Better Care Fund Plan 2016/17

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

Authorisation and signoff

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

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

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

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1.0 Introduction

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

1.1 Our Vision

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

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

1.2 Our Purpose

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

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

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

1.3 Our Values

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

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

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

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

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

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

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

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

1.4 One Halton – Five Areas of Focus

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.6 Five Year Forward View: Delivering the Triple Aim

Some fundamental challenges face the health and social care system.

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

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

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

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

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

2.0 An Evidence Base Supporting the Case for Change

2.1 Opportunities for Change

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

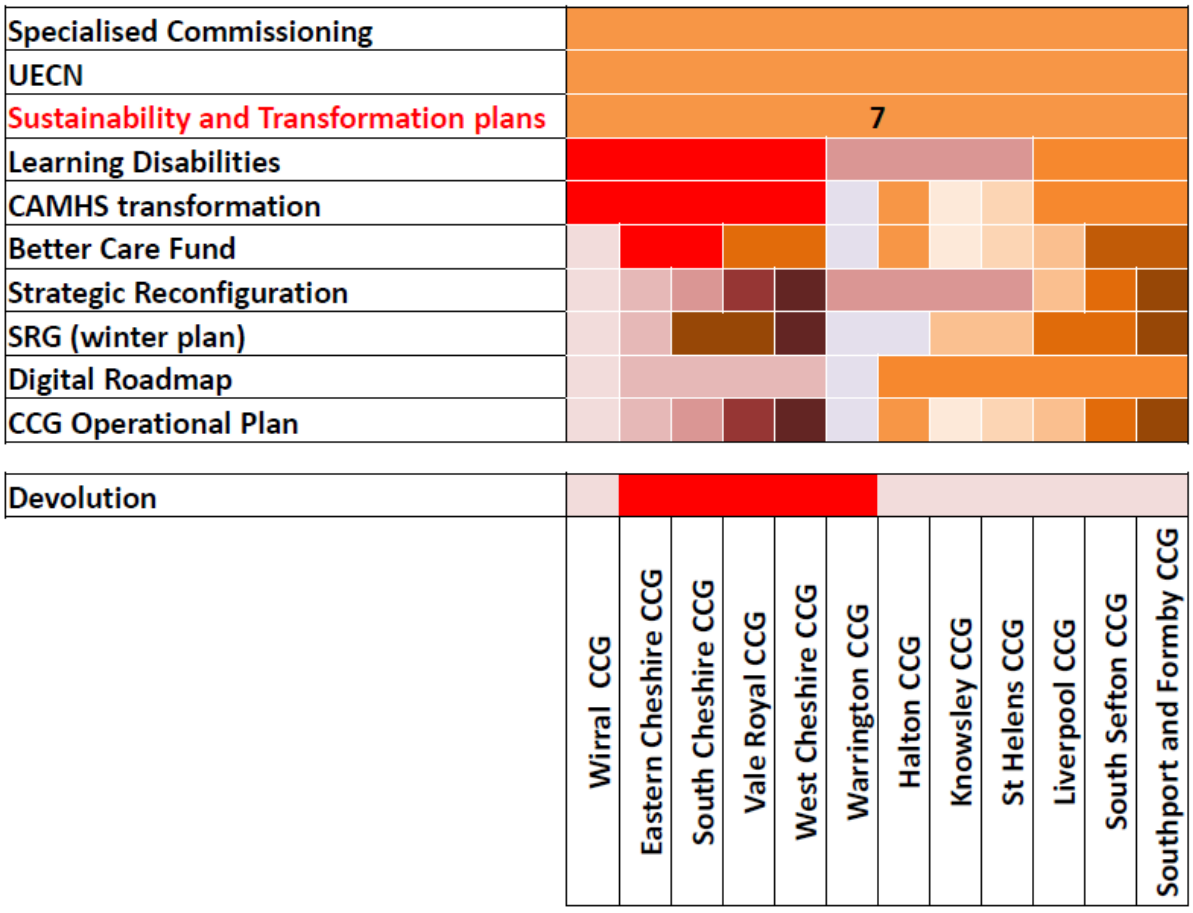
delivery required, this may involve care being delivered out of individual practices, at a town level, for example through the urgent care centres in Widnes and Runcorn, at a Borough level, or with partners outside of the borough including neighbouring local authorities and CCGs. For the five year sustainability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

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

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

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

Figure 1: Cheshire & Merseyside Planning Footprints



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

b) Returning the system to aggregate financial balance

b1) Financial Forecast

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

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

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

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

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

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

b2) Tackling unwarranted variation

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

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

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

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

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

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

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

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

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

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

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

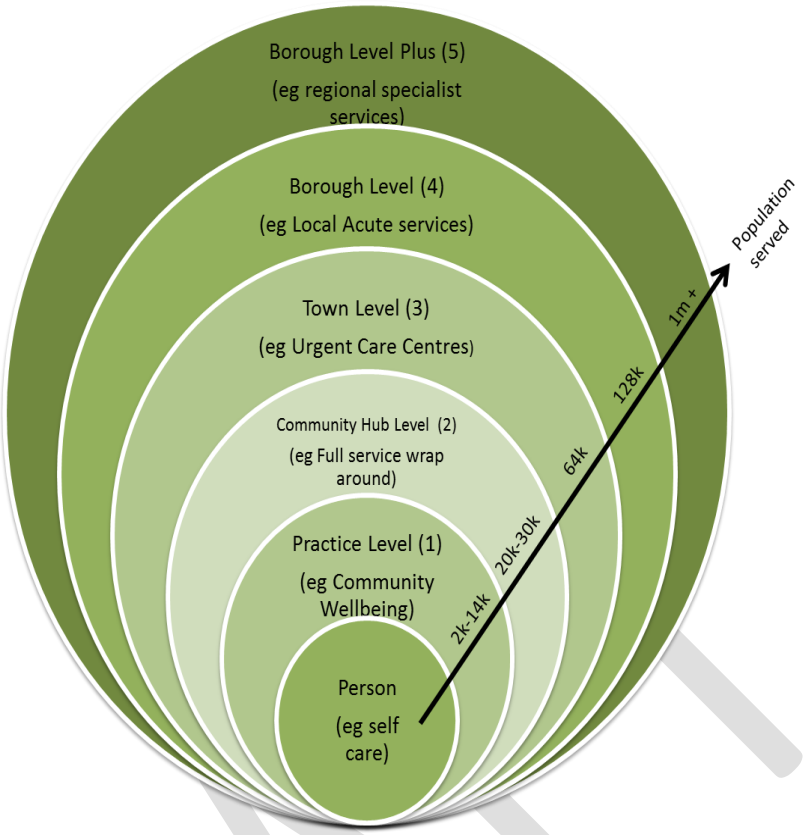
<30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	Total
2	9	9	9	10	8	12	5	1	66

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

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

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

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



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

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

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

b5) Referral to Treatment Times

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

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

b6) Deliver 62 day cancer waiting standard

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

b7) Achieve & maintain two new mental health access standards

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

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

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

b8) Local plans for people with learning disabilities

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

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

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

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

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

b9) Improvements in quality, avoidable mortality

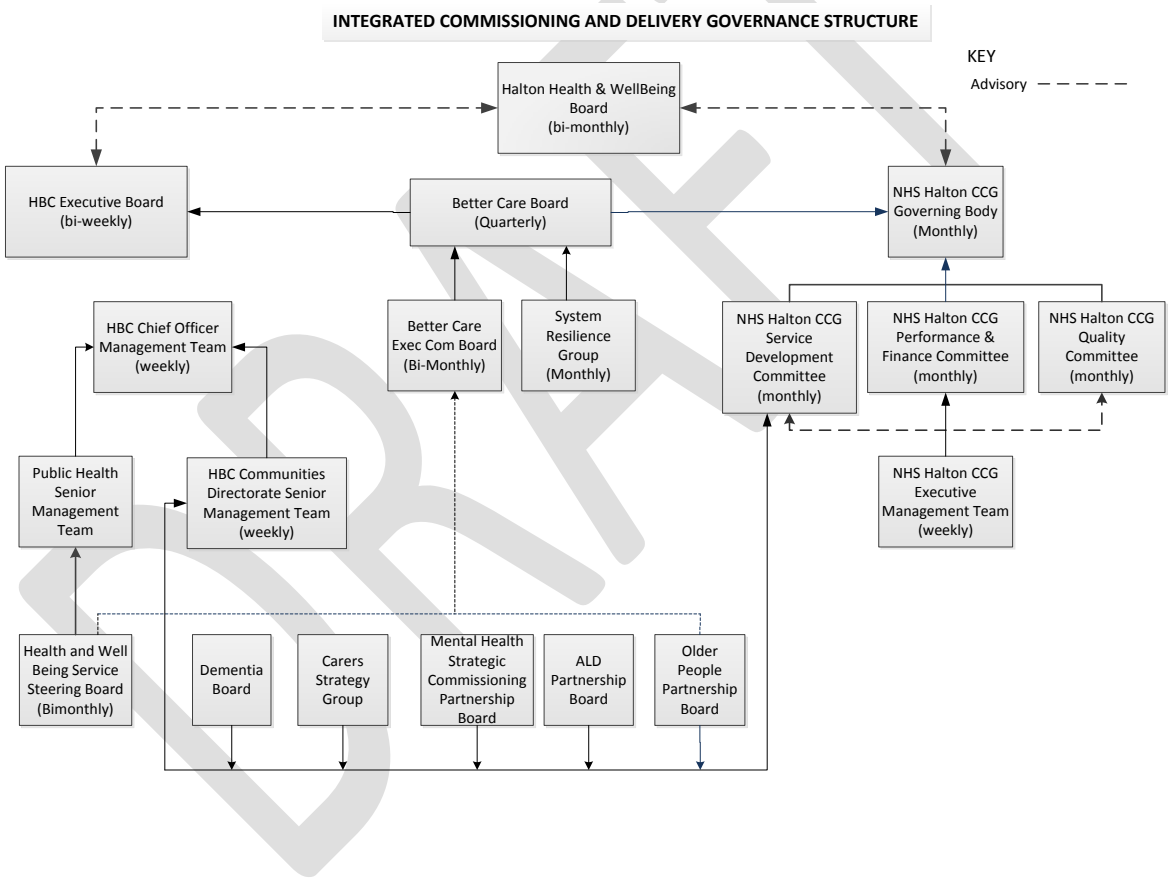
i) Develop & implement affordable plan to make improvements in quality; and
ii) Ensure annual publication of avoidable mortality rates by individual trusts

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

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

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

BCB Q3 template.xlsx



BCF Delivery Plan

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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


Joint care plan June 2016.pptx


Named Care Coordinator June 201

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

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

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

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

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

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

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

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

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

5.0 An agreed approach to Financial Risk Sharing and Contingency

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

Insert signed copy of Section 75

Risk Assessment & Mitigation

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

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

Controls to mitigate against these risks fall into three categories.

1) **Financial systems**

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

2) **Internal governance**

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

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

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

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

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

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