Better Care Fund

2014/15 to 2015/16

Between Halton Borough Council, the NHS Halton Clinical Commissioning Group and Stakeholders

Foreword

Social Care and Health services are already closely aligned in Halton with a high level of integration at strategic and operational levels. This has been strengthened this financial year by the introduction of the Public Health service into the council's structure. Public Health has the overall purpose to protect and improve health and reduce health inequalities through tackling the wider determinants of health while also improving the quality of healthcare services as such it is closely linked strategically to the wider council, but it also links to social care services and the clinical commissioning group, both of which it shares premises with.

By working together we can move toward full integration of health and social care for the benefit of the people of Halton to improve outcomes for both patients and people receiving health and social care services. We want to make a real and positive difference to the most vulnerable people in our community.

Many of the milestones and priorities within the Better Care Fund form the building blocks for the five year strategic plan for the NHS HCCG, and 70% of the actions are interlinked, moving us closer to full integration.

Dr Cliff Richards ***Chair*** ***NHS Halton Clinical Commissioning Group***		**Councillor Rob Polhill** ***Leader of the Council***
		
Simon Banks ***Chief Officer*** ***NHS Halton Clinical Commissioning Group***		**David Parr** ***Chief Executive*** ***Halton Borough Council***
		

1. Introduction and Vision

This plan sets out the shared vision of Halton Borough Council (HBC) and NHS Halton Clinical Commissioning Group (HCCG) for further improving health and social care services in the borough through the Better Care Fund (BCF).

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

The BCF is described as a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and Local Authorities. This document demonstrates how the BCF will be used in Halton during 2014/15 and 2015/16.

2. Background

Having separate budgets for health and social care services has often been a barrier to joint working and addressing the needs of service users holistically. It often results in shifting costs from one organisation to another rather than encouraging them to act in partnership.

People's needs might be categorised as medical or social by agencies and their professionals, but in practice individuals' lives are often more complex. People do not fit neatly into organisational business units, hence the need for different service providers being required to collaborate.

The Government's reforms and the introduction of the Integrated Transformation Fund will introduce a more comprehensive approach to joint working. These will also increase the influence of local people in shaping services, led by democratically-elected Councillors, the Health and Wellbeing Board and the local Health Watch, so that services can better address local need and be more joined up for the people using them.

3. National Picture

The emphasis nationally for health and social care includes (Support, 2013):

- Outcomes, quality of care, reducing inequalities and efficiency
- Empowerment of patients, people who use services, carers and parents
- Local ownership (including close working between health and local government)
- Working in a proactive way with communities
- Professional leadership to drive change and enable innovation

There are various statutory duties when it comes to integrating health and social care and support and they are highlighted in the table below.

Statutory Body	**Duty**
NHS England and Monitor	To promote and enable integrated care
Local Authorities	To improve the public's health
Clinical Commissioning Groups and Health and Wellbeing Boards	To promote and encourage the delivery and advancement of integration with their local areas at scale and pace

The ***National Collaboration for Integrated Care and Support*** incorporates 13 organisations in association with National Voices, including the Association of Directors of Adult Social Services (ADASS), Care Quality Commission (CQC), Department of Health (DH), Local Government Association (LGA), Monitor, NHS England and Public Health England. In May 2013 they published "Integrated Care and Support: Our Shared Commitment".

"We must always remember that our efforts in this area and ultimate aspirations should be targeted at improving the experiences and outcomes of individuals and their communities, whilst allowing people to be true partners in their own care and support".

The diagram below is aligned with the statements from TLAPs Making It Real initiative around the personalisation of care and support.

Our ultimate aim is to improve the outcomes and experiences of individuals and communities

National Voices have co-developed a narrative of integrated care and support:

"I can plan my care with people who work together to understand me and my carers, allow me control and bring together services to achieve the outcomes important to me".

4. Legislation

The Government's White Paper *Caring for our future: reforming care and support* (July 2012) set out a long-term programme to reform care and support. At the centre of the White Paper is a vision for a modern system that promotes people's well-being by enabling them to prevent and postpone the need for care and support, and puts them in control of their lives so that they can pursue opportunities, including education and employment, to realise their potential.

The ***Care Bill 2013*** is a major step forward towards that vision and introduces legislation to provide protection and support to the people who need it most and to take forward elements of the government's initial response to the Francis Inquiry.

The Care Bill will give people peace of mind that they will be treated with compassion when in hospital, care homes or their own home. It highlights the importance of preventing and reducing needs, and putting people in control of their care and support.

The Bill is split into 3 parts:

- Reform of Care and Support;
- Response to the Francis Inquiry on failings at Mid-Staffordshire Hospital; and
- Health Education England and the Health Research Authority.

A strategic group has been established to look in more detail at the implications of the Care Bill, in particular focussing on the 11 elements of the bill:

- Prevention, Information and Market Shaping
- Who is entitled to public care and support?
- Assessments and Eligibility
- Personalising Care and Support Planning
- Charging and financial assessments
- Care and Support funding reforms
- Protecting adults from abuse or neglect
- The law for carers
- Continuity of care when moving between areas
- Market oversight and provider failure
- Transition for children to adult care and support services

These elements will all have implications for the delivery of health and social care services in terms of resources, finances, partnership working, policies and procedures and skilled and informed workforce.

5. Better Care Fund

The Government announced in their June 2013 spending review the introduction of the Better Care Fund to ensure a transformation in integrated health and social care. The Local Government Association (LGA) and NHS England have set out a planning vision for the fund for Local Authorities and Clinical Commissioning Groups to work more closely together on delivering health and social care.

5.1 Stakeholders

In addition to the endorsement of NHS HCCG Governing Body and HBC Executive Board, Halton's approach to integration has the full endorsement of the Health and Wellbeing Board. Chaired by the Leader of the Council, the Board is multi-agency and inclusive of executive colleagues (including Member involvement) from across key partner agencies, such as statutory health and social care services, independent, voluntary and community sectors, including HealthWatch Halton and the Chamber of Commerce.

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

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

By embracing the challenges set through recent health reforms and current financial pressures, Halton is proud to be seen at the forefront in its approach to health and wellbeing. This is achievable by not only having an integrated steer at a strategic level in all Partner organisations, but also the commitment of people who use our services and those who provide them.

5.2 Workforce

Organisational development is an important factor in the successful delivery of integrated health social care outlined within our submission. On-going evaluation of teams and skill mix will ensure the infrastructure and capacity to deliver the schemes identified.

Transformation and the integration of health and social care are on-going and the Better Care Fund provides the opportunity to accelerate this integration at pace and scale. A fundamental element of this will be developing the workforce and the aligning of resources across all partner agencies and providers to deliver integrated care with improved outcomes for service users and carers.

Workforce Plans will be established and worked through for each scheme we have identified as part of the Better Care Fund to ensure that we have the right people with the right skills, knowledge and experience in the right place.

Better Care Fund planning template – Part 1

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

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

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

1) PLAN DETAILS

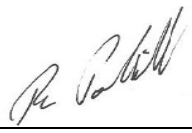
a) Summary of Plan

Local Authority	**Halton Borough Council**
Clinical Commissioning Groups	**NHS Halton CCG**
Boundary Differences	**N/A**
Date agreed at Health and Well-Being Board:	**15th January 2014**
Date submitted:	**14/02/2014**
Minimum required value of BCF pooled budget: 2014/15	**£3,945,000 (including capital)**
2015/16	**£10,598,000**
Total agreed value of pooled budget: 2014/15	**£36,511,000**
2015/16	**£41,540,000**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	
By	Simon Banks
Position	Chief Officer
Date	13/02/13

Signed on behalf of the Council	
By	David Parr
Position	Chief Executive
Date	13/02/14

Signed on behalf of the Health and Wellbeing Board	

By Chair of Health and Wellbeing Board	Rob Polhill
Date	13/02/14

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it.

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

There has been considerable engagement on this plan with a range of provider stakeholders including 5 Borough Partnership Mental Health Trust, Halton GPs and the Urgent Care Group. There was also a specific meeting organised with the Chief Executive and Warrington and Halton NHS Foundation Trust, the Director of Service Modernisation at St Helens and Knowsley Teaching Hospitals NHS Trust, the Director of Community Services and Operational Director for Integrated Commissioning at Halton to discuss and plan the schemes. It has also been discussed at length with the operational adult social care team within the borough council. Providers have advised how pathways can be improved, teams reconfigured to increase quality and productivity, systems be more efficient and teams more integrated. These changes coupled with the introduction within care pathways of appropriate technology will enable people to live independently, avoid emergency admissions, benefit from reablement services if necessary and have a better patient experience.

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

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

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

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

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

On 29 October, two HPHF events were held with hundreds of local people attending to learn about healthcare commissioning intentions for 2014-15 as well as have their say on the future of local health and social care services by taking part in a debate on NHS England's 'The NHS belongs to the people: a call to action' campaign, which is calling on patients and the public to talk about the future shape of the NHS,

so it can plan how best to deliver services, now and in the years ahead.

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

e) Related documentation

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

Ref	Document title	Synopsis and links
D1	**Joint Strategic Needs Assessment (JSNA)**	Joint local authority and NHS HCCG assessments of the health needs of the local population in order to improve the physical and mental health and wellbeing of the people of Halton.
D2	**Future impact of demographic changes on unplanned hospital care in Halton**	This document identifies areas with a potential for increased demand over the next five years in relation to demographic changes in the borough. These potential areas for increased demand are reflected within our aims and objectives.
D3	**Halton Health and Wellbeing Strategy**	The Halton Health and Wellbeing Strategy sets out the priorities and actions which the Health and Wellbeing Board are planning to carry out during 2013 – 2016.
D4	**CCG 5 year strategic plan**	Detailed plans by the CCG delivery of services and associated performance measures and efficiency targets.
D5	**CCG 2 year operational plan**	Detailed plans by the CCG delivery of services and associated performance measures and efficiency targets.
D6	**Urgent Care Strategy**	The Urgent Care Strategy outlines the strategic direction for the delivery of urgent care in Halton over the next five years. The Strategy facilitates a common approach to provision and creates a framework within which care providers and commissioners can work to ensure seamless, high quality and appropriate care. It will help ensure that unplanned care becomes better planned and understood by the people of Halton, those responsible for managing urgent care services and the work force required to deliver them.
D7	**Falls Prevention Strategy**	This strategy proposes the development of an integrated falls care pathway with sufficient capacity to deliver an agreed model of care to older people in Halton who are at risk of falling. The model would build on an agreed model of care that is highlighted in the local prevention and early intervention strategy.
D8	**Market Position Statement (MPS)**	This statement provides a powerful signal to the market, summarising important intelligence and explaining how the local authority intends to strategically commission, and encourage the

		development of high quality provision to suit local populations.

VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- ***What changes will have been delivered in the pattern and configuration of services over the next five years?***
- ***What difference will this make to patient and service user outcomes?***

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

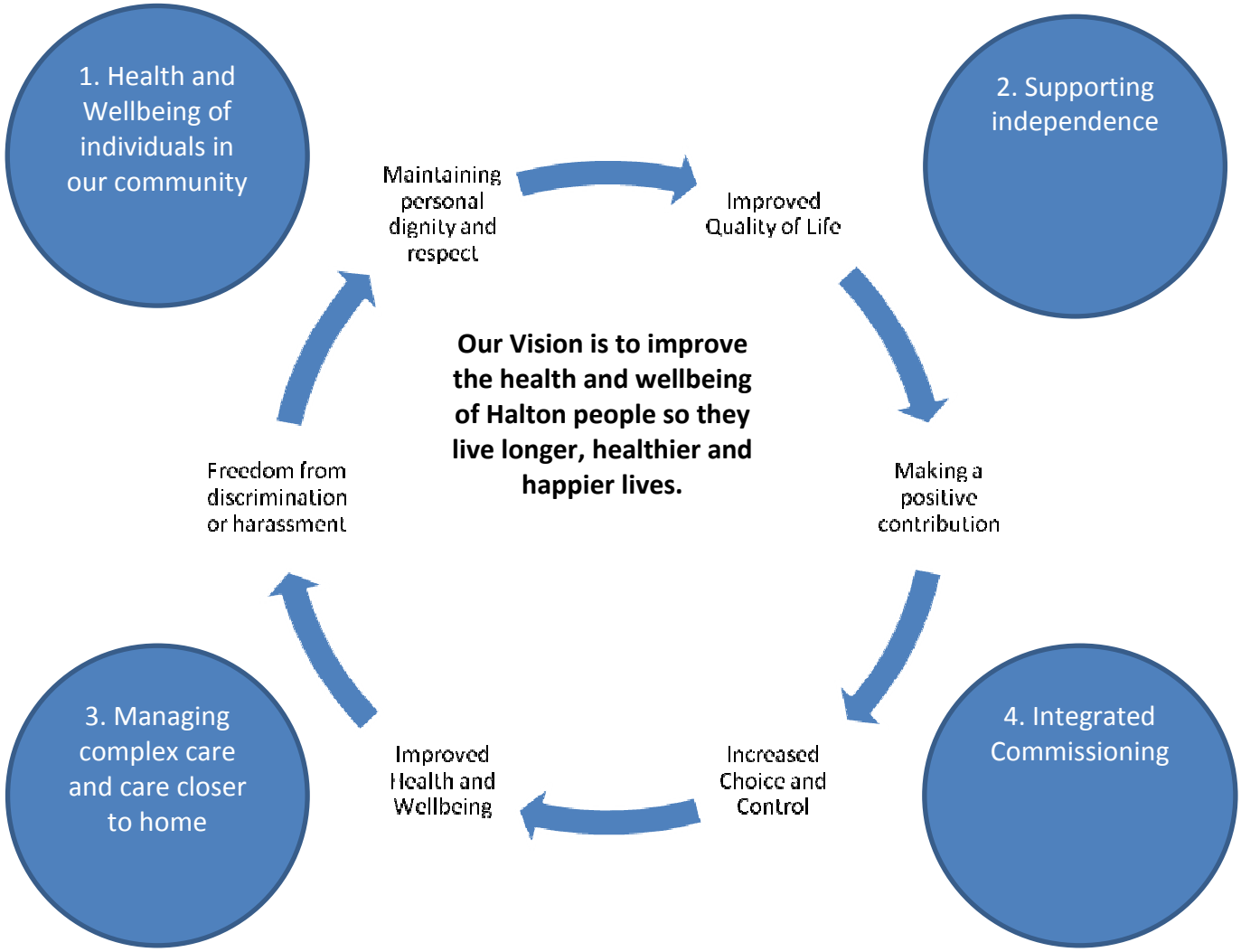
Pro-active prevention, health promotion and identifying people early when physical and / or mental health issues become evident will continue to be at the core of all our developments with the patient and service user outcome of a measurable improvement in our population's general health and wellbeing. We expect this to impact positively on people in the community whilst supporting secondary services to provide timely and appropriate care.

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

We will ensure that we:

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

Figure 1 – Our Vision



b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- ***What are the aims and objectives of your integrated system?***
- ***How will you measure these aims and objectives?***
- ***What measures of health gain will you apply to your population?***

Halton is a borough in the North West of England. Our population of approximately 125,000 is centred on two towns with strong, supportive and active local communities. We have 17 GP practices with NHS Halton Clinical Commissioning Group (HCCG) co-terminus with Halton Borough Council (HBC). The two acute hospitals used by the population are out of borough with a single community health care provider and a separate mental health provider. We have a thriving domiciliary and residential care market and an active third, faith and voluntary sector. Whilst we have high levels of deprivation and challenging health outcomes we are seeing improvements in a number of key areas.

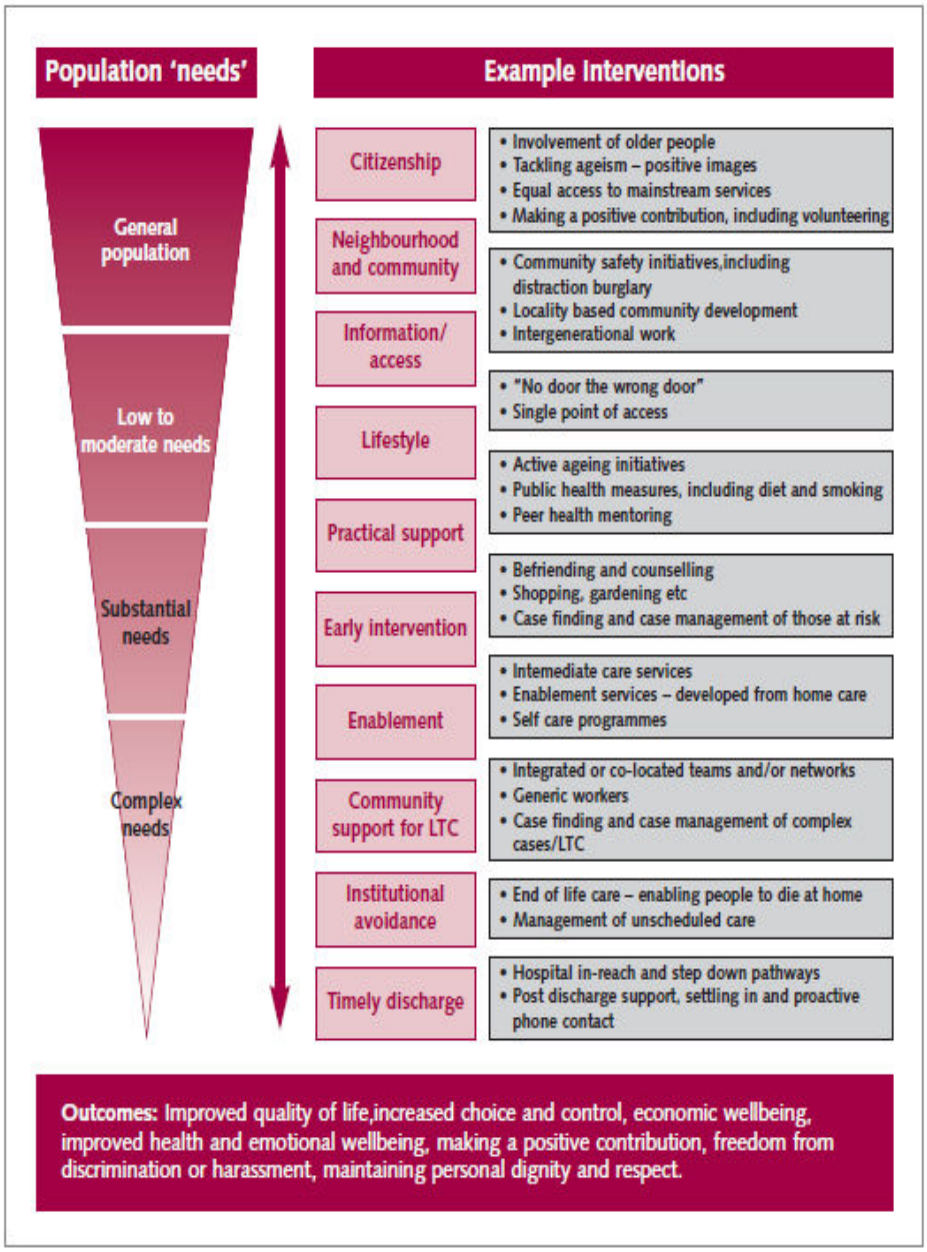
The changing landscape of health and social care provision over the past two years has enabled us to re-evaluate our overall approach to the commissioning and delivery of health and social care services and examine how we could do things differently to not only ensure value for money, but ensure that services

are affordable, sustainable and meet the needs, wants and aspirations of our community. There is a long tradition of working across organisational boundaries to achieve positive outcomes for local residents. The health and social care community is committed to taking current developments forward and knitting them into a coherent and integrated whole in order to achieve our vision of delivering person centre coordinated care within Halton. The HBC Public Health document "Future Impact of Demographic changes on unplanned hospital care in Halton" identifies areas with potential for increased demand over the next five years in relation to changes in demographics of the borough. These potential areas for increased demand are reflected within our aims and objectives, and outcomes and metrics.

With input and support from Partner Agencies across the Health and Social Care economy in Halton, HBC and NHS HCCG are moving forward at pace to deliver our shared vision of a whole system integrated approach to local health, care, support and well-being. The range of governance structures and boards bring together our two acute hospital providers, community healthcare and mental health providers, primary and social care and the independent and voluntary sectors. This ensures an alignment of the individual organisations' vision and priorities resulting in a borough focused approach. The Health and Wellbeing Board have been instrumental in the development of wellbeing areas, building on established Area Forums, to provide a springboard to an asset based community involvement and community led approaches to health and well-being. We see this approach as crucial to developing the sustainable approach to integrated care and support over the next five years.

Halton's Strategy is focussed on prevention of ill health and poor emotional wellbeing, early detection of disease, support people to remain independent at home, manage their long-term conditions, wherever possible avoid unnecessary hospital admissions and in situations where hospital stays are unavoidable ensure that there are no delays to their discharge. This is described in the diagram below:

Figure 2 'Triangle Framework' showing the relationship between different levels of population need and a relevant range of intervention



To ensure delivery of our strategic approach, there are four strategic aims that should apply to our transformational plan and they include:

1. **Health and Wellbeing of individuals in our community**
2. **Supporting independence**
3. **Managing Complex Care and Care Closer to Home**
4. **Integrated Commissioning**

To deliver these key aims a number of objectives are required and this plan sets out the deliverables and schemes which include:

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

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

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

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

The focus is on:

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

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

- Use of enabling technologies such as telecare and telehealth.

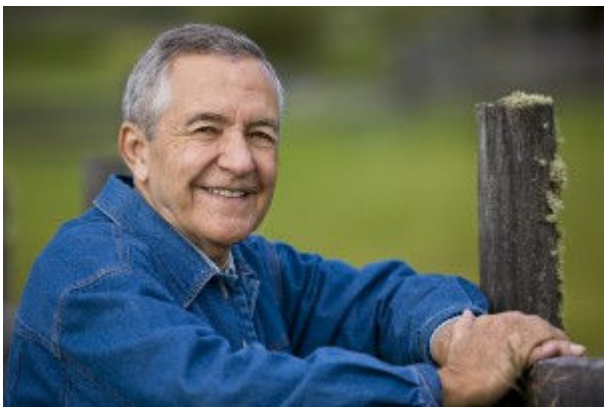
Halton have clearly defined our overall approach to health and wellbeing and can now begin to consider how addressing people's low-level needs and wants we can begin to shift service provision from high cost complex care to more cost effective low-level support.

A review of our Prevention and Early Intervention Strategy 2010 – 2015 has recently been undertaken and the initial mapping exercise has been completed which demonstrates the huge level of services that are being delivered in this area. However, the clear gap is the co-ordination/integration of these services. This approach sets out to address this and consider the benefits of developing a system of improved integration and increased navigation through the system to improve an individual's service experience/outcome.

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

A central objective of this approach is the development of an integrated wellness service following a review of current wellbeing services. A wellness service could be described as a service (or system of services) that specifically aim to promote and improve health and wellbeing, in its widest, most holistic definition, rather than diagnosis and treat illnesses or their direct cause. The service could include healthy lifestyles interventions and/or psychosocial interventions for an individual, for families or groups. The approach might involve a combination of services and interventions such as smoking cessation, weight management, physical activity, alcohol brief interventions, social prescribing/referral e.g. debt advice, welfare benefits, housing, legal advice, etc. psychological wellbeing interventions, e.g. mindfulness and stress management (or a range of any available services). Halton is also working with Primary Care to tackle health inequalities. This includes a proposal to use the National Support Team for Health

Inequalities priority actions based on best practice that could impact inequalities in mortality and life expectancy in the short term. Halton will run Master Classes, supported by NST Health Inequalities Workbooks, for GPs in driving up the quality and capacity of primary care to tackle specific chronic disease areas.



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

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

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

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

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

2. Supporting independence

HBC and NHS HCCG already have pooled budget arrangements in place to support people at home or within the community with various services to prevent more intensive intervention and to improve health gains. There are a range of integrated services which focus on promoting recovery from illness, preventing unnecessary hospital admissions or premature admissions to residential care, supporting timely discharge from hospital and maximising opportunities for independent living.

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

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

The following schemes will be implemented:

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

ii) Further develop our approach to Telecare and Telehealth interventions to support people to live as independently as possible within the community. Services will be tailored to individual needs and encourage a whole system/whole person approach to care.

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

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

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

vi) Re-design of primary care.

These will be measured by existing performance data including:

- Maintaining lower level of care home admissions
- Preventing admissions and keeping people at home longer
- Early detection of conditions and prevention of deterioration

- Increase in number of extra care housing
- Equipment and adaptations
- Quality of provision – domiciliary care, housing

These will be measured by existing performance data. In Part 2, the plan identifies outcomes and metrics that support this aim and the corresponding objectives.

My name is Anne, I'm 78, from Ditton

and I used to feel lonely

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

Sitting at home on my own with no one to talk to, it was as if the world was passing by without me. I started to become really down and my daughter mentioned how tired and fed up I looked.

It took a while but one day I started to tell her how I felt and it all came out. We sat and hugged and she said I needed to get out more and start to build a new life with different things in it. I knew I had to do something, this couldn't go on. She found loads of dancing groups, Bingo and a flower arranging group. I was nervous at first but with my daughters help I went. I met quite a few new people, two had lost their husbands and also took it badly. But because I could see how they was coping, it gave me hope that feeling lost every day would eventually go.

That was eighteen months ago and now I am busy and have new friends to have a laugh with; which I never thought I would say. I no longer feel lonely and on my own."

3. Managing complex care and Care Closer to Home

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

To support this approach a number of schemes will be further developed:

i) Continue to develop the reconfiguration of both Adult Social Care and Community nursing teams, including aligning the teams around local GP communities to strengthen the capacity of the teams, and provide for greater opportunities to work more closely to deliver integrated care and better outcomes and health gains for people in the community.

ii) Continue to progress the Community Multi-disciplinary Teams project, for high intensity users with multiple conditions, specific teams and levels of support focussed around the individual.

iii) Develop the Integrated care home support teams, including a community geriatrician to improve the range of healthcare interventions and services that currently are not easily accessible to people who live in residential and nursing homes. This will result in the improved health and well-being of residents of care homes.

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

v) Further develop the Integrated Safeguarding Unit to improve the delivery of a flexible and responsive multi-agency service, with a focus on the more complex cases within institutional settings.

vi) Re-design of mental health primary care. Reference has already been made to enhancing the role of the Mental Health Outreach Team in delivering focused interventions to people who may be at risk of being referred to secondary services. One social worker is already targeted at this group of people and the plan is to concentrate more resource in this area. This will enhance community based provision whilst supporting secondary care to focus on core service delivery.

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

These will be measured by existing performance data including urgent care targets and NHS planned care targets. In Part 2, the plan identifies outcomes and metrics that support this aim and the corresponding objectives.

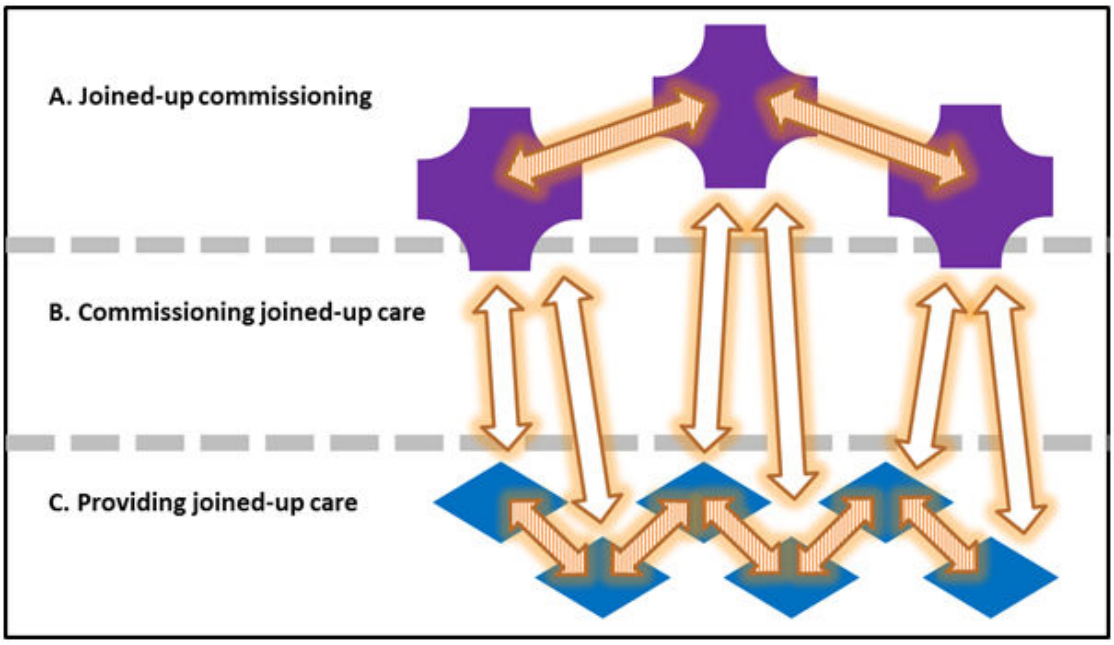
4. Integrated commissioning and clinical practice

Integrating Commissioning within Halton creates the three ***'foci of integration'*** which is necessary to achieve integration.

A. **Joined-up commissioning:** Commissioners within the Clinical Commissioning Group and the local authority develop shared vision, plans and budget. Although this can present challenges, it is necessary to ensure that the large gaps that may have previously been visible between health and social care planning and provision is addressed. Halton are able to clearly demonstrate the benefits of developing shared vision, plans and budgets between the Clinical Commissioning Group and Halton Borough Council.

B. **Commissioning joined-up care:** Commissioners across sectors collaborate with providers to design coherent, reliable and efficient patient pathways, and ensure the incentives are right for providers to provide interoperable services within these pathways. Engaging patients and carers is a vital part of designing better systems and pathways of care.

C. **Providing joined-up care:** Providers ensure reliable and timely transitions, supported by a culture of inter-team collaboration and modern information systems.



Halton's Integrated commissioning aligns commissioning plans, which avoids duplication, increases productivity and improves quality for patients and service providers. Added to this our focus will be on the joining up of expertise and lead roles with commissioners and practitioners. NHS HCCG Clinical Leads link directly with Champions from the Adult Social Care Assessment and Care Management Team therefore improving lines of communication and the sharing of information, as well as improving health gains.

The culture within and between organisations is focused on achieving real improvements in the health and well-being of our population through the delivery of high quality, effective and safe care. This approach recognises both the centrality of supporting people to have control over their health and well-being and the inter-dependency across the systems and organisations to achieve this. This is facilitated through existing and developing mechanisms to incentivise and performance manage providers of services. This is underpinned by a letter of intent which informally binds the organisations to joint working. A formal Section 75 agreement is being developed to take this process to the next stage and drive structural, patient-centred, fully integrated service change.

Within five years the commissioning and delivery of all aspects of health, social care and well-being will be transformed within the borough of Halton. Building on our innovative solutions. The communities of Halton will have a fully integrated system that tailors its responses to their needs as individuals, members of families, carers and participants in their communities.

The following will be the performance areas:

- Integration journey
- Performance Improvement
- Procurement efficiencies
- Quality, Access and Clinical pathways,
- Innovation and Value for Money

- Commissioning for Outcomes

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- ***The key success factors including an outline of processes, end points and time frames for delivery***
- ***How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care.***

Our Integration aims and objectives set out the four main priorities for integration. The planned changes build on what we have already achieved within these areas, and ultimately, moving towards full integration. These include:

- Quality Board linking in to the Overview and Scrutiny Committee, Safeguarding Adults Board and the restructure of the sub groups underneath this;
- Quality and Performance – the development of Integrated dashboards so the monitoring can be streamlined;
- Full integration of the Health and Wellbeing Services; and
- Mainstreaming our overarching approach to delivering health and social care, e.g. locality-based integrated working (Multi-Disciplinary Teams) in conjunction with GP practices.
- We will ensure that all related activity will align with the JHWS, CCG commissioning plan/s and Local Authority plan/s for social care**.**

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

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

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

If the focus is on prevention and reducing pressure on complex services, and the above implications are realised, the funding capacity achieved from the above will then be directed to sustain improvements within the community (see Figure 1).

By investing £2.7M in urgent care facilities across Runcorn and Widnes NHS Halton CCG aim to reduce inappropriate A&E attendances by 15% across 2 years (14/15 – 15/16) The financial impact of A&E reduction in year 1 is £240k and Year 2 £480k.

The aim is to reduce inappropriate non elective admissions into secondary care by moving emergency activity closer to home, increasing diagnostic activity in urgent care centre – this will impact non elective admission by 15% over 3 years. The financial impact of the reduction of Secondary care non elective admissions in year 1 amounts to £677,500 with an additional saving of £240,000 in relation to the reduction in A&E Activity. Over a three year period this is expected to generate a net saving £2.074m. This will allow the CCG to re-invest in planned care closer to home.

The above estimates are based on a foundation of solid contractual oversight, strong financial management and a governance structure dedicated to improving quality. However it is never a guarantee that outside influences or further pressure will not arise during this process. This in mind the integrated commissioning process is drawing in a clinical lead and economist to work through the activity of all our provider trusts. This work will determine further efficiencies (if required) by determining the activity that brings best value. Activity below the criteria of significant impact may need to stop to achieve the 15%. These actions will need close and careful consideration.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes.

Halton's Health and Wellbeing Board will monitor and review progress and evaluate with the BCF on a regular basis. Governance arrangements and accountability structures for integrated health and social care report into the Board. It has adopted a membership that adequately reflects its key responsibility of providing an integrated response to local needs, which has early intervention and prevention at the forefront. The structure attached indicates the current governance structure, along with how the Board links to other strategic partnerships and operational delivery. **Governance Structure attached at Appendix 1.**

We also recognise that we need to focus our transformation upon prevention and avoid hospital admissions and support people to remain independent. Our focus upon urgent care is therefore fundamental.

In addition to the above governance structure, Halton's approach to Urgent Care, via the establishment of the Urgent Care Working Group, demonstrates a significant level of trust and confidence in shared governance structures and a shared commitment to improving outcomes for service users and patients and their carers making effective and efficient use of public resources. This group is responsible for overseeing all significant service changes required to deliver Urgent Care across the whole of the Halton Health Community, and also addresses developments that may impact in neighbouring local health and social care economies e.g. Warrington. A whole system framework has been developed collaboratively with neighbouring CCGs and Local Authorities, clinicians, practitioners and commissioners to ensure the delivery of seamless, high quality and appropriate care. This framework is easily accessed and understood by the public. It removes duplication, improves efficiency and builds on the strong relationships between social care, health services, self-care services and the third sector. We have recently seen reductions in non-elective admissions, readmissions, lengths of stay, delayed transfers of care and we continue to participate in the North West AQuA benchmarking to support improved performance. Our ambition to reduce A&E attendances and non-elective admissions by 17% will move our performance to better than the national average.

2) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services.

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

- NHS and Community Care Act 1990 and associated regulations
- The Care Bill 2013 that meet the assessed eligible social care needs of people who are ordinarily resident in Halton

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

The BCF will help to protect these services by:

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

Please explain how local social care services will be protected within your plans.

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

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

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

diagnosis of dementia.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

7 day access to health and social care services currently exists within the borough for hospital discharges and for people in the community (both assessment for and the provision of services). The capacity and demand in the acute sector at weekends is being reviewed and developed alongside the developments in 7 day working in our local acute trusts. The development of integrated community health and social care teams will further support a consistent approach to treatment, rehabilitation, care and support throughout the whole week.

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

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

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

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by.

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

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

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

With this in mind, HBC and the NHS HCCG propose to embark on a dynamic interoperability programme which will have far reaching benefits for patients and the wider health economy in Halton. Through the sharing of clinical views from detailed care records and associated clinical documentation via a secure data exchange, clinicians will have access to accurate, timely information that supports patient care and

joins up health provision in an unprecedented way. This will be facilitated through the utilisation of the Medical Interoperability Gateway (MIG).

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

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

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

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

The NHS HCCG have all of the appropriate IG controls in place. The Local Authority has been compliant from last year and is currently awaiting approval for this year. Caldicott 2 has just been released and the Local Authority is working through the document to ensure compliance.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

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

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

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

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

The risk stratified data is used by General Practice through a multi-agency meeting to discuss patients, agree an assessment and joint care planning approach and identify an appropriate lead GP and professional. All those at level 3 and 4 have a joint care plan. Some of those at level 1 and 2 may be identified as requiring some lower level prevention and support intervention

This has been in operation for 3 months and will be further strengthened by the planned changes to the GP contract in 2014 in relation to named GP.

3) RISKS

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

Between HBC and the NHS HCCG there are a number of areas of focus on quality and safety to ensure that gaps are reduced and issues are dealt with as a whole. Some examples include: NHS HCCG have a Quality Committee which is closely aligned to the HBC Safeguarding Adults Board. It is anticipated that this Committee become the main Quality Board for both health and social care. To support this approach, the CCG and Local Authority have developed processes through which member practices of the CCG can raise issues of service quality in any service commissioned by the CCG and LA. The CCG/LA can then utilise this information to identify service/quality issues and take appropriate commissioning action. HBC also has a provider monitoring system which links into the Quality Assurance Team.

The table below identifies a number of high level risks that we have identified as being the most significant to the BCF and to integration as a whole.

Risk	Risk rating	Mitigating Actions
Improvements in the quality of care and in preventative services will fail to translate into the required reductions in the acute sector by 2015/16, impacting the overall funding available to support core services and future schemes.	High	Our integrated commissioning process is drawing in a clinical lead and economist to work through the activity of all our provider trusts. This work will highlight further efficiencies (if required) by determining the activity that brings best value. Activity below the criteria of significant impact may need to stop to achieve this.
The introduction of the Care Bill 2013 will have implications in the cost of care provision, partnership working, policies and procedures and skilled and informed workforce.	High	Strategic Group was established in October 2013 to begin to identify the implications of each element of the Care Bill.
Financial fragility	High	Work on-going to forecast financial situation and continue to identify efficiencies across both organisations.
Legal Challenge	High	Robust consultation processes in place, clear application of eligibility criteria, with policies and procedures in place to support decision-makers.
Failure to identify and deal with cultural issues across the HBC and NHS Halton CCG could result	High	Building trust through effective communication, shared values, equal opportunities and effective leadership is crucial

in staff feeling isolated; anxious and worried; and a reduction in job performance.		to the successful development of integrated teams.
Shifting of resources to fund new joint interventions and schemes will destabilise current service providers, particularly in the acute sector.	High	Our current plans are based on the strategies we have in place covering all service areas and linking in to the priorities of the Joint Health and Wellbeing Strategy and Joint Strategic Needs Assessment.
A lack of detailed baseline data and the need to rely on current assumptions means that our financial and performance targets for 2015/16 onwards are unachievable.	High	We are investing specifically in areas such as data management to ensure that we have up-to-date information around which we will adapt and tailor our plans throughout the next 2 years. This includes moving forward with data-sharing and developing a joint performance framework across all areas.
Operational pressures will restrict the ability of our workforce to deliver the required investment and associated schemes to make the vision of care outlined in our BCF submission a reality.	High	Organisational development is an important factor in the successful delivery of adult social care outlined in our BCF submission. On-going evaluation of teams and skill mix will ensure the infrastructure and capacity to deliver the schemes identified.
Communication	Medium	• Joint Local Authority and NHS HCCG commissioning team meetings take place on a bi-monthly basis communicating the vision and plans for the future and involving staff at the outset. • Communication and media tools have been identified as a future scheme to ensure the public are fully aware and involved in all aspects of the BCF and integration.