned In-year Surplus/(Deficit)	9,133	- 7,383	1,750
Planned Surplus/(Deficit) %	5.2%	6476.3%	1.0%
Running Costs Budget	3100	361	3100

Risk assessment and mitigation

In setting the budget the potential risk that the CCG will be unable to achieve the financial requirements and duties set by the NHS CB was considered. The main reasons this might occur include:

Activity growth for services subject to cost and volume payment systems e.g. payment by results (PbR) and continuing health care (CHC).
The specialised commissioning allocation reduction is not cost neutral as anticipated.
The delay or failure of QIPP schemes to deliver the planned savings.
The impact of unexpected cost pressures being inherited from PCTs.
Further unexpected cost pressures or allocation reductions.

Controls to mitigate against these risks fall into three categories:

Financial systems – Sound financial systems and procedures, including a robust ledger and budgetary control system. The CCG is on track with its project to set

up and use the Integrated Single Financial Environment (ISFE) general ledger provided by NHS Shared Business Services – a joint venture between the DH and Steria plc. Expertise in forecasting and budget-setting are key skills which the CCG has acquired through its shared finance team arrangements.

Internal Governance – These arrangements are intended to ensure that decisions are properly considered and approved and that lal members of the CCG can be assured and that risks are being properly managed. Elements of this include the Audit Committee, Finance and Performance Committee and meetings of the Governing Body and Membership. Other key elements relate to the internal and external auditors of the CCG who will test the robustness of the CCGs internal controls and systems.

Relationships and risk sharing – Examples of this include the risk share 'insurance pool' for high-cost patients who require care in independent private mental health hospitals, shared with neighbouring CCGs within the Mersey CCG network. This arrangement seeks to reduce the risk of a disproportionate number of such cases falling on a single CCG in any one financial year through random chance. A similar arrangement is the creation of a pooled budget between the CCG and Halton Borough Council for adult continuing health and social care cases. Each party agrees to share risk of costs jointly.

Should the CCG still be faced with significant financial pressures despite the controls outlined above then options to deliver short-term financial balance would be considered.

d) QIPP

Quality, Innovation, Productivity and Prevention (QIPP) is a large-scale transformational programme led by the Department of Health and with which NHS Halton CCG has been actively engaged to date. It encourages the exploration of alternative ways of providing services to achieve improved services and greater choice for patients, alongside better value for public money than can be gained from transactional savings.

The planning for QIPP for 2013/14 and beyond is governed by the Merseyside CCG Network at its monthly meetings and led by the CMCSU. The aim of the work is full integration of the principles of quality, innovation, productivity and prevention into the main commissioning agenda, so that those principles are at the heart of all commissioning.

In 2010/11 and 2011/12, the Merseyside health economy delivered QIPP efficiency savings of c. £260m and is expected to have delivered the c. £100m target for 2012/13. Work is currently underway to develop new governance arrangements, which will focus development, performance management, monitoring and delivery of QIPP at CCG level.

The table overleaf shows a headline summary of how the Halton financial QIPP challenge will be delivered within the plan. The sub-heading 'Inherited Transformation Schemes' refers to the following three schemes.

Psychological therapy for military veterans – The NHS Outcomes Framework 2012-13 placed a duty on the NHS to improve psychological support for military veterans. All CCGs in the North West are making a financial contribution to this service. NHS Halton CCG's share is £20,000.

Rehabilitation service – A 'hub and spoke' model has been developed, with The Walton Centre NHS Foundation Trust as the hub and two spokes, at St Helens Hospital (15 beds) and Broadgreen Hospital (10 beds). The CCG has identified £551,000 to support this expansion of services.

Trauma ambulances – In response to national policy, trauma centres have been developed. There is evidence to show that such centres improve outcomes for patients. The Merseyside centre is located on the main site of Aintree University Hospitals NHS Foundation Trust in Fazakerley, with support from The Walton Centre NHS Foundation Trust and the Royal Liverpool and Broadgreen University Hospitals NHS Trust main site in central Liverpool. Serious trauma cases will bypass local A&E departments and go directly to a trauma centre. This will mean longer ambulance journeys for some critically-ill patients and Halton CCG is contributing £47,000 as its share of additional funding for ambulance services.

COMMISSIONING INTENTIONS (QIPP) PLANS

CCG Service Transformational Schemes – project description & no.		2013-14 RECURRENT		2013-14 NON-RECCURENT		2013-14 TOTAL QIPP	
		Gross Saving £000	Investment £000	Gross saving £000	Investment £000	Gross saving £000	Investment £000
COPD pathway redesign	PC 11,12,14	-123				-123	0
Diabetic hypo pathway	PC 4	-21				-21	0
Community MDT Redesign ('Tailored care')	PCI 4	-312	300			-312	300
Wellbeing practices initiative	PCI 5		337			0	337
Out of hours tender saving	PCI 3	-9				-9	
Primary care quality access innovation fund • ECG in primary care • Atrial Fibrillation • Anti-coag clinics • End of Life Gold Standard Framework	PCI 7 PCI 8 MHUC 10 PC 3	-7	200		450	-7	650
Local hospice development	PC 2, PC 3		50			0	50
Orthoptic assessment special schools	WCF 3		70			0	70
Nasal pharyngeal services	WCF 5		20			0	20
MH access to psychological therapy impact	MHUC 4	-37				-37	0
LD Positive Behaviour support	MHUC 4		48				48
Rapid assessment dementia	MHUC 4		381				381
Dementia services	MHUC 2, 7		200				200
Inherited Transformational Schemes							
Psychological therapy for military veterans			20			0	20
Rehab service Walton hub and spoke			551			0	551
Trauma centre- ambulance increase			47			0	47
Prescribing Savings							
2012-13 FYE savings		-3,682				-3682	0
2013-14 4% efficiency target		-899				-889	0
Other Efficiency Savings							
Efficiency based on PbR tariffs		-3,768				-3,768	0
Other NHS providers tariff efficiency		-1,247				-1,247	0
Other non-NHS providers deflation		-507				-507	0
Other commissioner CIPs – PbR challenge re physiology counting		-422				-422	0
TOTALS		-11,034	2,224	0	450	-11,034	2,674

List of Appendices

List of Governing Body membership

Halton Shadow Health and Wellbeing Board terms of reference

NHS Halton CCG Organisational Development Action Plan

NHS Halton CCG Operational Delivery Plan and Commissioning Intentions

Glossary of terms

AQP	Any Qualified Provider – A way of procuring services which increases choice about who can offer NHS services
AQuA	Advancing Quality Alliance. A healthcare improvement body.
CAMS	Child and Adolescent Mental Health Service – for children and young people up to age 18
CCG	Clinical Commissioning Group
CHD	Coronary heart disease
CKD	Chronic kidney disease
CMCSU	Cheshire and Merseyside Commissioning Support Unit. This unit provides support in business intelligence; procurement; and business support services (e.g. communications, organisational development etc). CCGs can purchase the elements of support they require to supplement their core staff.
COPD	Chronic obstructive pulmonary disease
Commissioning	The planning and purchasing of services
CQUIN	Commissioning for Quality and Innovation. A payment framework which allows commissioners to link a proportion of a provider's payment to the achievement of local quality improvements
GP	Medical doctor who is a general practitioner
Local health economy	In this document this phrase is used to describe all the organisations which work together to deliver health services to the local population – the NHS CB; the CCG; hospitals; general practices; community service providers
NHS CB (also known as NHS England)	NHS Commissioning Board. A special health authority responsible for the direct commissioning of specialised services; primary care services; offender health care; some services for members of the armed forces; some public health screening and immunisation services. The NHS CB is also responsible for leading the delivery of improvements against the NHS Outcomes Framework and ensuring patient safety; authorising CCGs and carrying out annual assessments of CCGs. From April 2013, the NHS CB will be known as NHS England
NICE	National Institute for Health and Clinical Evidence. This organisation is responsible for setting standards for quality in healthcare and produces guidance on medicines, treatments and procedures.

PFI	Private finance initiative. A way of creating public-private partnerships by funding public infrastructure projects with private funding.
RTT	Referral to treatment
Statutory organisation	A statutory organisation (also known as a statutory body) is one that is required to exist by law. In addition to CCGs, examples include the police service and local councils.
STEIS	Strategic executive information system. Software system used within the NHS for collecting and reporting management information on secondary care access, adverse incidents and delayed discharges.

References

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The Mandate: A mandate from the Government to the NHS Commissioning Board: April 2013 – March 2015; Department of Health, Nov 2012

Organisational Development Strategy and Action Plan 2012-2015, NHS Halton CCG

NHS Outcomes Framework 2013-14; Department of Health, November 2012

Health and Social Care Act 2012

Halton Health and Wellbeing Strategy 2012-2015

Halton Joint Strategic Needs Assessment

Framework for Integrated Commissioning in Halton

White Paper: *Equity and Excellence: Liberating the NHS*

Everyone Counts: Planning for Patients 2013/14, NHS Commissioning Board, December 2012