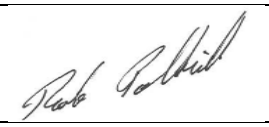
Better Care Fund Plan 2017 - 2019

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:	**This will be retrospectively**
Date submitted:	**11th September 2017**
Minimum required value of BCF pooled budget: 2017/18	**£9,660,843**
Total agreed value of pooled budget: 2017/18	**£14,686,914**

Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	
By	Dave Sweeney
Position	Interim Chief Officer
Date	

Signed on behalf of the Council	
By	David Parr
Position	Chief Executive
Date	

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Rob Polhill
Date	

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1.0 Introduction

Halton's Better Care Fund (BCF) in 2017 - 2019 builds on the work undertaken by the fund in previous years 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 required funding or were supported by funding sources from other parts of the system. The BCF is integrated with the Cheshire and Merseyside (C&M) 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) including 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 as outlined in the One Halton Health and Wellbeing Strategy 2017 - 2022:

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 Cheshire and Merseyside Sustainability and Transformation Plan (STP)[1]

[1] CM STP 8_21 Oct submission_Version 2

Partners across Cheshire and Merseyside (C&M) have been working together over the past six months to further develop and accelerate the implementation of the 5 Year Forward View[2] for our Communities. The STP summaries our plans to address the challenges we face, under 4 common themes:

- support for people to live better quality lives by actively promoting the things we know have a really positive effect on health and wellbeing;
- working together with partners in local government and the voluntary sector to develop more joined up models of care, outside of traditional acute hospitals, to give people the support they really need in the most appropriate setting;

C+M Next Steps on
2 NHS 5 year forward v

- designing an acute care system for our communities that meets current modern standards and reduces variation in quality; and
- making ourselves more efficient by joining up non front-line functions and using the latest technology to support people in their own homes.

Our core purpose is to create sustainable, quality services for the population of C&M. This is effectively our ambitious blueprint to accelerate the implementation of the 5 Year Forward View across C&M. Sustainable means delivering services within the amount of finance made available to C&M for the provision of health and social care. Quality means services that are safe, and deliver excellent clinical outcomes and patient experience. We have devised a portfolio of 20 programmes, each with clear objectives, scope and emerging governance structures – some are further ahead than others in developing their detailed plans.

Halton is part of the Local Delivery System (LDS) programme[3] detailed in the attached. The LDS programmes are the delivery vehicles that deliver the principles, guidance and clinical models developed across the other programmes. To effectively deliver the strategy it is important that this is well understood to avoid duplication of effort. The STP provides a platform for the key themes and direction that we are taking in order to deliver our goals. It draws on much of the work that is already underway across the three LDSs, and aims to deliver additional scale economies, learning and collaboration through the focus on a one C&M approach to those activities where additional scale can bring benefits.

The key themes we are pursuing

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

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

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

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

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

[3] Alliance LDS Refresh Chapter (May 2017).

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

What stage are we at now?

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

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

In addition to the work already underway within our three LDS we identified the strategic STP priorities that would make our health and care system sustainable in the near medium and long term:

1. **Improve the health of the C&M population** (previously referred to as 'Demand Management' and 'Prevention at Scale') by:
   - Promoting physical and mental well-being; and
   - Improving the provision of physical and mental care in the community (for example outside of hospital).

2. **Improve the quality of care in hospital settings** (previously referred to as 'Reducing variation & improving quality in support of hospital reconfiguration') by:
   - Reducing the variation of care across C&M;
   - Delivering the right level of care in the most appropriate setting; and
   - Enhancing delivery of mental health care.

3. **Optimise direct patient care** (previously referred to as Productive back office and clinical support services collaboration) by:
   - Reducing the cost of administration; and
   - Creating more efficient clinical support services.

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 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.

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)[4] but additional sources of information are also used such as Right Care's Commissioning for value pack[5], 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 expanded the services available in our Urgent Care Centres in Widnes and Runcorn to provide real alternatives to A&E. Utilising GP and Consultant oversight offers a central location for 7 day GP access, speedy diagnostics and a 'one stop' approach to minor illness and injury.

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.

[4] http://www3.halton.gov.uk/Pages/health/JSNA.aspx
[5] http://www.rightcare.nhs.uk/index.php/commissioning-for-value/

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 are working together to develop services centred around care homes, including medication and dementia screening and strengthening clinical nursing support for residents and staff alike.

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 continue to support the developing Rapid Clinical Assessment Team, with consultant oversight and utilising the diagnostic capacity at the Urgent Care Centres.

The 5-year STP is totally aligned with the BCF and has been developed in collaboration with the Local Authority, 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.

3.0 Review of BCF Plan 2016/17

3.1 Impact and outcomes – Key successes

Schemes/projects within the BCF Plan, and just generally, are evaluated on an ongoing basis to ensure they are impacting positively and producing the outcomes that are needed to improve the health and wellbeing of the people of Halton. All schemes within the BCF Plan report progress on a regular basis to the Operational Commissioning Committee.

In November 2016, the Better Care Support Team (BCST) visited Halton. The event focused on ***'The Halton Way' - the local approach to integrated services*** and covered the many schemes funded through the local BCF and operational managers/staff working within the teams came along to present their presentations. The event clearly demonstrated that the multi-agency staff involved with the teams work very much as one "integrated" team and do not have any barriers to their work because of being employed by different agencies. The event also highlighted the passion and enthusiasm that the staff all have, striving to improve the health and social care journey for each individual and to improve their overall quality of life and outcomes. Halton was also showcased in the National BCF Support Team's report ***"Local Learning 2016/17 Report".***

The table below gives an overview of the main schemes within the BCF Plan, and a brief overview of the scheme/project, the aims/objectives and the key successes and challenges from 2016/17.

3.2 Review of Schemes 2016/17

Local Scheme	Outline	Aims/Objectives	Challenges/Successes
Integrated Hospital Discharge team	Established in 2011, the team contribute to reductions in length of stay and delayed transfers of care by adopting trusted assessor principles, tracking patients stay and focusing on rehabilitation and increasing independence.	HIDT undertake a proactive approach to identifying Halton residents within Warrington Hospital and do not necessarily wait for a formal referral to be made. There is a clear focus on rehabilitation services and increasing independence, sharing skills and expertise, and reducing in-patient stay. The team track the patients stay, liaising with the Multi-Disciplinary team to plan and expedite discharges in a safe and timely manner, with a focus on delayed transfer of care to prevent delayed discharges. On a daily basis a list of adults (50+) that have been admitted overnight is provided to the HIDT. Designated Care Managers track and monitor the person's hospital journey during the duration of their stay. System established to ensure that individual's rehabilitation needs are maximised before consideration for long term care and NHS Continuing healthcare assessment. Arrangements in place for transitional funded beds to ensure that NHS CHC assessment is completed in the appropriate setting where needs can be more clearly identified.	• Availability of resources/system pressures. • Winter Pressures. • Ageing population. • Quality of referrals/ assessment paperwork. • 7 days working/the future.
Urgent Care Centres	There are two community-based primary care facilities operating 7am – 10.30pm, 365 days per year. With close links to services including: Ambulance Service,	• Make care easier to access and closer to home; • Avoid patients making unnecessary visits to A&E;	There has been a decrease in Type 1 A&E attendances during 2016/17 by 2.5%.

	Primary Care, Secondary Care, Out of Hours, Mental Health Services, Community Nursing, Social Care and Health Improvement Services.	• Avoid any unnecessary delays, transfers of care, and duplication in care; • Support patients to effectively manage their own health and wellbeing; • Extend and standardise primary care provision for Halton residents into the weekend and evening periods; • Effect a cultural and behavioural change in the population of Halton enabling greater knowledge of, and confidence to utilise, local services; • Maximise the utilisation of all available resources. • Make services more accessible via two Urgent Care Centres, one in Runcorn and one in Widnes • Provide diagnostics closer to home and in an alternative venue to an acute hospital setting • Provide a suitably trained, competent and integrated workforce which includes a range of Health Care Professionals • Provide clean and pleasant environments, with well maintained, safe and hygienic facilities.	
Rapid Clinical Assessment Team	Supporting older people to remain home during periods of acute illness, with the aim of preventing hospital admission and reducing the length of hospital stay. The service works with patients in their own homes and also within dedicated intermediate care beds. The Elderly Consultant Physician; a team of	The service is for those 75+ who are not critically ill. Promoting patients choice, the Rapid Clinical Assessment Team (RCAT) aims to prevent avoidable admissions to hospital / attendance at accident and emergency departments, in frail older people, by providing expert clinical assessment and examination, diagnostic testing as required and	Between April 2016 and March 2017, out of the 194 referrals made, 165 non-elective admissions were avoided. For NHS Halton CCG, the average cost of an emergency attendance and admission via ambulance in 2015/16 was £2,786 (Age 75+).

	Registered Nurses including Advance Nurse Practitioners provide expert clinical assessment, examination and diagnostic testing, to prevent avoidable admissions and A&E attendances in frail older people.	management in the individuals own home. Provision of high quality multi-disciplinary care within the older persons own home, utilising existing health and social care community services within Halton.	Based on this figure, a total saving of £459,690 was made in hospital avoidance. Offset against the annual cost of the RCAT service, which is circa. £350k, then in 2016/17 a total saving of £109,690 was made. The scheme was shortlisted for a BMJ clinical leadership award 2017. Feedback from patients, families and GPs on the whole has been excellent. Challenges have included:- • Ensuring timely communication with GPs, which has been addressed with the introduction of shared electronic records with GPs. • Persuading multiple- admission avoidance providers that RCAT offer alternatives to existing primary care services. • Building the confidence of local GP's in the service. We overcame this by rapid response times, good communication and keeping older people safely at home. A continuing challenge is ensuring the long term sustainability of the service and we continue to work with our local

			acute trusts on this.
Integrated Health and Social Care - Social Care in Practice (SCiP)	Since 2008, the core aim is to promote independence; a presence in the GP Surgery has reduced the barriers for health professionals making social care referrals, and provides a holistic assessment. A merged health and social care IT portal is under development which will allow access to current records, by GP, Community Matrons, District Nurses and Social Work staff.	**Aim** • Develop a bespoke self-management focused, patient centred care plan. • Identification of the Lead Professional • Develop authentic integrated health, social care and well-being teams • Improve communication, record keeping and patient experience. **Care Planning** • Following MDT discussion comprehensive Care Plans will be developed for the patient, carer and service providers outlining appropriate information regarding management of the condition. • Identification of a Lead Professional • Development of a self-care plan using the local electronic care plan library • Signposting to other services including names and contact details of providers. •	• Effective joint leadership • Patient centred health and social care • Care management through multidisciplinary team working by integrated health and social teams • A service that is wrapped around and linking into primary care neighbourhood. • Improved communication between all services, identify pathways and future merging of appropriate documentation • Reduction of duplication
Community Therapy Team	An integrated team taking referrals from across all intermediate care services, hospital discharge teams, GPs, consultants, and other healthcare professionals to promote independence in the home. Receiving approximately 130 referrals per month, patients on average have 4-5 follow up visits, with short waiting times, often less than 24	• Support the whole system by offering rapid assessment and intervention. • Manage capacity on a daily basis – create a rapid access pathway for community patients. • To provide a level of support for all other community pathways as described in our locally developed "map" of Halton therapy services – reducing the likelihood of unnecessary onward referral; reducing	A patient satisfaction survey from 2016 highlighted some of the successes of the team including: Effectiveness of the help/treatment you were given? – 86% responded excellent and 14% responded good. Level of support you received from the therapist? – 79% responded excellent and 21% responded good.

	hours.	duplication of service provision; resolving inappropriate/avoidable crisis; reducing admission & readmission - by **"getting it right first time"** with an earlier, lower intensity, level of input. • Early access and intervention to improve patient flow – by developing and improving the proactive support the team can give to Hospital discharge pathways; Halton Falls Service and Halton Palliative Care Services & embedding the appropriate pathways within the established teams. • To work closely with all services to support holistic patient care and by providing an easily accessible route for direct referral resolving patient issues at an appropriate level without escalation into crisis; multiple agency interventions or avoidable admission.	Challenges over the next 2 years: • Increase in demand – complexity, patient expectation, older population. • Increased pressure in acute sector – need to develop even stronger links & discharge pathways to support winter pressures. • Discharge to assess model. • Neighbourhood working. • 7 day working • Accommodation, as Team grows and/or effects of Halton site estates rebuild. • The New Bridge – impact of traffic now and impact of toll charges on future workforce recruitment.
Rapid Access and Rehabilitation Service	The Rapid Access Rehabilitation Service (RARS) offers a range of integrated Intermediate Care (IC) services in Halton that focuses on: promoting recovery from illness, preventing unnecessary hospital admission and premature admission to long term residential care, supporting timely discharge from hospital and maximise independent living. This staff group are employed by one of the following three organisations: Halton Borough Council; Warrington & Halton Hospitals NHS Trust or Bridgewater	The service aims to build a multi-disciplinary team around the individual based on their needs and key areas of work to be undertaken. Ensuring adults and older people are given the opportunity to maximise their independence and fully engage with their local communities. A multi-disciplinary team of health and social care professionals that provides initial and ongoing assessment, admission to other Intermediate Care services and rehabilitation, treatment and care to people: in their own homes; in a residential intermediate care unit or in a sub-acute unit.	Successes • Total number of referrals approximately - 1400 per year • Response time on average within 2-4 hours • Self-referrals for patients or service users • Integrated Health & Social Care team • Integration of Falls intervention service into RARS

	Community NHS Trust. A clear pathway across primary, secondary and social care organisational boundaries enables seamless provision of services, the team works with patients who are in their own homes - including crisis response or in designated bed based or Intermediate Care units. More information can be found here.	The service has a 22 bedded IC Sub-acute unit and a 19 bedded IC Residential Care unit. Also flexible bed provision – ability to increase IC bed capacity as and when need arises. The service is able to meet the needs of people with complex, sub-acute, chronic conditions, rehabilitation and reablement needs; this includes people with mental, physical and learning impairment. The service is provided in the least intensive setting as appropriate to the patient's need and appropriate risk assessment and the service has clear pathways across primary, secondary and social care boundaries, ensuring seamless provision of services.	Challenges • Hospital escalation • Domiciliary Care provision • Ageing population • Increase in frailty • Implementation of Care Act • 7 days working/the future
Stroke Early Supported Discharge (ESD)	The scheme was set up in 2015, helping to reduce length of stay for Stroke patients; improving patient flow, reducing social care packages, reducing readmission rates, and achieving high levels of patient satisfaction and functional outcomes. The Early Supported Discharge (ESD) enables stroke patients to be discharged home from hospital more quickly, whilst still receiving specialist rehabilitation. Reducing pressures on acute hospital beds and allowing patients to return home more rapidly.	To discharge patients early to enable stroke patients to get home from hospital more quickly. The Early Stroke Discharge team is based on the stroke ward, and made up of; physiotherapists, occupational therapist, speech and language therapist and assistant practitioner. Rehabilitation therapists visit patients in their own homes to provide therapy, working closely with other agencies and services; GP's, Psychologists, Care Agencies, Equipment Services, Carer Support Services and the Stroke Association. Within 24 hours of discharge, the team will aim to visit patients in their own home. Patients must be committed to engage with the rehabilitation programme for up to 8 weeks.	The Early Supported Discharge (ESD) enables stroke patients to be discharged home from hospital more quickly, whilst still receiving specialist rehabilitation. Reducing pressures on acute hospital beds and allowing patients to return home more rapidly. Patients who receive ESD have an increased likelihood of remaining at home long-term and also of regaining independence with daily activities.

		Based on patient need, sessions are provided daily (Monday to Friday) for 45 minutes a day.	
Falls Prevention	In 2012 a review was undertaken to look at the falls service in Halton. This work was conducted by a multi-agency steering group and it became clear from very early on that services linked to falls were fragmented and there was no overarching vision. In addition to this fragmentation; overall performance was significantly worse than the national average, for example the hip fracture rate in people over 65 in Halton was 750 per 100,000, and the National average was 674 per 100,000. At this point it was agreed that a new falls strategy was required for Halton for the period 2013 – 2018. The strategy focused on key objectives which included : • To develop an integrated falls pathway for Halton • To develop a prevention of falls pathway for Halton • To develop a package of workforce training • To develop an awareness raising campaign with both the public and professionals	To date many key actions identified in the plan have been fully implemented and although performance is still below the national average in a number of areas there has been a significant decrease in the gap as illustrated in section 3 (performance). This links in with the key strategic priorities for falls prevention in Halton, which are to reduce: • Emergency hospital admissions for injuries due to a fall (65+) • Emergency hospital admissions due to fracture of neck of femur (65+)	In summary progress has been made in a number of areas in line with the key priorities to reduce emergency hospital admissions for injuries due to a fall (65+) and emergency hospital admissions due to fracture of neck of femur (65+). However work needs to continue to close the gap and to reduce the numbers of people who fall in Halton. See attached report:  OCC Paper Falls 6th March 2017.doc

	• To improve partnership working across all agencies involved and improve governance arrangements to support falls.		
Admiral Nurse Scheme	Admiral Nurses are specialist dementia nurses who give practical and emotional support to family carers, as well as the person with dementia. They offer support to families throughout their experience of dementia that is tailored to their individual needs and challenges. They provide families with the knowledge to understand the condition and its effects, the skills and tools to improve communication, and provide emotional and psychological support to help family carers carry on caring for their family member.	The service comes with an element of a *given* remit to work with those patients and families with the most complex needs as a result of coping with a diagnosis and the associated behaviours. However, the Admiral Nurse service has been tailored to the needs identified in Halton, and complements the range of existing community provision within the borough.	Service has commenced with paperless care records Referrals accepted from 7/03/16 Service leaflet for Knowsley and Halton now approved and going to print will then be distributed widely across Halton Ongoing contribution to the GEANS project Development of case studies Team have completed Advanced Care Planning training, Gold Standards Framework, Opening the Spiritual Gate, Six Steps. Room space at Brooker Centre now confirmed with Castlefield's surgery as a base on Wednesdays Dementia Action Alliance (DAA) End of Life event to be confirmed in September 1 2 1 Employer clinics Internal safety walkabout 28/10/16 Internal Quality reviews 28/04/16

			(Bridge ward) and 26/04/17 (St Helens Home Treatment Team) MSNAP review 26/04/17 (South Sefton) Dementia UK Living with Dementia masterclass 20/10/16
Care at the end of Life	End of life care in Halton is provided in a variety of settings by a wide range of organisations. To meet individual needs and deliver high quality care, a whole system approach is needed that co-ordinates care across professional and organisational boundaries.	See attached report on Scope of Care at the End of Life:  End of Life Scoping Paper.docx	It is recommended that further work is undertaken including a 'deep dive' into the cost of care at the end of life, to support the development of a different commissioning process that will enable a new delivery model for end of life care. It is recommended, from an analysis of the available evidence and discussions with stakeholders, that serious consideration should be given to include end of life care in the STPs. To develop a different type of commissioning, NHS Halton Clinical Commissioning Group will be required to formulate an end of life strategy, jointly with local people and key partners, which clearly sets out the vision for end of life care. The strategy will in turn drive a whole-systems approach that will support the implementation of 'The Priorities for Care of the Dying Person' framework; • The possibility that a person may die within the coming days and hours is recognised and communicated clearly; decisions

			about care are made in accordance with the person's needs and wishes and these are regularly reviewed and decisions revised accordingly. • Sensitive communication takes place between staff and the person who is dying and those important to them. • The dying person, and those identified as important to them, are involved in decisions about treatment and care. • The people important to the dying person are listened to and their needs are respected. • An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion. A key element of the strategy must include the Electronic Palliative Care and Coordination System (EPaCCS). This will enable the recording and sharing of people's end of life choices, their preferences and individualised care plan.
Integrated Mental Health	To redesign the existing service to be able to deliver shorter-term, outcome focused interventions to residents in Halton who have mental health issues and have	• Carry and be responsible for own caseload • Work with individuals to identify priorities for intervention • Operate an agreed performance and	• As the volume of referrals have greatly increased over the last few months and referral points further widened as a result of the redesign,

	identified support needs. To create more capacity through changing processes that addresses current capacity issues and increased demand for the service. This model meets the service redesign proposals identified as a result of the Tony Ryan report and will also apply to the physical and sensory disability section of the service.	outcome management process with each individual • Complete risk assessment and care plans in accordance with principles of personalisation • Complete the identified specific outcome-focused intervention over a specified time frame of 6 weeks initially, but which can be expanded if required - Desensitisation program - Anxiety / stress management programme - Travel training - Confidence course - Budgeting skills - Introduction to community social activities - Educational / vocational placements - Physical health / wellbeing programme • Support to access and attend physical health appointments • Work in partnership and create pathways to appropriate services (Health improvement, housing, CAB, Welfare Rights, Community Bridge Builders, Women's Centre, Jigsaw, Nightstop, Sure Start, Wellbeing Enterprises, etc) • Contribute to multi-disciplinary, ECC and adults and children safeguarding meetings • Maintain effective record systems • Act as Appropriate Adults under PACE	it may create some capacity issues. Increasing the number of workers (by 2-3) would allow the service to develop and increase accessibility and early intervention for Halton residents. This will result in reducing long term care and service cost as well as impacting on other costs such as housing and health related costs and has been evidenced already by the addition of a temporary (until March 2018) support worker funded by Supporting People monies • Funding of £80,000 was initially allocated from the Better Care Fund to support this redesign / expansion of the service however had to be diverted and invested in another service (IAPT) therefore Outreach did not receive any additional monies. The cost of a support worker (with on costs) on HBC3 is £20,708 - £22,226 • In order to continue to provide effective and efficient PACE duties there will need to be more staff trained and included on the rota, possibly from other service areas

Frailty Pathway	Development of an end to end pathway of care for frail older people in Halton; Living and Aging Well in Halton.	While many people remain well, engaged and active well into later life, increasing age can also bring an increasing chance of long term medical conditions, frailty, dementia, disability, dependence or social isolation. By working together, in an integrated way, we can do much to prevent these problems or help people live with them, to retain their independence and keep them out of hospital. However we also have to acknowledge that older people often do need to go into hospital, have to move into residential/nursing care or need to access rehabilitation services following illness. By working together across the whole of the health and social care economy, via the end to end pathway, we will ensure that the right services are in place and that people can access them at the right time.	Patients will enter the pathway at different levels, or may require identification in primary care in order to access appropriate services along the pathway. However, identification of frail older people and the level of frailty can be a challenge. Frail older people at different stages of the pathway will require a range of interventions that are clinically effective and appropriate for their level of frailty. These interventions may well involve voluntary and community sector groups, in addition to clinical assessment and support, particularly at the early stages of frailty when the focus should be on maintaining independence and optimising function and health. Below are examples of the work undertaken as part of the pathway's development:- • An information leaflet on recognising frailty in Older People • A Joint Health and Social Care Plan. The introduction of the Care Plan will be supported by the development of a Joint Assessment. • Establishment of an Older People's Reference Group

			• Reinforced with General Practice the need to monitor and review Emergency Department attendances etc. as part of the Multi-Disciplinary Team (MDT) process. • Completion of an End of Life Review and associated provision in Halton. • Development of the Rapid Clinical Assessment Team (RCAT) in Halton • Development of an Older People's Performance Management Framework which is intended to provide information as to whether the various components of the pathway are having a positive impact or not.

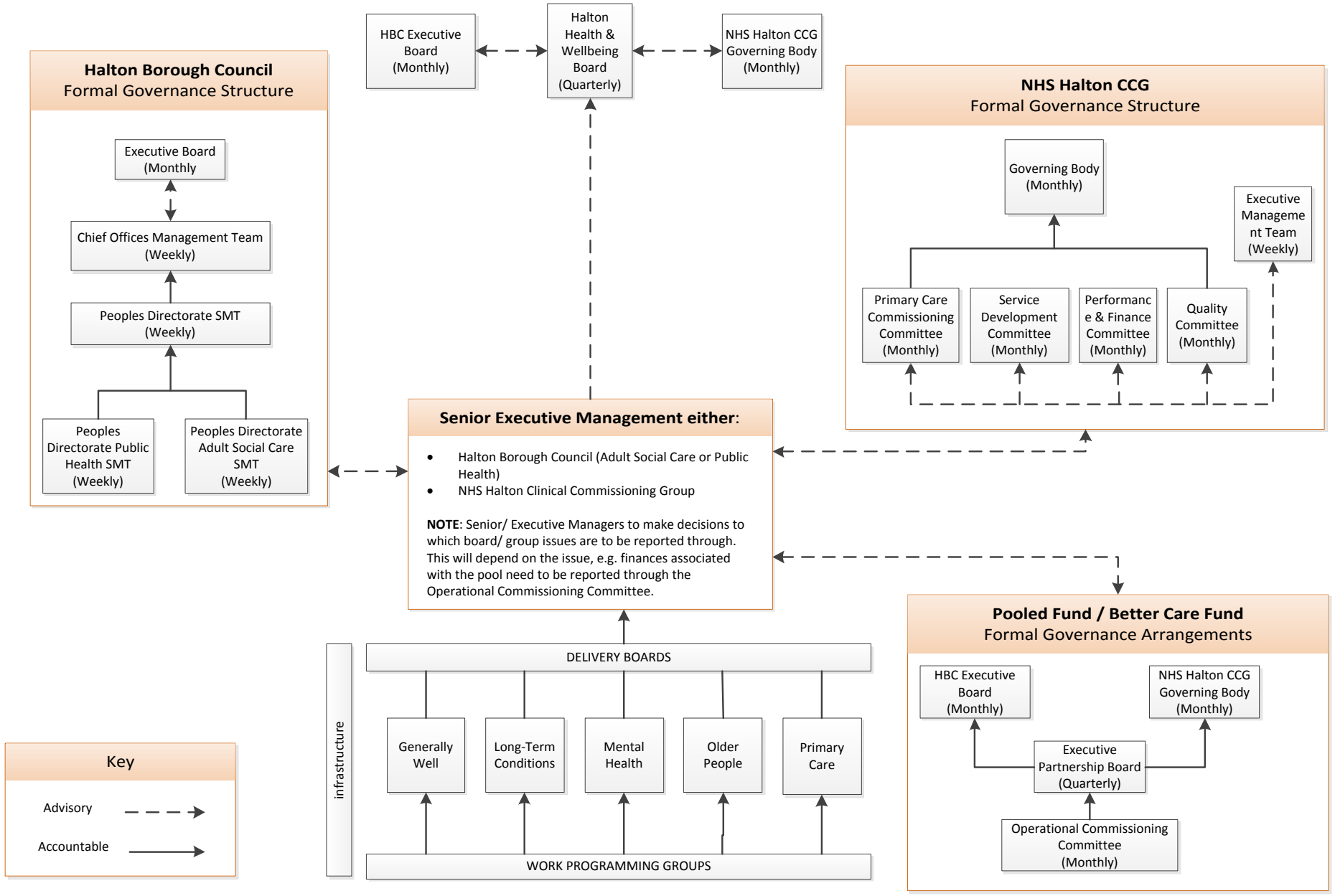
4.0 A Co-ordinated and Integrated Plan of Action for Delivering the BCF

The performance management and governance arrangements set up for the 2015 pool will continue for 2017 – 2020 with a few minor changes. The BCF Executive Commissioning Board has been renamed the Operational Commissioning Committee (OCC) and now meets on a monthly basis and the Better Care Board is now called the Executive Partnership Board. The governance structure is detailed below.

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

Copy of OCC 2017-18.xlsx

On the following page chart shows the Integrated Commissioning and Delivery Governance Structure.


HBC Executive Board (Monthly)
Halton Health & Wellbeing Board (Quarterly)
NHS Halton CCG Governing Body (Monthly)
Halton Borough Council
Formal Governance Structure
Executive Board (Monthly
Chief Offices Management Team (Weekly)
Peoples Directorate SMT (Weekly)
Peoples Directorate Public Health SMT (Weekly)
Peoples Directorate Adult Social Care SMT (Weekly)
NHS Halton CCG
Formal Governance Structure
Governing Body (Monthly)
Executive Management Team (Weekly)
Primary Care Commissioning Committee (Monthly)
Service Development Committee (Monthly)
Performance & Finance Committee (Monthly)
Quality Committee (Monthly)
Senior Executive Management either:
Halton Borough Council (Adult Social Care or Public Health)
NHS Halton Clinical Commissioning Group
NOTE: Senior/ Executive Managers to make decisions to which board/ group issues are to be reported through. This will depend on the issue, e.g. finances associated with the pool need to be reported through the Operational Commissioning Committee.
Pooled Fund / Better Care Fund
Formal Governance Arrangements
HBC Executive Board (Monthly)
NHS Halton CCG Governing Body (Monthly)
Executive Partnership Board (Quarterly)
Operational Commissioning Committee (Monthly)
infrastructure
DELIVERY BOARDS
Generally Well
Long-Term Conditions
Mental Health
Older People
Primary Care
WORK PROGRAMMING GROUPS
Key
Advisory
Accountable

4.1 BCF Delivery Plan 2017/18

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 Ongoing	Dr G O'Hare 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	Ann Nolan
5	Falls Prevention	Review of existing investment in primary and secondary prevention		Lisa Taylor
6	Dementia	Evaluation of Admiral Nurse scheme	Evaluation	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	Stiofan O'Sullibhan
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	This has been taken out as a scheme – now have IT Strategy in place.	N/A	Jonathan Greenough/ Emma Alcock
15	Prevention	Continue implementation of strategy	Ongoing	Damian Nolan
16	DFG and Equipment/Adaptations	Continue service provision	Ongoing	Helen Moir
17	Wellness Service	This is no longer a scheme in the BCF	N/A	Dave Sweeney
18	Frailty Pathway	Continue development of pathway	Ongoing	Michelle

		and identify key areas for investment		Creed 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

4.2 Integrated BCF (i-BCF)

At the Spring Budget 2017, the Government announced that an additional £2 billion will be given to councils in England over the next 3 years for adult social care. Halton's additional funding allocations are outlined below:-

- 2017/18: £2,974,314
- 2018/19: £1,827,114
- 2019/20: £904,208

This additional funding is to be spent on adult social care and used for:-

- Meeting adult social care needs;
- Reducing the pressures on the NHS, including supporting more people to be discharged from hospital when they are ready, as there is an expectation that the additional funding will result in a reduction in Delayed Transfers of Care; and
- Stabilising the social care provider market.

A number of pressures have been identified within our local system, as a direct result of reductions in available funding, including:

- Ability to manage increases in demand;
- Domiciliary Care capacity and model of provision;
- Care Homes - sustainability/risks from closures/model of provision;
- Transfers of care from hospital - speed and availability of care; and
- Capacity and availability of Reablement packages.

Seven initiatives/developments have been identified for 2017/18 which will address issues within our local system and the requirements/expectations outlined by Government, for use of the funding. Associated action plans have been developed to ensure that these initiatives will be implemented during 2017/18. A review of the outcomes and financial impact achieved will be completed at the end of 2017/18 and will form the basis of recommendations for further initiatives/developments for 2018/19 and 2019/20.

ASC Funding Action Plan - 300817.docx

4.3 Transforming Domiciliary Care (TDC)

In Halton the overall budget for Domiciliary Care is approximately £4.3million and currently supports 742 people. However, it is clear that the current system is not sustainable in light of an ageing population and does not offer people an opportunity to better manage their own quality of life whilst living at home. The project that will be developed will specifically work with people who are currently receiving Domiciliary Care or who are assessed for an identified need in the future. The service will be delivered through a unique partnership between HBC, NHS Halton CCG, the voluntary sector and the Domiciliary Care providers who are already working in the borough. The change in design will mean that rather than just offering the standard task focussed domiciliary care, the service will instead work with an individual to identify their needs and critically work towards improving their overall quality of life, which in turn will have a positive impact on their overall health and wellbeing. Examples of such interventions could include support in accessing groups and networks, reconnecting with friends, receiving escorted shopping trips, building confidence and helping individuals and families to manage some of the caring aspects that people need support with. The attached TDC Work Programme gives more detail on the project.

TDC Programme Overview Document \

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

5.1 Plans to be Jointly Agreed

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

5.2 NHS Contribution to adult social care is maintained in line with inflation

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.

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

5.3 Agreement to invest in NHS commissioned out-of-hospital services

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 **£510k** to manage potential increases in demand during 2017/18 across key service areas and outcomes for the Fund. This is in lieu of a pay for performance fund which does not feature in Halton's 2017/18 BCF plan. This can only be spent through reports to the Operational Commissioning Committee 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.

5.4 High Impact Change Model

National condition four requires health and social care partners in all areas to work together to implement the High Impact Change Model for Managing Transfers of Care. BCF plans should set out how local areas are implementing the model, which was agreed by local government and health partners in December 2015 and republished in April 2017. This model sets out eight broad changes that will help local systems to improve patient flow and processes for discharge and so help reduce delayed transfers. It provides a framework to assess local services and offers practical options to support improvements. The changes cover:

- Early discharge planning;
- Monitoring patient flow;
- Discharge to assess;
- Trusted assessors;
- Multi-disciplinary discharge support;
- Seven day services;
- Focus on choice (early engagement with patients and their families/carers); and;
- Enhancing health in care homes.

5.4.1 Early Discharge Planning

The Halton population accesses elective and non-elective care at two main hospitals, St Helens and Knowsley NHS Teaching Hospital Trust and Warrington and Halton Hospitals NHS Foundation Trust. Both Trusts have processes in pace for the early identification of discharge needs and monitoring the flow through the in-patient episode. Both have regular length of stay processes which the multi-disciplinary discharge teams are engaged in. This is supported by regular senior management input from Halton. Both trusts have commenced transfer to assess processes utilising community based services to continue the assessment of need (this includes supporting <15% of CHC assessments undertaken in an acute environment). All intermediate care and social care services are available and accessible 7 days a week with a programme of work commenced exploring 'trusted assessor'

model for care homes. A single coordinating provider for domiciliary care in the borough will play a crucial role in expediting hospital discharge whilst the 'reablement first' approach (with funds from the iBCF) will link directly to transfer to assess and hospital discharge. The 'enhancing healthcare in care homes' programme is supported by the wider programme of work for care homes linked into the iBCF.

5.4.2 Monitoring Patient Flow

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. Both hospital trusts use a discharge to assess (D2A) model. Increases in capacity in the discharge teams, continuing healthcare team and Intermediate Care will go some way to the management of DToC's. A large amount of delays are due to either patient choice or delays in arranging home care, residential care and domiciliary care packages. Many of these people have complex needs. Pressures within the domiciliary care sector within Halton are less problematic than reported nationally, but remain present. The council is undertaking a Transforming Domiciliary Care programme including a re-procurement of fewer providers and increased resources.

The reduction of delayed in DToC is a key priority for the NHS; an area of focus from NHS England is to improve the NHS Continuing Healthcare assessment process. It is estimated that delays in completing NHS CHC assessment is a contributing factor for DToC. NHS England will be monitoring CCGs to ensure the CCG has plans in place to improve the NHS CHC pathways and processes relating to NHS Assessment within the acute sector. NHS Halton CCG and HBC have established systems in place to ensure individual's rehabilitation needs are maximised before considering long-term care needs.

The two key standards required are:

1. CCGs must ensure that less than 15% of all full NHS CHC assessments take place in an acute hospital setting; and

2. CCGs must ensure that in more than 80% of cases with a positive NHS CHC Checklist, the NHS CHC eligibility decision is made by the CCG within 28 days from receipt of the Checklist (or other notification of potential eligibility).

Within the Borough of Halton we operate a joint approach to assessment for complex care having designated CHC Complex care nurses working within the Complex care service; this integrated service has led to a removal of duplication and timely authorisation of transfers of care from the acute sector. The team currently do not undertake Decision Support Tool (DST) assessments within the acute sector as there is a transitional funding system in place. An area for improvement is completing the DST within the 28 day time scale; NHS Halton CCG has a CHC implementation plan in place and will work jointly with HBC to ensure compliance; activity will be reported through to the Operational Commissioning Committee.

5.4.3 Discharge to Assess

The focus of discharge to assess is where people who are clinically optimised and do not require an acute hospital bed, but may still require care services are provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting. Assessment for longer-term care (this could include continuing healthcare) and support needs is then undertaken in the most appropriate setting and at the right time for the person. Commonly used terms for this are: 'discharge to assess', 'home first', 'safely home', 'step down'. This does not detract in any way from the need for agreed multi professional assessment or from the requirement to ensure safe discharge and it may work alongside time for recuperation and recovery, on-going rehabilitation or reablement.

Putting people and their families at the centre of decisions, respecting their knowledge and opinions and working alongside them to get the best possible outcome are essential. We need to ensure we have taken steps to understand the perspectives of the patient and their carers and the communities they live in, their needs, aspirations, values and their definition of quality of life. Where the patient may not have capacity for a decision about discharge placement/assessment, apply the Mental Capacity Act 2005 (MCA), informed by the MCA Code of Practice and relevant case law.

Supporting people to go home should be the default pathway , with alternative pathways for people who cannot go straight home, for example if a person's needs are more complex or they require continuing healthcare funding to move to another residential setting. Halton residents are offered transitional placements to enable patients and their families to have the time to coproduce a comprehensive assessment. The success of this initiative has ensured that less than 15% of patients have a continuing healthcare assessment in an acute setting (national target).

5.4.4 Trusted Assessors

See Section 4.2

5.4.5 Multi-disciplinary Discharge Support

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

Summary of 201718 GMS contract negotia

5.4.6 7-Day Services

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.

In the spring budget the chancellor announced an additional £2 billion of new funding for councils in England over the next three years to spend on adult social care services. This will be broken down as £1 billion to be provided in 2017-18 with £674m in 2018-19 and £337m in 2019-20. This has been recognised by the Directors of Adult Social Services as an important step towards closing the gap in Government funding for Adult Social Care, whilst we are waiting for the Green paper on future sustainability of the sector.

This additional funding is to be spent on adult social care and used for the purposes of meeting adult social care needs, reducing the pressures on the NHS- including supporting more people to be discharged from hospital when they are ready- and stabilising the social care provider market. A small number of grant conditions have been applied, to ensure that the money is spent on adult social care services and supports improved performance at the health and social care interface.

The grant will be pooled into the Better Care Fund pooled budget, once agreement has been reached at the HWBB we will be in a position to allocate and spend funding immediately.

There is an expectation that allocation of this funding will result in a reduction in Delayed Transfers of Care, a series of metrics will be developed by the DH and DCLG to assess improvements in patient flow across the NHS and social care interface.

Additional capacity in the two Hospital Discharge teams continues to support 7 day access to assessment and care provision. This was 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.

5.4.7 Focus on Choice (early engagement with patients and their families/carers)

Within Halton the focus on choice is paramount. Early engagement with patients, families and carers ensures that people have time to consider their options appropriately. We have processes in place at both Trusts that ensures patients and relatives are fully aware that they need to make arrangements for discharge promptly.

Voluntary sector provision by the Red Cross and Age UK is integrated into the two discharge teams to support people home from hospital. This gives patients and their families/carers really meaningful support in considering their options about their future care.

We also use a Choice Protocol in both Trusts to proactively challenge people.

5.4.8 Enhanced Care in Care Homes

A primary goal of health and social care services is to support people in their own home for as long as possible. If this is no longer possible, we must ensure that the best possible care is provided to those in residential settings. In many parts of the country, the care for people who are living in care homes or who are at risk of losing their independence is being held back by a series of care barriers, financial barriers, and organisational barriers:

Care barriers - A narrow focus on medical rather than holistic needs - Lack of integrated care planning that focuses on prevention and pro-active care - Variable access for care home residents to NHS services - Lack of continuity of care and the difficulties faced by the current workforce crisis

Financial barriers - Few system-wide incentives around preventative care across health and social care providers - A financially distressed care provider market which will impact on quality in some care homes - The financial challenges that the national living wage and other centrally imposed cost increases put on the finances of the providers and local authority/clinical commissioning group commissioners - Recruitment and retention (including training) within the care sector - Contractual mechanisms for provision of preventative health care for those in care homes and those at risk of losing their independence

Organisational barriers - Barriers between organisations in different parts of the health service and between the NHS and other sectors, in particular social care - A lack of financial and clinical accountability for the health of the defined population - Variations in policy, process and supporting systems (such as information technology (IT)) across organisations.

This new care model seeks to overcome as many of these challenges as possible by ensuring that:

- people have access to enhanced primary care and to specialist services;
- budgets and incentives are aligned so that all parts of the system are unequivocally focussed on improving people's health and wellbeing;
- the working environment is optimised for staff employed by social care providers so that they feel at the heart of an integrated team that spans primary, community, mental health, and specialist care, as well as social care services and the voluntary sector;
- people maintain their independence as far as possible by reducing, delaying or preventing the need for formal social care services; and

- health and social care services are commissioned in a coordinated manner, and the role of the social care provider market is properly understood by commissioners and providers across health and social care.

Halton have a Care Home Development Group in place focussing on developing a new commissioning model, implementation of enhanced care in care homes, using technology, GP care home alignment, developing the workforce and enhancing quality.

5.5 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 transition to EMIS Web to allow interoperability with primary and community services whilst new schemes such as the Rapid Clinical Assessment Team in the community also have EMIS Web as their IT platform.

The Council and NHS 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 21% 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. This work is ongoing.

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.

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

Please refer to C&M'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 non-elective admissions target.

6.0 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 Executive Partnership 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.

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; and
- 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.