NHS

Halton Clinical Commissioning Group

5 Year Strategy

and

2 Year Operational Plan

2014-2019

V3 June 2014

Contents

NHS Halton CCG
5 Year Strategy
2014/15 – 2018/19

5-Year Strategic Plan on a page 2014/15 to 2018/19

NHS Halton Clinical Commissioning Group

Halton health economy is a system comprised of partners from primary, secondary and community care who have come together with Halton Borough Council and local population to agree, refine and implement the following vision:

"To involve everybody in improving the health & wellbeing of the people of Halton"

- Outcome Ambition 1 - Securing additional years of life for the people of Halton with treatable mental and physical health conditions by 18%
- Outcome Ambition 2 - Improving the quality of life for people with long term conditions by 8%
- Outcome Ambition 3 - To reduce the number of avoidable emergency admissions to hospital by 15%
- Outcome Ambition 4 - To Increase the proportion of people living independently at home
- Outcome Ambition 5 - To Increase the number of people having a positive experience of hospital care by 8%
- Outcome Ambition 6 - To increase the number of people having a positive experience of care outside hospital by 18%
- Outcome Ambition 7 - To reduce hospital avoidable deaths

Priority Area 1 – Maintain and improve Quality Standards: NHS Halton CCG is committed to maintaining and improving wherever possible the quality of care provided

Priority Area 2 – Fully integrated commissioning and delivery of services across health and social care: NHS Halton CCG will drive Collaborative Commissioning with joint strategy, planning and collaborative commissioning with NHS England and Halton Borough Council

Priori Area 3 – Proactive prevention, health promotion and identifying people at risk early: This will be at the core of all our developments with the outcome of a measureable improvement in our population's general health and wellbeing

Priority Area 4 – Harnessing transformational technologies: Technology will be central to supporting people to improve and maintain their health and wellbeing, offering a range of platforms and sophistication dependant on intensity of need and desired outcomes

Priority Area 5 – Reducing health inequalities: Halton's Health and Wellbeing service combines expertise from Public Health, Primary care and Adult Social Care, this will be developed to continue the good results already seen and reduce the health gap

Priority Area 6 – Acute and specialist services will only be utilised by those with acute and specialist needs: Bringing services closer to home will support the transformation of the acute hospital sector and associated demand management issues

Priority Area 7 – Enhancing practice based services around specialisms: NHS Halton CCG, will support member practices to develop to deliver sustainable general practice, to result in an increase in capacity, enable 7/7 working and increase patient choice and control.

Priority Area 8 – Providers working together across inter-dependencies to achieve real improvements in the health and wellbeing of our population: NHS Halton CCG will investigate the implementation of Prime Contractor arrangements for a whole pathway of care or model of care.

Governance

Success will be measured by NHS Halton CCG meeting its financial responsibilities, achieving service improvement and the move of activity away from acute settings and into the community. This will be measured by the views of the local population, providers, clinicians and the metrics highlighted here and in the Operational Plan and Better Care Fund Plan.

Overseen through the following governance arrangements

- Robust ledger and budgetary control system
- Internal and external audit
- Board Assurance Framework and Risk Register
- Performance management and oversight groups

Sustainability

NHS Halton CCG faces a 'do nothing' 5 year finance gap of £39m. For the health economy to be sustainable the goals are:

-All organisations within the health economy are financially viable in 2018/19

-System objectives are achieved

-Long term reduction seen in A&E activity

-Long term reduction seen in inappropriate non-elective admissions into secondary care

System Values and Principles

- Partnership
- Openness
- Caring
- Honesty
- Leadership
- Quality
- Transformation

1. Introduction

NHS Halton CCG is the organisation that is principally responsible for the planning and purchasing of health services (known as commissioning) for the people of Halton. NHS Halton CCG is a clinically led organisation, formed from the 17 GP practices in the borough.

NHS Halton CCG commissions services in partnership with Halton Borough Council and NHS England. Halton Borough Council have responsibility for public health, education, housing, social care and a range of other services that impact on the health and wellbeing of people in the borough. NHS England are responsible for commissioning GP services, pharmacies, opticians, dentists and specialised services for the Halton population. They also have a role in monitoring how effective NHS Halton CCG is as a commissioning organisation, this is known as assurance.

As set out in *The NHS Belongs To The People: A Call to Action*[1], the NHS faces many challenges over the next five years and beyond. Every day the NHS in Halton helps people to stay healthy, recover from illness and live independent and fulfilling lives. Sometimes the NHS doesn't live up to the high expectations people have of it. We want a health and social care system that delivers excellence and a positive experience for those who need our services. We know that demand for health and social care services is rising and the financial resources we have to meet this demand are increasingly scarce and constrained. Unchecked, these pressures threaten to overwhelm the health and social care system. We need to find a new approach to how we deliver and use health and care services so that we can continue to provide high quality healthcare, and meet the future needs of the population. This 5 year strategic plan sets out this new approach for Halton. We have to make radical and far reaching changes – the status quo is not an option.

1.1 About NHS Halton CCG

NHS Halton CCG is responsible for commissioning health services for approximately 128,000 people who are registered with our 17 GP practices. We are also responsible for commissioning emergency care for other people from outside of Halton whilst they are in the borough.

Halton's resident population live in two main towns, Runcorn and Widnes, as well as a number of parishes and villages. The geographical area covered by NHS Halton CCG is coterminous with the local authority boundary of Halton Borough Council.

NHS Halton CCG is clinically led by GPs and other healthcare professionals. We are formed and built on a membership model, drawn from the 17 general practices located within Halton. Each practice has nominated a GP as its lead for liaison with NHS Halton CCG. Each area of our commissioning work has a nominated clinical

[1] http://www.england.nhs.uk/wp-content/uploads/2013/07/nhs-belongs.pdf

lead, usually a GP or a nurse. There are also regular meetings of Practice Managers and a Practice Nurses Forum has now been developed.

NHS Halton CCG has existed in shadow form since November 2011. We were established as a sub-committee of the Board of NHS Merseyside in January 2012. NHS Halton CCG became a statutory body on 1st April 2013.

2. System Vision & Values

2.1 Our Vision

NHS Halton CCG and Halton Borough Council 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 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'**.

2.2 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 Halton Borough Council, healthcare providers and the voluntary sector. This will ensure that the people of Halton experience smooth, co-ordinated, integrated and high-quality services to improve their health and wellbeing.

2.3 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 as a commissioning organisation.

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

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

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

3. 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, Halton Borough Council 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 2 year operational delivery plan.

NHS Halton CCG commissioned two organisations, i5 Health and Capita, to provide a detailed analysis[2] [3] of where opportunities existed for the Health economony in Halton to change to provide services which provided better outcomes and better value for money and ensured that acute services were only used by people in acute need. The analysis highlighted that both A&E attendances and Hospital admissions for certain conditions were the significant areas where opportunities for change existed.

By redesigning primary care access we aim to enable 7 day GP access same day appointments. Integrating Acute and Community services we aim to align clinical

[2] I5 Health – Commissioning Opportunity – NHS Halton CCG – May 2014
[3] Capita End-to-end care assessment – NHS Halton, Knowsley, St Helens & Warrington CCG's – May 2014

pathways enabling a seamless approach to patient care. Focusing on the vulnerable through multi-disciplinary teams will allow for significant efficiencies.

Evidence gathered from our residents and Acute hospitals indicated that 23% of the A&E attendances did not warrant acute care. In 2014/15 we plan to bolster 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 one stop approach to minor illness and injury. Aligning this with the North West Ambulance Service NHS Trust (NWAS) pathfinder scheme will give a triage option to ambulances that would ordinarily be heading to an acute setting.

By pump priming £2.7m into urgent care we aim to significantly reduce A&E and non-elective activity bringing a 4 year net saving of £2.1m.

The overall NHS Halton CCG financial pressure is a gap in income and demand over five years of around £39m therefore additional tightening of contracts and better use resources will drive the 5 year plan.

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.

Pro-active prevention, health promotion and identifying at risk people 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.

Choice, partnership and control will continue to be developed based on integrated approaches to needs assessment. With bringing care out of acute settings and closer to home an essential part of providing health and social care over the next five years.

The 5-year strategic plan is totally aligned with the Better Care Fund (BCF), This integrated approach has identified 8 priority areas where the opportunities are greatest to transform our healthcare delivery, these are;

3.1 Maintain and improve quality standards

NHS Halton CCG is committed to maintaining and wherever possible improving the quality of the care provided. Quality standards will not be allowed to slip despite the strain on the budget

3.2 Fully integrated commissioning and delivery of services across Health & Social care

NHS Halton CCG will drive Collaborative Commissioning with joint strategy, planning and collaborative commissioning with NHS England and Halton Borough Council, ensuring there is alignment of our commissioning towards outcomes and how each party works to lead on pathways of care.

3.3 Proactive prevention, health promotion and identifying people at risk early

Pro-active prevention, health promotion and identifying people early when physical and/or mental issues become evident will continue to be at the core of all our developments with the outcome of a measurable improvement in our population's general health and wellbeing.

Halton Borough Council's Mental Health Outreach team is currently piloting work with GP surgeries in order to identify people who may benefit from this service and prevent relapse.

3.4 Harnessing transformational technologies

Strategically, NHS Halton CGG are working with NHS Warrington CCG on a whole system IT transformation, which will allow data to flow across all systems, this will reduce the need for bulky/expensive back office functions. Technology will be central to supporting people to improve and maintain their health and well-being, offering a range of platforms and sophistication dependent on intensity of need and desired outcomes.

3.5 Reducing health inequalities

Halton's Health and Wellbeing service brings together the Health Improvement Team, the Wellbeing GP Practices Team and the Adult Social care Early intervention and Prevention team. This is a new approach that combines and aligns expertise from Public Health, Primary Care and Adult Social Care. This will be developed further over the next five years to continue the good results already seen and reduce the health gap between Halton and the England average.

3.6 Acute and specialist services will only be utilised by those with acute and specialist needs.

Timely return to the Borough from acute and specialist services will be enabled through network approaches to case management. Proactive case finding, long term condition management, monitoring systems and a range of alternatives for urgent care needs will be in place. This will support the transformation of the acute hospital sector and associated demand management issues.

3.7 Enhancing practice based services around specialisms

NHS Halton CCG with NHS England will support member practices to deliver sustainable general practice services in Halton. To result in a reduction in variation, an increase in capacity, enable 7/7 working, increase patient choice and control and the development of specialist skills, knowledge and service delivery.

3.8 Providers working together across inter-dependencies to achieve real improvements in the health and wellbeing of our population.

NHS Halton CCG will investigate the implementation of Prime Contractor arrangements for a whole pathway of care or model of care, enabling alignment of incentives and accountability for quality improvement and capacity management.

NHS Halton CCG will work with the Operational Delivery Networks to ensure that outcomes and quality standards are improved and that evidence based networked patient paths are agreed.

4. Prioritisation

Working with Health and Wellbeing partners, specific actions underpinning the eight identified priority areas in Halton and the seven NHS outcome ambitions have been developed. These actions have been developed in line with the 'Commissioning for Prevention' 5 steps of:

4.1 Analysing key health problems

Using the resources available including the JSNA, Public Health Intelligence unit, Atlas of Ambition and Commissioning for Value tools the most significant health issues facing the people of Halton have been identified. These include cancer, respiratory conditions, cardiovascular conditions, diabetes, mental health conditions and unplanned hospital attendances and admissions.

4.2 Prioritise and set common goals

The actions identified in the commissioning intentions have been reviewed, those with the greatest likely impact have been prioritised and targets set which all partners have signed up to. This is an on-going process and the commissioning intentions will be reviewed throught their lifespan to ensure that they are acheiveing their goals and providing value for money

4.3 Identify high impact programmes.

Using the 'Anytown health system' tool, 'high impact' programmes have been identified.

Two of the most high impact programmes identified to address the problems identified are

- The development of the Urgent Care Centres to reduce both the number of unnecessary attendances at A&E and unplanned hospital admissions.
- The development of the primary care strategy

In addition work commissioned by NHS Halton CCG by i5 Health and Capita have provided detailed analysis into the areas of Acute care where significant savings can be made by shring best practice across all GP practices and by implementing schemes to reduce activity within acute settings.

4.4 Plan resources

The financial impact of these commissioning intentions, both in terms of recurrent and non-recurrent expenditure has been calculated, as have potential levels of financial saving. Ambitious but realistic targets for savings have been agreed and resources have been allocated in the budget for the commissioning intentions

4.5 Measure and experiment

Where possible nationally proved metrics will be used to demonstrate the level of improvement made by the projects, however where national metrics are not appropriate locally developed ones will be used.

5. Delivering Transformational Change

Characteristics of a high quality and sustainable health and care system

In December 2013 NHS England published "Everyone Counts: Planning for patients 2014/15 to 2018/19. This document described the characteristics of a high quality and sustainable health care system and how this could be achieved through transformational change. The passage below describes the changes required by NHS England but these are also just as relevant to NHS Halton CCG.

'Fulfilling our long-term ambitions will require a change in the way health services are delivered. People are living longer, and our ability to treat and help to manage conditions that were previously life-threatening is improving all the time. With this has come a change in what can be delivered safely, effectively and efficiently in different settings. For example, patients can be cared for in their own homes, supported by experienced clinicians and technology which enables them to monitor their condition and get expert help to manage it. The result is that patients who would previously have needed hospital treatment can now stay at home.'[4]

[4] Everyone Counts Planning for patients 2014/15 to 2018/19: pg9 para17.

NHS England has identified that any high quality, sustainable health and care system in England will have the following six characteristics in five years:

The six characteristics of a high quality sustainable health and care system are:

1. Ensuring that citizens will be fully included in all aspects of service design and change, and that patients will be fully empowered in their own care

2. Wider primary care, provided at scale

3. A modern model of integrated care

4. Access to the highest quality urgent and emergency care

5. A step-change in the productivity of elective care

6. Specialised services concentrated in centres of excellence (as relevant to the locality)

NHS Halton CCG has developed eight priority areas after extensive consultation with all key stakeholders, these priorities meet the 6 characteristics of a high quality sustainable health and care system as below. Within those priority areas specific intentions have been identified. For further details of the specific intentions and the priority areas please see Appendix A.

5.1 Ensuring that citizens will be fully included in all aspects of service design and change, and that patients will be fully empowered in their own care

NHS HALTON CCG PRIORITY AREA 3 – Proactive prevention, health promotion and identifying people at risk early.

NHS HALTON CCG PRIORITY AREA 6 – Acute and specialist services will only be used by those with acute and specialist needs

NHS HALTON CCG PRIORITY AREA 4 – Harnessing Transformational Technologies

Specific intentions:

Continue to work with Healthwatch and making the best use of the Halton People's Health Forum events to fully include citizens in all aspects of service design.

Continue to work with people with learning disabilities to develop awareness and understanding of services available in Halton. i.e. Health checks, Cancer, mental health and lifestyle. Through innovative methods such as the SPARC (Supporting People Achieving Real Choice) comics. Current allocated budget for 14/15 is £50,000

ADD141502 – continue to develop mechanisms to ensure we listen to the whole population, including young people and BME communities

PC141508 – Review access to lifestyles service for patients with cancer, for example breast cancer, weight loss and exercise programme - Potential increase in costs in the short term, dependent on increased uptake, should enable longer term cost savings.

PCI141501 – Strengthen the GP's role at the heart of out of hospital care by identifying people at risk of hospital admission and introducing named accountable clinician. - This is one of the actions which will be funded in part through the £5 per head GP strategy of £646,000

PC141501 – Consider the use of technology to manage sleep apnoea in the community

PC141506 – Implement the EPACCs IT system – improve the use of special patient notes in the end of life care

PCI141510 – Develop an integrated Health & Social care IM&T Strategy and work plan to include the use of telehealth and telemedicine to improve patient care - £100,000 recurring expenditure has been allocated in both 14/15 and 15/16 with a non-recurring expenditure of £500,000 in 15/16. There are planned savings of £200,000 per year from 15/16 onwards.

5.2 Wider primary care, provided at scale

NHS HALTON CCG PRIORITY AREA 7 – NHS Halton CCG with NHS England will support member practices to deliver sustainable general practice services in Halton. To result in a reduction in variation, an increase in capacity, enable 7/7 working, increase patient choice and control and the development of specialist skills, knowledge and service delivery.

Specific Intentions:

PCI141505 – To support GP Practices to deliver services over and above their contractual responsibilities. – This is one of the actions which will be funded in part through the £5 per head GP strategy of £646,000

PCI141506 – Develop the strategy for sustainable General Practice in Halton – This will also form part of the recurring £646,000 expenditure linked to the £5 per head GP strategy, however there is also non-recurring expenditure allocated of £300,000 in 2015/16 for weekend and evening access which will also be part of the sustainable General Practice strategy.

5.3 A modern model of integrated care

NHS HALTON CCG PRIORITY AREA 2 – Fully integrated commissioning and delivery of services across Health & Social Care

Specific Intentions:

ADD141509 – Better care fund actions are implemented (recurring expenditure from 15/16 identified as £6,522,000)

ADD141508 – Further develop integrated services between the NHS and Local Authorities for people with complex needs (finance included in expenditure of ADD141509)

ADD141512 – Develop an integrated approach with Halton Borough Council with community pharmacies – financial impact not known yet

PCI141514 – Secure provision of community services from 2015, VfM contract to reflect the needs of the population supporting more integrated care – The expectation is that this will result in a reduction in the current community contract value, however this will be informed by the new service specifications

5.4 Access to the highest quality urgent and emergency care

NHS HALTON CCG PRIORITY AREA 1 – Maintain and improve quality standards

Specific intentions:

EA6 - Warrington & Halton Hospital Foundation Trust A&E department Friends and Family test results have been identified as an area for targeting for specific improvement, this is being written into the quality schedule and has been chosen as a Quality Premium measure for NHS Halton CCG for 2014/15. With a planned improvement from a baseline of 35 (Dec 13) to 57 by 2015/16

ADD141505 – CQUINS developed with the providers to implement the commissioning outcomes of both the Francis report and the government response. This will be supported by evidence of duty of candour, quality strategy, and training programmes including mandatory training.

ADD141506 – Quality standards improved in the acute sector providers by appropriate use of SHMI and HSMR mortality figures to identify areas for further investigation and evidence of improvement actions where appropriate

MHUC141502 – Review the AED liaison psychiatry model, ensuring that acute and emergency care for people in mental health crisis is as accessible and high quality as for physical health emergencies.

5.5 A step-change in the productivity of elective care

NHS HALTON CCG PRIORITY AREA 8 – Providers working together across interdependencies to achieve real improvements in the health and wellbeing of our population

Specific intentions:

PC141509 – Review pathways for patients with cancer attending hospital to explore alternative models of follow up. i.e. telephone follow up or GP led – this will initial look at the prostate cancer pathway and should result in financial savings for hospital follow ups.

PCI141503 – Review the design of community services to focus on outcome based services – the desired outcome is for there to be increased integration, improved outcomes for patients and a reduction in inappropriate hospital admissions for conditions normally managed in the community.

5.6 Specialised services concentrated in centres of excellence (as relevant to the locality)

NHS Halton CCG is aware of the plans by NHS England to concentrate specialised services in centres of excellence, linked to Academic Health Science Networks. Whilst NHS Halton CCG is not the co-ordinating commissioner for any of the specialised service providers we are conscious of the potential impact that the concentration of services in centres of excellence could have on Halton residents and will be fully involved partners with NHS E in the implementation of these changes.

There is an intention locally to create centres of excellence based around practice based services

NHS HALTON CCG PRIORITY AREA 7 – Enhancing practice based services around specialisms

Specific Intentions:

PCI141505 – To support GP Practices to deliver services over and above their contractual responsibilities. – This is one of the actions which will be funded in part through the £5 per head GP strategy of £646,000

PCI141506 – Develop the strategy for sustainable General Practice in Halton – This will also form part of the recurring £646,000 expenditure linked to the £5 per head GP strategy, however there is also non-recurring expenditure allocated of £300,000 in 2015/16 for weekend and evening access which will also be part of the sustainable General Practice strategy.

6. Integration & Innovation

NHS Halton CCG is currently moving towards a fully integrated commissioning unit. Focusing on commissioning, contracting & quality. This commissioning for outcomes approach will bring full system / operational delivery. NHS Halton CCG and Halton Borough Council have harnessed the recent reforms in health and social care to create the platform for a fully integrated approach to commissioning. This whole system ensures we meet the political directions whilst providing services that are affordable, sustainable and meet the needs, wants and aspirations of our community.

With input and support from partner agencies across the health and social care economy in Halton, Halton Borough Council and NHS Halton CCG are moving forward at pace to deliver our vision of a whole system integrated approach to local health, care, support and wellbeing. Utilising the expertise of our integrated Public Health Team all of the 2014/15 commissioning intentions will be scrutinised to ensure a robust outcome driven evidence base.

We aim to continue our innovative approach to health and wellbeing, building the nationally recognised Community Well Being Practice Model. This approach will be in all 17 practices by midyear 2014. An economic analysis will be implemented early 2014 to indicate a fiscal return on this approach.

Under the Public Services (Social Value) Act (2012), social value will drive every commissioning decision, every piece of work and procured service will be tested under a social value lens ensuring the Borough of Halton benefits from a wider approach to community resilience. A social value charter will be completed in March 2014 in readiness for the new contractual round. Each contract will contain reference to social value and the added value providers can bring to reducing inequality etc.

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

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

The culture within and between organisations is focused on achieving real improvements in the health and well-being of our population through the delivery of high quality, effective and safe care. This approach recognises both the centrality of

supporting people to have control over their health and well-being and the inter-dependency across the systems and organisations to achieve this. This is facilitated through existing and developing mechanisms to incentivise and performance manage providers of services. This is underpinned by a letter of intent which informally binds the organisations to joint working. A formal Section 75 agreement is being developed to take this process to the next stage and drive structural, patient-centred, fully integrated service change.

In overall strategic terms the health and adult social care system will focus on prevention, supporting people to remain independent at home, manage their long term conditions and wherever possible avoid unnecessary hospital admissions.

The strategic aims of the plan are:

1) **Integrated Commissioning**
2) **Health and wellbeing of individuals in our community**
3) **Supporting Independence**
4) **Managing complex care and care closer to home**

6.1 Integrated Commissioning Function

NHS Halton CCG is co-located alongside Halton Borough Council Social Care and Public Health and we have already seen the positive impact this has had on breaking down organisational, professional and cultural barriers. Halton's approach to urgent care, via the establishment of the urgent care partnership board, demonstrates the shared commitment to improving outcomes for service users/patients and their carers whilst making the most efficient use of public resources.

6.2 Health and Wellbeing of individuals in our community

Health inequalities in Halton are reducing and there have been significant improvements in rate of Cardio Vascular Disease (CVD), Smoking prevalence, Child obesity and Chronic Obstructive Pulmonary Disorder (COPD). However, challenges remain if we are to close the gap between Halton and the national average. Integrated senior management teams, commissioning meetings and planning meetings with staff from a range of backgrounds ensures a joined up approach to improving health inequalities.

Halton's Health and wellbeing service brings together the Health Improvement Team, the wellbeing GP Practices Team and the Adult Social care early intervention and Prevention team. This is a new approach that combines and aligns expertise from Public Health, Primary Care and Adult Social Care.

6.3 Supporting Independence

There are a range of integrated services which focus on promoting recovery from illness, preventing unnecessary hospital admissions or premature admissions to

residential care, supporting timely discharge from hospital and maximising opportunities for independent living.

Technology will be central to supporting people to improve and maintain their health and wellbeing, offering a range of platforms (such as Telecare and Telehealth) and sophistication dependent on intensity of needs and desired outcomes.

6.4 Managing Complex Care and Care Closer to Home

The development of new pathways in addition to a pooled budget arrangement for all community care, including intermediate care, equipment and mental health services enables practitioners to work more effectively across organisational boundaries, utilising the flexibility within the pooled budget to commission holistic services and to improve health gains.

6.5 Innovation in Mental Health Practice

Mental Health services across Halton will be delivered in a way that values the expertise of users enabling them to make their own contribution and be part of a shared decision making process about their treatment and care.

NHS Halton CCG plans to commission services that support a multi-disciplinary team response that is integrated across primary and secondary care, this will include a seamless stepped model to improve access to psychological therapies.

Further innovation will be developed across AED liaison services and developing a street triage model to respond to Section 136 Crisis calls that diverts people away from AED and reduced potential Section 136 assessments under the Mental Health Act 1983. Following a successful pilot running from December to February 2014 which (as of 6th Jan) showed a 72% reduction in the number of Sections under Section 136.

6.6 Research

NHS Halton CCG are linking with the North West Coast Academic Health Science Network (NWCAHSN) to build up an overview of innovations that we can quickly roll out. We will be working with the NWCAHSN through the commissioning cycle. We have a shared objective in ensuring that we deliver the best treatment, care, pharmaceutical products and technologies for patients and residents at the lowest cost. We particularly want a relationship with NWCAHSN in regard to stroke, neurological conditions and child and maternal health.

7. Clinical Priority Areas

These clinical areas have been identified as key to improving the health and wellbing of the people of Halton, this strategic and operational plan has been delevoped with these clinical areas making a significant contribution. The Clinical Lead areas are:

7.1 Cancer & End of Life

Current position

Prevalence of cancer remains high[5] and mortality worse in Halton[6]. Halton are good at referring and getting tests done quickly but patients still present late and social factors (smoking, obesity, lack of exercise etc) need improving. Screening uptake could be better. Halton has good access to tests compared with other areas of Merseyside and Cheshire but we are not complacent.

Our Aims

For End of Life care the aim is to maintain the current quality of service taking into account increasing demand. We will also look to increase GP education in this area.

For cancer prevention the aims are focussed on lifestyle factors and are covered more completely in the Health & Wellbeing strategy. We want to see quicker and more local access to diagnostics, eg. Local ultrasound and X-ray. We are undertaking the primary care cancer audit to assess where cancer diagnosis delays are and then address these issues. We are looking at the wellbeing of cancer pateints particularly regarding exercise and also looking at bringing follow up treatment closer to home eg. patients with prostate cancer having blood tests done locally and then either seeing the GP or the specialist as appropriate.

Performance

Screening statistics – a comprehensive breakdown of cancer screening statistics for Halton can be found on the Halton Public Health website:
http://www3.halton.gov.uk/healthandsocialcare/318895/318907/

Selected cancer screening statistics have been reproduced here.

[5] Halton Borough has the 11th highest incidence of cancer (all cancers) 2010-2012 of 326 Local Authorities, Source: Halton Borough Cancer Profile Series No1 – All cancers Jan 2014
[6] The Standardised Mortality Ratio (SMR) for Halton 2008-10 was 136, compared with 110 for the North West and 100 for England – Source – Halton Public Health Annual Report 2012 - http://www3.halton.gov.uk/lgnl/policyandresources/318448/318454/Public_Health_Annual_Report_2012.pdf

Bowel Screening

Bowel screening uptake and coverage (indicators), 60-74 year old, all persons, 2012 - *Figures from HSCIC*

Area	England	North West	Halton
Screened within 6 months of invitation	1,969,711 (55.37%)	279,919 (52.67%)	4,765 (48.00%)
Screened in previous 30 months	4,139,129 (52.14%)	548,592 (49.99%)	9,222 (48.91%)

According to HSCIC figures (GP level data), 48.00% of people aged 60-74, who were invited for screening (uptake), were actually screened within six months of their invite. This is lower than the proportions of 52.67% and 55.34% witnessed in the North West and England respectively.[7]

Breast Cancer Screening

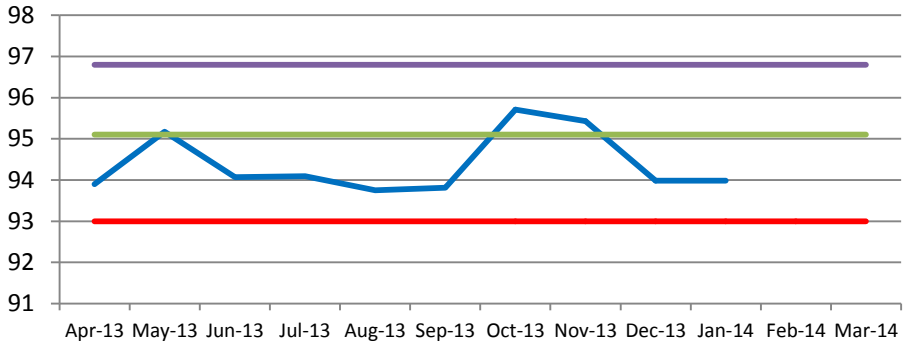
Breast cancer screening coverage for 53-70 year old females in Halton was below that of England for the years 2010 to 2012. There has been an increase of breast screening coverage in Halton across the three years, which is in direct contrast to the North West, which has seen a reduction in coverage from 2010 to 2012.

Coverage in Halton during 2012 was at just below 76%, compared to just below 75% in the North West and just below 77% in England.[8]

[7] Halton Borough: Cancer Profile Series 4 Bowel Cancer – Jan 2014: http://www3.halton.gov.uk/lgnl/policyandresources/318448/318454/Bowel_Cancer_Profile_2013
[8] Halton Borough Cancer Profile Series 3 Breast Cancer, January 2014 - http://www3.halton.gov.uk/lgnl/policyandresources/318448/318454/Breast_Cancer_Profile_2013

Maximum 2 week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP[9]

Percentage of patients waiting 2 weeks or less for outpatient appointment from urgent GP referral for suspected cancer



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
NHS Halton CCG	93.9	95.17	94.07	94.09	93.75	93.81	95.71	95.43	93.98	93.98		
NHS Constitution Standard	93	93	93	93	93	93	93	93	93	93	93	93
Median value	95.1	95.1	95.1	95.1	95.1	95.1	95.1	95.1	95.1	95.1	95.1	95.1
Top Quintile (National)	96.8	96.8	96.8	96.8	96.8	96.8	96.8	96.8	96.8	96.8	96.8	96.8

NHS Halton CCG performs well against the NHS Constitution measure standard, however there is room for improvement. Current performance places NHS Halton CCG in the lowest quintile when compared nationally and for most months below the national median value.

Commissioning Intentions

PC141505 – Review pathway around cancer presentations – this will look at the evidence across all pathways, and will include examining the evidence to introduce a targeted screening programme to increase early detection rates of lung cancer

PC141506 – Implement tools to improve the sharing of information at the end of life – Work towards implementing the EPACCs IT system – Improve the use of special patient notes in end of life care.

PC141507 – Implement the replacement for the Liverpool care pathway

PC141508 – To review access to lifestyles services for patients with cancer, for example breast cancer weight loss and exercise programme

PC141509 – Review pathways for patients with cancer attending hospital to explore alternative models of follow up eg. Telephone follow up or GP led.

[9] Data from NHS Operational Planning Atlas as of 14/04/2014 – Median value and Top quintile value taken as most recent value available Q2 2013/14

7.2 Mental Health

Clinical Measures

Reducing Hospital admissions for people with Mental Health problems

Increasing number of people with mental health problems treated in their own home

Decreasing waiting times for appointments

Increasing access to appointments

Reducing the amount of Mental Health medication prescribed.

Current position

There are good examples of mental health services already commissioned by the CCG, including 'Operation Emblem' where a CPN accompanies police calls where a mental health issue is suspected. A pilot of this scheme has demonstrated a significant reduction in the number of S136 issued and a consequent saving in both police and social worker time and improved outcomes for the patient. The work some in developing a joint specification for a Tier 2 CAMHS service with the local authority is an excellent example of joint commissioning which provides an improved and equitable service. Work done around developing Psychological Therapies services for Halton residents will soon begin to show benefits with a single provider now overseeing all IAPT services for Halton residents.

Waiting times for secondary care outpatients is reducing and the psychiatric liaison service at Whiston is performing well

Our aims

To build on the psychiatric liaison service at Whiston by developing the service further at Warrington and Halton Hospitals Foundation Trust

To implement the actions within the Halton suicide prevention strategy

To building on the good work done around the tier 2 CAMHS service by reviewing the Tier 3 service.

To review the number of admissions to hospital for people with mental health problems.

To look at the shared care model of prescribing of anti-psychotic medication between primary and secondary care, with a view to increasing the numbers of patients under shared care.

To review the number and appropriateness of patients with dementia being prescribed anti-psychotic medication

To review the ADHD pathway with or without other mental health problems, to include new presentations as adults in collaboration with other CCG's

7.3 Ambulance Service

Paramedic Emergency Service (PES)

Commissioning Intentions for the Paramedic Emergency Service (PES) have been produced by the lead commissioner (NHS Blackpool CCG) on behalf of the 33 CCGs in the North West (NW). The Blackpool Ambulance Commissioning Team (BACT) utilised the agreed governance framework within the Memorandum of Understanding between them and the NW CCGs to produce commissioning intentions for 2014/15, and high level strategic intentions for 2014 to 2019, Consultation and engagement was carried out with each group within this governance framework, and NHS Halton CCG attended a planning workshop held in December 2013 and contributed to this process, as well as attending the Merseyside Area Ambulance Commissioning Group, working with the BACT and contributing to the final document.

The PES commissioning intentions document recognises the need for whole system transformation in order to move towards the healthcare system described by both the House of Commons Health Committee 'Urgent and Emergency Services' report (July 2013), and the Keogh 'Urgent and Emergency Care Review' (November 2013). Both reports describe PES as having a changed role within an enhanced system of urgent care; a role where conveyance to hospital will be one of a range of clinical options open to ambulance services and allow PES to become "mobile urgent treatment centres" (Keogh, 2013). One of these key required changes is to achieve a reduction in conveyance to hospital and the PES contract for 2014/15 has been designed to encourage this by incentivising this through CQUIN. This will allow the provider, North West Ambulance Service (NWAS), to build on the progress they have already made with commissioners over recent years; developing and implementing initiatives such as the Urgent Care Desk, Paramedic Pathfinder, Referral Schemes into Primary Care, Targeting Frequent Callers, and increasing the percentages of patients that are treated by 'See and Treat' and 'Hear and Treat'. All of these schemes support the achievement of 'Safe Care Closer to Home', which is a strategic goal of NWAS, as well as supporting NHS Halton CCG's plans for integration.

In NHS Halton CCG we have been working closely with NWAS in the development of the two Urgent Care Centres being developed in Halton, as part of this development NWAS sits on the Urgent Care Working Group the Urgent Care Centre development board and the Clinical Pathways Group.

The governance framework includes an 'Ambulance Strategic Partnership Board' (SPB), and each county area has a representative. In Halton, our ambulance commissioning lead feeds back from the SPB to our Merseyside Ambulance Commissioning Group, where NHS Halton CCG has representation. The SPB

maintains the strategic oversight of all county area reconfigurations, both at county and CCG level; acting as 'Change Management Board' and seeking assurance that county and local changes, translate into a North West level. A work shop has been arrange for June 2014, to begin this work. NHS Halton CCG will continue to ensure local plans align with the SPB via the Merseyside Area Commissioning Group.

Patient Transport Services (PTS)

Five PTS contracts are in place across the NW, which were awarded following a procurement exercise. Each are three year contracts, which began on 1 April 2013. There is one provider for each of the county areas; the provider for Halton is NWAS although the two acute trusts St Helens & Knowsley NHS Trust and Warrington & Halton NHS Foundation Trust also have separate contracts to provide Patient Transport Services.

The current service specification contains increased operating hours, and higher quality standards than the previous one. The service is provided for eligible patients. Planning for the next tender will begin during 2014/15, which will include reviewing the current service specification against new and emerging policy and guidance, such as 24/7 working. NHS Halton CGG will engage in this process via the Merseyside Ambulance Commissioning Group, and the wider governance as described above.

7.4 Womens Health

Clinical measures

Teenage Pregnancies – measured as Under 18 conception rate per 1000 females aged 15-17 (crude rate) 2009-2011 – 51.8 Halton, 34.0 England Average, 58.5 England Worst.(from public health profiles Sept 2013)

Chlamydia rates – July to Sept 2013. Halton 2303 per 100,000. Compared with 1736 for Cheshire & Merseyside area and 1785 for England as a whole. ((from public health England Table 1.3 chlamydia testing data for 15-24 year olds)

Chlamydia screening – July to Sept 2013. Halton 7% tested, compared with 5.4% for Cheshire & Merseyside area, and 5.8% for England as a whole. (from public health England Table 1.3 chlamydia testing data for 15-24 year olds)

Cervical cytology – (NHS Cervical screening programme – Target age group 25-64, % less than 5 years since last adequate test) 2012-2013 Halton & St Helens PCT 78.1%, North-West 78.1%, England Average 78.6%) – from HSCIC Cervical screening programme 2012/13 Table 13

Current Position

Teenage pregnancies are high, significantly higher than the England average

Chlamydia screening is good, with a high rate of screening (7%) compared with both the Cheshire and Merseyside area (5.4%) and England as a whole (5.8%)

However the diagnosis rate of people with chlamydia is high in Halton, with a rate of 2,303 per 100,000, compared with 1,785 per 100,000 for England as a whole

Our Aims

Teenage pregnancies in Halton are too high, this should be an area to focus on over the next 2-5 years by greater use of long lasting contraception.

Prescribing of long lasting contraception across practices will be investigated, with focus on variation between practices. Improved training of Nurses in General Practice will be developed to improve rates of use of long lasting contraception, this should also reduce the number of terminations.

7.5 Dementia

Measures

Admissions to hospital for people with dementia (aiming for a reduction)

Dementia diagnosis rate (aiming for an increase)

Current Position

NHS Halton CCG is improving services in most areas for people with dementia, with an improving dementia diagnosis rate which is already one of the highest in the region with plans to improve this further. Support for people with dementia to live in their own homes needs to be increased by improving services which are already in place such as the dementia care advisors.

Our Aims

NHS Halton CCG aims to increase the diagnosis rate for people early on in the disease, avoid the need for hospital admissions and provide more support at home, including improving the psychological and social support that is available to enable people with dementia to live life to the full.

7.6 Integration, Adult safeguarding & complex care

7.6.1 Integration

Current Position

There is room for improvement in integration between primary care and community services and integration with social services is not as good as it should be, especially in relation to front line integration between nurses and social workers. Working practice between these workers needs to improve to obtain the benefits of integration.

Our Aims

To improve the links between staff in primary and community care settings.

7.6.2 Safeguarding Adults

Measures

Number of people referred to safeguarding team

Current Position

The current service is performing well although it is very busy. It is expected that the number of referrals will plateau as saturation is reached.

Our Aims

To maintain the current level of service with a similar volume of referrals

7.6.3 Care Homes Programme

Measures

Reduction in admissions to hospital from care homes

Current Position

Current admission figures are very good, reductions have been seen in both the number of admissions to hospital relating to UTI's and falls. Services in place are having an impact.

Our Aims

To continue the work already being done in minimising the number of admissions to hospital from care homes

7.7 Falls

Measures

Acute admission rate due to falls (aiming for a reduction)

Current Position

The clinical pathway for falls is not fully developed and not promoted. The current falls service has capacity issues.

Our Aims

The pathway needs to be fully developed. There is a need to develop services that will keep older people active and therefore less likely to fall. There needs to be a greater use of medical prevention treatments and appropriate medication management, this would reduce the number and/or severity of fractures following a fall.

7.8 Respiratory

Current position

Respiratory disease is one of the key contributing factors to reduced life expectancy in Halton and is the third leading cause of death after circulatory disease and cancer. There are significant health inequality issues in Halton concerning respiratory diseases where the mortality rate in our most deprived areas is double that of Halton as a whole, and historically, COPD detection rates have been lower in these more deprived areas.

Headline Facts

- It is estimated about 3,916 people aged 16+ living in Halton had Chronic Obstructive Pulmonary disease (COPD) in 2010. By 2020 this figure may be as much as 4,420.

- Estimations have also been calculated for the number of people predicted to have a longstanding health condition caused by bronchitis and emphysema. It was estimated that 328 people over the age of 65 were affected by this in 2012, and that the number will rise to 406 by 2020.

- There have been improvements in case finding since 2009/10 closing the gap between the modelled estimated number of people with COPD and those of GP disease registers. However, the number of people on the asthma register remains lower than the expected number.

- There is significant ward level variation in emergency hospital admission rates and at GP practice level. There is also a relationship with temperature, with a greater percentage of admissions seen in the winter months.

- Death rates for COPD have been falling but are above the North West and England rates. Death rates from respiratory causes in those aged under 75 years and pneumonia are also higher than England but similar to the North West.

- Prescribing of respiratory drugs accounts for 15.7% of Halton CCG prescribing spend and there is significant variation in prescribing across the 17 GP practices

Our Aims

We are developing a plan to improve respiratory health in the Borough encompassing prevention through to end of life care. In the short term our focus will be on;

- Adopting unified personalised action plans across both primary and secondary care for patients with COPD & Asthma

- Adopting a unified template in Asthma and COPD across all Primary care practices .

- Improved recognition, recording and follow up of acute exacerbations for both asthma and COPD

- Supporting patients and their carers to better manage their own care

- Implementing a learning and development programme to support professionals, patients and carers to improve their knowledge, skills and understanding of respiratory health care.

In the longer term we aim to

Ensure patients and their carers experience integrated care along the respiratory pathway

Provide support to GP practices that have been identified as outliers with regards to emergency hospital admissions and/or prescribing respiratory medication

Ensure patients have appropriate inhaler medication and know how to use them correctly

Provide quality assured spirometry with robust interpretation

7.9 Primary Care

Current Position

Current GP services are of a high standard and most paramters are at par with national average and some areas exceeding it. The Primary Care Group has the prime function of improving quality among all the member practices as part of its work it has identified four areas where further improvements could be made, these are;

- Prevalence rates (identifying the unidentified patient) in respect to CVD, Stroke, Cancer, COPD etc.
- Access to GP
- Flu Immunisation rates
- Cervical Screening

Our Aims

Greater collaborative working between practices beginning with the areas highlighted above, identifying and sharing good ideas in other practices. Especially focussing on Flu immunisation performance as there is a large variation in performance between practices and with our neighbouring areas.

To support individual practices in bidding for enhanced services.

GP Development, there is an increase in workload and expectations, the current was of working is not sustainable, a considerable number of Halton GP's are approaching retirement and there is a national issue regarding recruitment, with General Practice not being considered as desirable a career.

Performance

Primary care dashboard is currently in development, this should be completed within 2014/15

7.10 Stroke

Clinical Measures

The early death rate from heart disease and stroke in Halton has fallen but remains worse than the England average.

NHS Halton CCG is not consistently achieving targets around the percentage of people who spend 90% of their time on a stroke unit and the percentage of people with a high risk of stroke who have a TIA and are assessed and treated in 24 hours.

Current Position

A Stroke Board had been established and is meeting regularly.

Some changes have already been made, for example both trusts have increased the number of beds ring-fenced for people who have had a stroke

St Helens & Knowsley NHS Trust are noted as doing well on initial assessment and treatment of Stroke but not on rehabilitation and the opposite is true at Warrington & Halton Hospitals NHS Foundation Trust.

A contract query was issued to Warrington & Halton Hospitals NHS Foundation Trust and an action plan established as a result which is being managed through the Stroke Board.

Discussions are taking place about options for models for stroke services – there is national pressure to opt for a model based on Hyperacute Units but that there is little support for this with the local Networks.

Aims

To achieve consistently high standards of delivery in stroke services

To develop and implement a stroke strategy setting out a clear vision for the future of stroke services

8. Quality Improvement

NHS Halton CCG has a Quality Committee as an intergral part of the governance arrangements, the committee has representation from across the health economy, including commissioners and providers and is a vital part of Halton's strategy to ensuring quality improvement across the whole system. The Early Warning Dashboard, Performance report and regular deep dives provide assurance when things are going right and early warnings when interventions may be required.

The NHS outcomes framework consists of five domains and seven outcome ambitions, the five domains are:

1. Prevent people from dying prematurely
2. Improved quality of life for people with long term conditions
3. Quick recovery from episodes of ill health or injury
4. Improved patient experience
5. Improved patient safety

These domains are served by the seven outcome ambitions. NHS Halton CCG has the following services and improvement programmes in place.

8.1 Securing additional years of life for the people of Halton with treatable mental and physical health conditions

As part of NHS Halton CCG's work with its partners and providers there are several areas where specific work is being done to secure additional years of life. This includes working with 5 Boroughs Partnership, NHS Foundation Trust, with regards to reducing the harm from suicide, lessons learnt and physical health checks of people with mental health problems. We will also work with Bridgewater Community Healthcare, NHS Trust, in increasing the number of people with learning disabilities who have had a physical health check.

Work is being done with the acute providers (Warrington & Halton Hospitals NHS Foundation Trust and St Helens & Knowsley Hospitals NHS Trust) to improve the reported hospital mortality figures Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI).

8.2. Improving the health related quality of life with one or more long term conditions, including mental health conditions

NHS Halton CCG has worked with Bridgewater Community Healthcare NHS Trust to develop a screening programme for the over 65's, this will identify conditions sooner, enable treatment to start earlier and provide the best outcomes for both the patient and the health economy.

NHS Halton CCG has one of the best dementia diagnosis rates in the country (currently 62%), however, we are not complacent and are committed to reaching the target of 67% by 2014/15.

The successful Multi-Disciplinary Team (MDT) programme is in the process of developing a Quality of Life survey which will enable us to quantify the amount of difference to a person's quality of life the involvement of the MDT has been able to make.

8.3 Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital

The development of the urgent care centres will have a significant impact on the number of people attending hospital avoidably; this is quantified as a 2.5% reduction in 2014/15 with a 15% reduction seen by 2017/18.

The Multi-Disciplinary Teams are promoting self-care to enable people to manage their own care at home.

The planned Practice Nursing audit will also highlight what training needs may be required to ensure that the highest standards for competence are maintained.

8.4 Increasing the proportion of older people living independently at home following discharge from hospital

The use of pooled budgets between Social Care and Health, the reablement team, Multi-disciplinary team and the review of stroke services will enable 70% of older people to remain at home 91 days after discharge from hospital into reablement.

8.5 Increasing the number of people having a positive experience of hospital care

NHS Halton CCG will continue to monitor the levels of complaints with regard to its two acute services providers, with particular focus on the response times to complaints and whether or not the complainant was comfortable with the response. NHS Halton CCG will also ensure that the providers have mechanisms in place to learn from the complaints that are received.

8.6 Increasing the number of people with mental and physical conditions having a positive experience of care outside hospital, in General Practice and in the community

NHS Halton CCG will work towards improving the patient experience of their GP surgery with the aim of increasing the percentage of people answering 'good' or 'very good' in the GP Patient survey with regards to their experience of the GP surgery to exceed the national average.

5 Boroughs Partnership NHS Foundation Trust has already begun a local Friends and Family test as part of commissioning for quality and innovation payment which will provide focus around improving a person's experience of care.

8.7 Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

NHS Halton CCG is involved in several initiatives to reduce the amount of harm related to problems in care. These include the Safer Care Collaborative; One area of focus of this group is Medicines Management. Another initiative is the Mid-Mersey Health Care Acquired Infection (HCAI) taskforce which is looking at providing a consistency of approach with regard to HCAI's across the Mid-Mersey footprint.

NHS Halton CCG has to-date had no HCAI incidences of MRSA and is committed to maintaining this level of performance. Halton is also forecast to have a low reported incidence of clostridium difficile for 2013/14 which we aim to improve upon for 2014/15

8.8 Quality in Mental Health

NHS Halton CCG will continue to support recovery focussed mental health support services that are integrated across health, social care and the criminal justice system.

Services will be supported to develop innovation through organisational change and be commissioned to ensure meaningful outcomes are achieved such as:

- Reduce stigma and discrimination
- Reduce waiting times and ensure parity across services that will in turn support an integrated provision across cluster pathways
- Improve access
- Increase the level of involvement of service users in the quality agenda within the Trust – Such as serious untoward incident (SUI) panels
- Sustaining and supporting 5 Boroughs Partnership NHS Foundation Trust to be a pilot area for the Mental Health Friend and Family Test and continuing to support the Trust in the advancing quality agenda.

9. Sustainability

NHS Halton CCG faces a 'do nothing' 5 year finance gap of £39 Million. For the health economy to be sustainable the goals are;

- All organisations within the health economy are financially viable in 2015/16
- Operational plan objectives are met
- Reduction seen in A&E activity at the Acute providers
- Reduction seen in inappropriate non-elective admissions into secondary care

9.1 Demographics

The population structure of Halton is projected to change in the next 5 years to 2018. Office for National Statistics predict that there will be an increase of 6.8% in the population aged 0-15 and 23.8% in those aged 65+. Conversely, it is estimated that there will be a decrease in those aged 16-24 by 13.6% and in 25-64 year olds by 2.3%. When looking at this change in the demographic profile of Halton over five years and taking into account the age profile of people using health services the following table has been created to give a baseline for population related growth in the health economy. This has been taken into account for all planning calculations for services in the acute sector.

	2014/15	2015/16	2016/17	2017/18	2018/19
0-64 popn change*	-100	100	-500	200	-100
65+ popn change*	500	800	300	1000	200
Overall change*	400	900	-200	1200	100
% Change*	0.32%	0.71%	-0.16%	0.94%	0.08%
% Weighted change**	0.74%	1.16%	0%	1.55%	0.17%

** ONS Interim 2011-based Subnational Population Projections*

*** From ONS report on Hospital admissions by age & sex 2007/08: NHS Information Centre for Health & Social care, Halton UA hospital admissions were split 70 / 30 between 0-64's and 65+*

9.2 Activity

It is likely that there will be more demand on unplanned hospital care over the next five years from those living and registered with GPs in Halton, particularly in relation to these younger and older age groups.

Areas identified with a potential for increased demand, due to population changes, are;[10]

Emergency admissions for:

- Falls in those aged 65 and over
- Injuries to the body, particularly in those aged 65+
- Dementia (aged 65+)
- Respiratory conditions (infections and asthma 0-15; flu, pneumonia and chronic obstructive pulmonary disease in 65+)
- Digestive conditions (65+)
- Circulatory conditions (heart disease and stroke aged 65+)

Emergency re-admissions within 28 days, for those aged 65+

A&E attendances in those aged 65+

Analysis of activity demands on Halton Health economy

Older people 65+[11]	2012	2014	2016	2018	2020
With a limiting long-term illness	10782	11419	12185	12675	13300
Predicted to have dementia	1229	1256	1314	1421	1518
Predicted to have a longstanding health condition caused by a heart attack	948	1018	1073	1116	1166
Predicted to have a longstanding health condition caused by a stroke	444	473	501	528	551
Predicted to have severe depression	523	554	591	606	636
Predicted to have a fall	5048	5363	5665	5921	6206
With a BMI of 30 or more	5191	5585	5906	6127	6359
Predicted to have diabetes	2430	2605	2755	2895	3017
Adults 18-64[13]	2012	2014	2016	2018	2020
Predicted to have a learning disability	1901	1878	1858	1841	1824
Predicted to have a common mental disorder	12608	12499	12365	12269	12172
Predicted to have a moderate physical disability	6267	6190	6154	6136	6109
Predicted to have a serious physical disability	1878	1852	1842	1844	1845
Predicted to have diabetes	2625	2603	2584	2594	2585

[10] Future impact of demographic changes on unplanned hospital care in Halton
[11] http://www.poppi.org.uk
[13] http://www.pansi.org.uk

Contribution of Health and Wellbeing priority areas to emergency admissions in 2011/12[14]

		Number	Percentage of all emergency admissions	Change since 2010/11	
Falls	Falls in ages 65+	934	6.2%	7.1%	↑
Alcohol	Alcohol specific	864	5.7%	7.9%	↑
Mental Health	Mental and behavioural disorders	631	4.1%	-0.5%	↔
	Dementia (primary or secondary cause)	563	3.7%	-28.6%	↓
	Self-harm	362	2.4%	-15.6%	↓
Cancer	Cancer	291	1.9%	-19.8%	↓

Of those Health and Wellbeing priority areas that have an impact on hospital admissions, the emergency activity relating to falls and alcohol has increased from 2010/11 to 2011/12.

The number of falls over the last three years in those aged 65+ has increased each year

	2009/10	2010/11	2011/12	% change 2009/10 to 2011/12	
Number of admissions for falls[15]	740	872	934	26.2%	↑

- Left unchecked this increase is likely to continue, as the number of falls in people aged 65+ is projected to rise from 5048 in 2012 to 5665 in 2016[16]

[14] Source: Future impact of demographic changes on unplanned hospital care in Halton
[15] Source: SUS data (commissioning Support Unit) as reported in 'Future impact of demographic changes on unplanned hospital care in Halton'
[16] Source: POPPI.org.uk

9.3 Finance

9.3.1 Introduction

The guidance "Everyone Counts: Planning for patients 2014/15 to 2018/19" sets out the aims for the NHS – meeting the promises of the NHS Constitution, empowering clinical commissioning through assumed autonomy whilst at the same time ensuring that services are safe and responsive to patients. The planning guidance also set out the requirements for CCG financial plans to 2018/19:

- They deliver 1% surplus at year end
- A minimum ½% non-recurrent contingency reserve is created
- For 2014/15 use 2.5% non-recurrently, dropping to 1% in the remaining years.

In developing the longer term strategy only the allocations for 2014/15 and 2015/16 are set – assumptions have had to be used for the remaining 3 years. Although the guidance does suggest that current levels of funding should continue the impact of potential alternative scenarios for future funding have also been considered.

9.3.2 Key prinicples and assumptions

In looking ahead to the future a degree of estimation and assumption will be required. Although NHSE has confirmed the next 2 years allocations there is no such certainty about funding beyond 2015/16. Clearly the General Election in 2015 and the relative state of the Public Finances could have a major impact on the level of resources available to the NHS. In looking at the future scenarios although Government borrowing is still very high constraining spending, the current economic down-turn does appear to be ending. This more positive view is therefore reflected in the scenario planning undertaken as part of the Financial Strategy.

Whilst NHS Halton CCG has benefitted from the inequalities component of the allocation this has been offset by the impact of the relatively low registered population growth estimates compared to the national average over the next 2 years. For 2014/15 and 2015/16 they set out a minimum uplift of 2.14% and 1.7% respectively.

The Planning guidance recently released suggests that for longer term strategic plans that the CCG should assume a continutation of the NHSE's current allocation policy although no decisions on allocation beyond 2015/16 have yet been taken. *"Commissioners should assume that income growth increases in line with the GDP deflator"* (1.8% for 2016/17 and 1.7% for the remaining 2 years)

The Running Cost Allowance (RCA) – the management costs of the CCG - have been redcued in 2014/15 from £25 per head of population to £24.78. In line with the announcement in the Comprehensive Spending Review (CSR), NHS administration costs are to be reduced by 10% in 2015/16. If the NHSE continue a policy of not increasing the total RCA nationally (even to reflect pension and pay award cost

increases) then the projected drop in ONS population forecast for NHS Halton CCG will mean that over the two years the CCG will have to cope with a 19% real terms cut in its RCA.

In developing the Financial strategy no attempt has been made to try and second guess the outcome of the Stenvens review of specialist and primary care commissioning and the potential that it may change the balance of commissioning responsibilities between the CCG and NHSE.

In terms of the strategy the key issue will be how far the CCG can control the costs of the services it commissions. These can vary due to inflationary price changes set nationally by Monitor in conjunction with the NHSE from 2014/15 and a re therefore out of the CCG's control. In recent years the inflationary uplift (of 2.2% - 2.5%) has been more than offset by the -4% efficiency built into NHS tariff inflation so that commissioners have benefitted from negative price rises. The planning guidance suggests that CCGs should assume that this continues over the 5 years to 2015/19

The other area of cost increase will be due to changes in activity – either in violume or in the type of treatment. Clearly the most important area is in acute Payment by Results (pbR) were activity multiplied by national tariff prices determine CCG costs. The model used to develop the financial strategy does build in some assumptions for activity growth. It should be noted that Monitor is consulting on new tariff currencies but it it still too early to assess the potential impact on commissioner costs and no allowance has been made in the strategy for such a change.

Although some cost increases may be as a direct consequence of CCG commissioning intentions, others will be driven by growth in patient demand which might be challenging to control, as payments cannot easily be stopped if patients continue to access services or prescriptions are written. This represents a potential risk to the CCG's financial viability and might prevent CCG commissioning decisions to invest to improve services being taken forward. Certainly the growing numbers of the elderly and the obese are longer term population trends which are expected to impact on the demand for NHS services.

The strategy maintains the Clinical Quality Incentives Scheme (CQUINS) at 2.5% over the 5 years

Some of the commissioning investments are due to national guidance. Within the strategy the largest example of this is the Better Care Fund in 2015/16. Although the CCG will receive an allocation of £2.292m in 2015-2016 towards the Better Care Fund it will need to find attiional sums either from growth or efficiencies to add new money to the Fund totalling £9.451m. There is likely to be recognition in the DH that significant mandate investement requirements cannot be made if the NHS finding increases are low.

The majority of the demand management will come from the impact of the beter Care Fund as well as the development of the CCG's Urgent care Centres. It should eb noted that the resources required setting up the Centres and the Fund in advance of the delivery of the associated QIPP efficiency savings will consume the bulk of NHS Halton CCG's available resources in 2015/16 and 2016/17. Clearly there are risks that failure to achieve the anticipated QIPP savings will put pressure on the CCG's finances.

9.3.3 Finanical Risks

- The Key risks to NHS Halton CCG achieveing its financial duties are;-
- The relative gap between annual allocation growth and national price or tariff uplifts net of the efficiey factor
- Activity growth for services subject to cost and volume payment systems e.g. PbR and CHC
- Increased costs due to PbR case mix changes or higher cost better practice tariffs
- National NHS Operating Framework "must do's" which require investment
- Failure to deliver the savings from the CCG's QIPP schemes

9.3.4 Financial risk management

The likelihood and impact of these risks can change over time NHS Halton CCG has various tools in place to mitigate or control these risks. These can be split into three types.

9.3.4.1 Financial Systems

NHS Halton CCG has a robust ledger and budget control system in place to enable actions to be taken quickly to address financial pressures.

NHS Halton CCG will keep back some of its allocation as a contingency reserve to deal with any in-year cost pressure

9.3.4.2 Governance arrangements

NHS Halton CCG has a robust internal governace arrangement which ensures that decisions are properly considered and approved and that all members can be assured that risks are being managed. Elements within this form of control include the work of the Audit Committee, performance and Finance Committee and meetings of the Governing Body and Membership. Other Key parts of this governance framework relate to the internal and external auditors of the CCG

9.3.4.3 Relationships and risk sharing

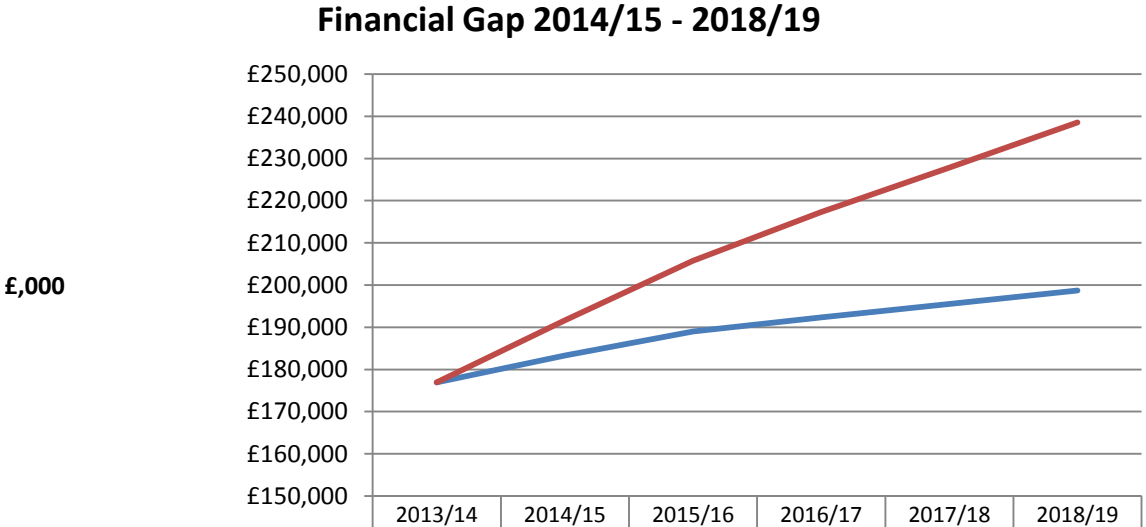
A third control mitigation is to try and share financial risk with other organisations. Examples of this include the risk share between NHS Halton , Knowsley and St Helens CCGs for the number of high cost patients with an acquired brain injury at Vancouver House in Liverpool. This arrangement seeks to reduce the risk of a disproportionate number of such cases falling on a single CCG in any one financial year through random chance. A similar arrangement applies to the creation of the £13.383m pooled budget between the NHS Halton CCG and Halton Borough Council for complex health and social care cases, with the risk of increased costs shared rather than trying to pass the cost on to the other party.

9.3.5 Financial Strategy

As part of the strategic financial modelling required by the NHSE NHS Halton CCG has completed a 5 year financial model, full details of this are available in the 5-year financial plan, A summary of the modelling used is described below.

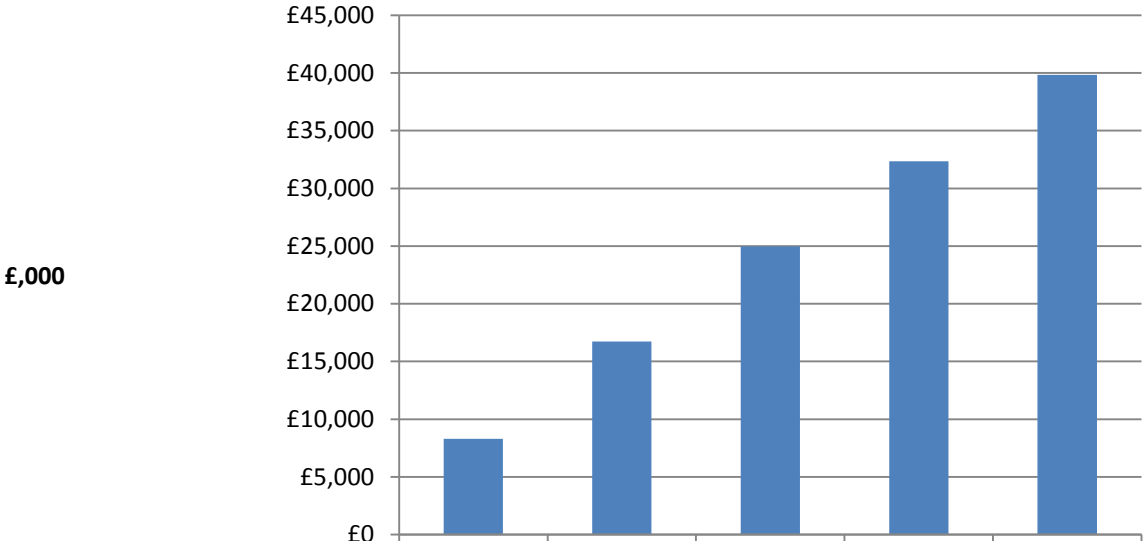
The starting point is the 2014/15 annual budget already approved, figure 8.3.6 describes the financial gap facing the CCG between 2014/15 and 2018/19. This gap between the 'do nothing' position and the planned budget position is based on a series of a series of assumptions, to maintaina balanced budget, this 'gap' is filled by efficiency and QIPP savings.

9.3.6 Overall financial position & do nothing position



	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Planned Budget (excluding surplus)	£176,914	£183,321	£189,026	£192,343	£195,506	£198,711
Budget excluding efficiency & QIPP savings	£176,914	£191,616	£205,746	£217,309	£227,865	£238,543

Financial Gap 2014/15 - 2018/19 - Efficiency/QIPP Savings



	2014/15	2015/16	2016/17	2017/18	2018/19
TOTAL Cumulative QIPP & efficiency savings	£8,295	£16,720	£24,966	£32,359	£39,832

The table and chart above show a summary of the overall financial position of NHS Halton CCG for the next five financial years. Taking anticipated growth into account £8.3M of savings need to be found in 2014/15. The cumulative effect of the 'do nothing position' would be a shortfall of £39.8m over the five year period. Savings are required to be found in each of the next five years with the largest gap being seen in 2015/16 where a saving of £8.4M will need to be found to achieve a balanced budget.

9.3.7 Financial Planning assumptions

Table 2 Planning Assumptions - Base Scenario 1						
Description	Type	2014/15	2015/16	2016/17	2017/18	2018/19
Allocation Growth (+%)	Programme	2.14%	1.70%	1.80%	1.70%	1.70%
	Running Costs	-0.58%	-10.51%	-0.51%	-0.55%	-0.51%
	Weighted Average	2.11%	1.49%	1.77%	1.67%	1.67%
Gross Provider Efficiency (-%)	Acute	-4.00%	-4.00%	-4.00%	-4.00%	-4.00%
	Non Acute	-4.00%	-4.00%	-4.00%	-4.00%	-4.00%
Provider Inflation (+%)	Acute	2.60%	2.90%	4.40%	3.40%	3.40%
	Non Acute	2.60%	2.90%	4.40%	3.40%	3.40%
Demographic Growth (+/- %)		0.32%	0.32%	0.31%	0.31%	0.23%
Non-Demographic Growth (+/- %) e.g. casemix	Acute	0.68%	0.68%	0.69%	0.69%	0.77%
	CHC	0.88%	1.88%	0.49%	0.49%	0.97%
	Prescribing	0.50%	0.50%	0.50%	0.50%	0.50%
	Other Non Acute	0.00%	1.88%	0.49%	0.49%	0.97%
Contingency (%)		0.50%	0.50%	0.50%	0.51%	0.53%
Non-Recurrent Headroom (%)		2.50%	1.02%	1.02%	1.02%	1.02%
Running Cost (spend per head (£)		0.024	0.021	0.021	0.021	0.020

The base case scenario 1 assumptions suggest that the CCG will stay in financial balance (delivering a 1% surplus) over the next 5 years – as limited allocation growth together with tariff efficiency and other CCG QIPP savings combine to give limited re-investment and development opportunities to the CCG over the period, the table below set out the forecast position to 2018/19 based on these assumptions

Table 3 Scenario 1 Base Case Summary	Year 1 - 2014/15			Year 5 - 2018/19		
	Recurrent Cashflows £000	Non Recurrent £000	Total Cashflows £000	Recurrent Cashflows £000	Non Recurrent £000	Total Cashflows £000
Total Expected Sources	181,551	1770	183,321	196,750	1,961	198,711
Total Planned Application of Sources	175,456	6,029	181,485	194,775	1,943	196,718
Planned Surplus / (Deficit)	6,095	-4,259	1,836	1,975	18	1,993
Percentage Surplus / (Deficit)	3.36%		1.00%	1.00%		1.00%

Two further scenarios have been developed, the first is that the Government will fund the proposed increase to employers NHS pension contributions in 2016/17. This has been estimated to add 0.7% to commissioner prices and tariff costs in that year.

Table 4 Scenario 2 Pension Cost Funded	Year 1 - 2014/15			Year 5 - 2018/19		
	Recurrent Cashflows £000	Non Recurrent £000	Total Cashflows £000	Recurrent Cashflows £000	Non Recurrent £000	Total Cashflows £000
Total Expected Sources	**181,551**	**1770**	**183,321**	**198,007**	**4,482**	**202,489**
Total Planned Application of Sources	**175,456**	**6,029**	**181,485**	**194,775**	**1,943**	**196,718**
Planned Surplus / (Deficit)	**6,095**	**-4,259**	**1,836**	**3,233**	**2,539**	**5,771**
Percentage Surplus / (Deficit)	3.36%		1.00%	1.63%		2.85%

The second scenario looks into an assumption that over target CCGs would receive a further 1% less than the current guidance about the base level of uplift. In effect a reduction in allocation growth by 1% after 2015/16

Table 5 Scenario 3 From 2016-17 Allocations 1% less	Year 1 - 2014/15			Year 5 - 2018/19		
	Recurrent Cashflows £000	Non Recurrent £000	Total Cashflows £000	Recurrent Cashflows £000	Non Recurrent £000	Total Cashflows £000
Total Expected Sources	**181,551**	**1770**	**183,321**	**191,004**	**-3,694**	**187,310**
Total Planned Application of Sources	**175,456**	**6,029**	**181,485**	**194,775**	**1,943**	**196,718**
Planned Surplus / (Deficit)	**6,095**	**-4,259**	**1,836**	**-3,771**	**-5,637**	**-9,408**
Percentage Surplus / (Deficit)	3.36%		1.00%	-1.97%		-5.02%

This reduced income would lead to the CCG posting a deficit from 2017/18 unless further corrective action is taken in addition to the efficiency and QIPP savings required in the base scenario. Further strategies needed to bridge this deficit are outlined below.

i) Request a reduction in surplus delivery target
ii) Reduce investments – in recurrent first, then the non-recurrent second
iii) Increase the CCG's QIPP plans to control activity growth in its health economy

It should be noted that whilst the downside scenario will present a significant challenge to the CCG, the continuation of the 4% tariff efficiency presents an even greater challenge to the providers of NHS services.

9.3.8 Investments in Urgent Care £000,s

Investments in Urgent Care	2014/15	2015/16	2016/17	2017/18	2018/19
Recurrent investments Urgent Care centre	300	500	900	490	130
Non Recurrent investment Urgent care centre	1,785	1,270	1,295	1,379	1,486
Total investment	2,085	1,770	2,195	1,869	1,616

9.3.8.1 Reduction on A&E Activity

By investing £2.7M in urgent care facilities across Runcorn and Widnes NHS Halton CCG aim to reduce inappropriate A&E attendances by 15% across 4 years (14/15 – 17/18) The financial impact of A&E reduction in year 1 is £240k and Year 2 £480k

9.3.8.2 Reduction on Non Elective Admissions

The aim is to reduce inappropriate non elective admissions into secondary care by moving emergency activity closer to home and increasing diagnostic activity in urgent care centres. This will impact non elective admission by 15% over 4 years. The financial impact of the reduction of secondary care non elective admissions amounts to

Year	Gross Saving
2014/15	£0.65m
2015/16	£1.35m
2016/17	£1.35m
2017/18	£0.65m
Total gross saving	£4.7m (across both A&E and non-elective admissions)
Total net saving	£2.07m

This will allow the CCG to re-invest in planned care closer to home.

9.3.9 Planned Application of Funds – NHS Halton CCG

Appendix 3 Base Scenario 1 Source & Application of Funds	2014/15			2015/16			2016/17			2017/18			2018/19		
	Rec't £000	Non-Rec £000	Total £000	Rec't £000	Non-Rec £000	Total £000	Rec't £000	Non-Rec £000	Total £000	Rec't £000	Non-Rec £000	Total £000	Rec't £000	Non-Rec £000	Total £000
Allocation- Programme	**178,469**	**1,770**	**180,239**	**184,432**	**1,836**	**186,268**	**187,699**	**1,899**	**189,599**	**190,840**	**1,937**	**192,777**	**194,035**	**1,961**	**195,996**
Allocation- RCA	**3,082**		**3,082**	**2,758**		**2,758**	**2,744**		**2,744**	**2,729**		**2,729**	**2,715**		**2,715**
Total	**181,551**	**1,770**	**183,321**	**187,190**	**1,836**	**189,026**	**190,443**	**1,899**	**192,343**	**193,569**	**1,937**	**195,506**	**196,750**	**1,961**	**198,711**
Application of Funds															
Acute services	92,404	2340	94,744	92,238	-	92,238	93,689	-	93,689	93,911	-	93,911	94,087	-	94,087
MH services	16,276	120	16,396	16,298	300	16,598	17,009	-	17,009	17,043	-	17,043	17,144	-	17,144
Community services	18,029	409	18,438	17,154	-	17,154	17,890	-	17,890	18,375	-	18,375	18,485	-	18,485
Continuing Care services	10,856	682	11,538	19,882	-	19,882	20,939	-	20,939	21,816	-	21,816	23,829	-	23,829
Primary Care services	26,130	450	26,580	27,323	450	27,773	29,519	-	29,519	31,254	-	31,254	32,194	450	32,644
Other Programme services	8,680	1111	9,791	7,409	2,370	9,779	6,761	900	7,661	6,475	940	7,415	6,358	440	6,798
Total - Commissioning services	**172,374**	**5,112**	**177,486**	**180,304**	**3,120**	**183,424**	**185,806**	**900**	**186,706**	**188,874**	**940**	**189,814**	**192,098**	**890**	**192,988**
Running Costs	**3082**		3,082	2,756		2,756	2,736		2,736	2,727		2,727	2,677		2,677
Contingency		**917**	917		946	946		963	963		1,004	1,004		1,053	1,053
Total Application of Funds	**175,456**	**6,029**	**181,485**	**183,060**	**4,066**	**187,126**	**188,543**	**1,863**	**190,406**	**191,601**	**1,944**	**193,545**	**194,775**	**1,943**	**196,718**
Surplus/(Deficit)	6,095	- 4,259	1,836			1,899			1,937			1,961			1,993
% Surplus/(Deficit)			1.0%			1.0%			1.0%			1.0%			1.0%

9.3.10 Savings / Investments from other operational plan schemes (from Appendix A)

9.3.10.1 Baseline QIPP savings £'000

Scenario 1 - Baseline Qipp Savings 2014/15 to 2018/19	2014/15			2015/16			2016/17			2017/18			2018/19		
	Recurrent £000	Non Rec £000	Total £000	Recurrent £000	Non Rec £000	Total £000	Recurrent £000	Non Rec £000	Total £000	Recurrent £000	Non Rec £000	Total £000	Recurrent £000	Non Rec £000	Total £000
Commissioning Schemes															
Opthalmology Procurement	**(280)**	**0**	(280)	**0**	**0**	0	**0**	**0**	0	**0**	**0**	0	**0**	**0**	0
Childrens Commissioning Procurement	**(40)**	**0**	(40)	**0**	**0**	0	**0**	**0**	0	**0**	**0**	0	**0**	**0**	0
Community MDT Redesign	**(75)**	**0**	(75)	**0**	**0**	0	**0**	**0**	0	**0**	**0**	0	**0**	**0**	0
Reduction in NEL activity 2.5% - 5%	**(678)**	**0**	(678)	(1,355)	**0**	(1,355)	(1,395)	**0**	(1,395)	(678)	**0**	(678)	**0**	**0**	0
Mental Health Capacity Claims	**(10)**	**0**	(10)	0	**0**	0	0	**0**	0	0	**0**	0	**0**	**0**	0
Acute Other	**(300)**	**0**	(300)	0	**0**	0		**0**	0		**0**	0	**(1,000)**	**0**	(1,000)
Reduction in A&E Activity by 5%	**(240)**	**0**	(240)	(480)	**0**	(480)	(480)	**0**	(480)	(240)	**0**	(240)	**0**	**0**	0
Telemedicine Impact	**0**	**0**	0	(200)	**0**	(200)	(200)	**0**	(200)	(100)	**0**	(100)	**0**	**0**	0
Redesign of Community Nursing	**0**	**0**	0	(50)	**0**	(50)	(50)	**0**	(50)	(50)	**0**	(50)	**(50)**	**0**	(50)
Total - Commissioning services	**(1,623)**	**0**	**(1,623)**	**(1,835)**	**0**	**(1,835)**	**(1,875)**	**0**	**(1,875)**	**(918)**	**0**	**(918)**	**(1,000)**	**0**	**(1,000)**
Running Costs	(115)	0	(115)	(115)	0			0			0			0	
Total	**(1,738)**	**0**	**(1,738)**	**(1,950)**	**0**	**(1,835)**	**(1,875)**	**0**	**(1,875)**	**(918)**	**0**	**(918)**	**(1,000)**	**0**	**(1,000)**
Tariff/Price Efficency															
Acute Services	(3,879)	0	(3,879)	(3,666)	0	(3,666)	(3,690)	0	(3,690)	(3,748)	0	(3,748)	(3,756)	0	(3,756)
MH Services	(570)	0	(570)	(628)	0	(628)	(652)	0	(652)	(680)	0	(680)	(682)	0	(682)
Community Services	(750)	0	(750)	(672)	0	(672)	(686)	0	(686)	(716)	0	(716)	(735)	0	(735)
Continuing Care Services	(258)	0	(258)	(288)	0	(288)	0	0	0	0	0	0	0	0	0
Primary Care Services	(1,008)	0	(1,008)	(985)	0	(985)	(1,093)	0	(1,093)	(1,181)	0	(1,181)	(1,250)	0	(1,250)
Other Programme Services	0	0	0	245	0	245		0	0		0	0		0	0
Total - Commissioning services	**(6,465)**	**0**	**(6,465)**	**(5,994)**	**0**	**(5,994)**	**(6,121)**	**0**	**(6,121)**	**(6,325)**	**0**	**(6,325)**	**(6,423)**	**0**	**(6,423)**
Running Costs	(92)		(92)	(231)		(231)	0	0	0	0	0	0			
Total	**(6,557)**	**0**	**(6,557)**	**(6,225)**	**0**	**(6,225)**	**(6,121)**	**0**	**(6,121)**	**(6,325)**	**0**	**(6,325)**	**(6,423)**	**0**	**(6,423)**

9.3.10.2 Baseline Investments (£000,s)

Scenario 1 - Baseline Investments 2014/15 to 2018/19	2014/15			2015/16			2016/17			2017/18			2018/19		
	Recurrent £000	Non Rec £000	Total £000	Recurrent £000	Non Rec £000	Total £000	Recurrent £000	Non Rec £000	Total £000	Recurrent £000	Non Rec £000	Total £000	Recurrent £000	Non Rec £000	Total £000
1/2% Contingency	0	892	892	0	941	941	0	944	944	0	986	986	0	1,040	1,040
A&E Liason Whiston/Warrington	261	0	261	0	0	0	0	0	0	0	0	0	0	0	0
Care Home Project	200	0	200	0	0	0	0	0	0	0	0	0	0	0	0
GP Strategy £5 per Head of Population	646	0	646	0	0	0	0	0	0	0	0	0	0	0	0
Hospice Investment	47	0	47	0	0	0	0	0	0	0	0	0	0	0	0
UCC Centre Development (Inc 1% transformational funding)	300	1,785	2,085	500	1,270	1,770	100	1,295	1,395	100	1,379	1,479	100	1,486	1,586
Designated Safeguarding Doctor	100	0	100	0	0	0	0	0	0	0	0	0	0	0	0
MH 136 Triage Pilot	27	0	27	0	0	0	0	0	0	0	0	0	0	0	0
Innovation fund	200	450	650	0	450	450	200	450	650	200	450	650	200	450	650
Prescribing Efficiencies	500	0	500	500	0	500	500	0	500	500	0	500	500	0	500
Activity Management Reserves	1,251	0	1,251	1,163	0	1,163	1,069	0	1,069	1,048	0	1,048	1,042	0	1,042
CHC Restitution	0	682	682	0	0	0	0	0	0	0	0	0	0	0	0
IM &T Intergration	0	500	500	0	0	0	0	0	0	0	0	0	0	0	0
Other Savings	0	514	514	330	164	494	251	144	395	212	144	356	0	144	144
Vascular and 18 Week Backlog	0	550	550	0	0	0	0	0	0	0	0	0	0	0	0
Better Care Fund	0	0	0	9,451	0	9,451	0	0	0	0	0	0	0	0	0
Total - Commissioning services	**3,532**	**5,373**	**8,905**	**2,493**	**2,825**	**5,318**	**2,120**	**2,833**	**4,953**	**2,060**	**2,959**	**5,019**	**1,842**	**3,120**	**4,962**
Running Costs	0	0	0	0	0	0	0	0	0	0	0		0	0	0
Total	**3,532**	**5,373**	**8,905**	**2,493**	**2,825**	**5,318**	**2,120**	**2,833**	**4,953**	**2,060**	**2,959**	**5,019**	**1,842**	**3,120**	**4,962**
Inflation															
Acute Hospital Services	2,519		2,519	2,657		2,657	4,058		4,058	3,185		3,185	3,193		3,193
Mental Health Services	371		371	456		456	717		717	578		578	579		579
Community Services	488		488	487		487	755		755	608		608	625		625
Continuing Care Services	258		258	288		288	398		398	209		209	233		233
Primary Care Services	1,160		1,160	1,199		1,199	1,366		1,366	1,476		1,476	1,563		1,563
Other Programme Services	0		0	245		245	133		133	64		64	63		63
Total - Commissioning services	**4,797**	**0**	**4,797**	**5,332**	**0**	**5,332**	**7,427**	**0**	**7,427**	**6,120**	**0**	**6,120**	**6,256**	**0**	**6,256**
Running Costs	14		14	20		20	0	0	0	0	0	0			
Total	**4,811**	**0**	**4,811**	**5,352**	**0**	**5,352**	**7,427**	**0**	**7,427**	**6,120**	**0**	**6,120**	**6,256**	**0**	**6,256**

9.3.11 Running costs

One of the challenges facing NHS Halton CCG is in relation to the running costs. NHS Halton CCG covers a relatively small population and its Running Cost Allowance is proportionate to this, however some of the demands placed upon CCG's are the same regardless of size. The current running cost allowance is £3.1M there is no uplift in 2014/15 and a 10% real terms cut in 2015/16 to £2.87M

9.4 Provider Sustainability

NHS Halton CCG commissioned Capita to provide an assessment of the retrospective current and future view of the health and social care activity, spend and patient flows across the Mid Mersey Area. As part of this project the impact of the modelled reduction in emergency admissions and emergency length of stay on St helens & Knowsley Hospitals NHS Trust and Warrington & Halton NHS Foundation Trust was calculated. While recognising that NHS Halton CCG commissions services and not providers, this report provided reassurance that the potential impact on main providers would not have a destabilising effect.

Without accounting for population growth (which would in itself offset reduction in income), the impact in these areas would be a reduction in income for these Trusts, The bed shift associated with early supported discharge would offset this income reduction.

10. Improvement Interventions

The eight priority areas identified through extensive consultation with partners will provide real improvements in the health and wellbeing of the people of Halton. These improvements are highlighted below with some of the key actions to be undertaken over the next two years. Commissioning intentions highlighted in brackets () are cross referenced in Appendix A.

10.1 – Maintain and improve quality standards.

- Specific targets have been written in the quality schedule of the Community healthcare provider to increase the rate of medication error reporting as this has been highlighted as below the national average.
- The quality of services will be reported at GP practice level at as near to real-time as possible. (ADD141503)
- The Friends and Family test will be piloted with GP practices and rolled out to the Mental Health and community care providers (ADD141504)
- CQUINs developed with the providers to implement the commissioning outcomes of both the Francis report and the government response. Reviewing performance against last year and against Cavendish review,

'patients first' government response and Berwick re patient safety collaborative. This will be supported by evidence of duty of candour, quality strategy and training programmes including mandatory training. (ADD141505)

- Quality standards improved in the acute sector providers by appropriate use of SHMI and HSMR mortality figures to identify areas for further investigation and evidence of improvement actions taken where appropriate. (ADD141506)
- Investigate the reasons behind the number of people who do not attend appointments (DNA's) review practices and develop methods for reduction (ADD141501)
- Develop clear and transparent process for applying for grants from the CCG (ADD141507)

10.2 – Fully integrated commissioning and delivery of services across health and social care.

- Better Care Fund plan actions are implemented (ADD141509)
- Further develop integrated services between the NHS and Local Authorities for people with complex needs (ADD141508)
- Develop an integrated approach with Halton Borough Council with community pharmacies (ADD141512)
- Deliver single specification with the Local Authority to deliver Children's speech and language services (WCF141505)
- Deliver revised Tier 2 CAMHS specification as a joint project with the Local Authority (WCF141508)
- Secure provision of community services from 2015, VfM contract to reflect the needs of the population supporting more integrated care (PCI141514)

10.3 – Proactive prevention, health promotion and identifying people at risk early

- Examining the evidence to introduce a targeted screening programme to increase early detection rates of lung cancer (PC141505)
- To work with the NHS England Merseyside area team in the shared pursuit of improving uptake and early diagnosis of bowel, breast and cervical cancers (Public Health Commissioning Intentions 2014/15 – Merseyside Area Team)
- To review access to lifestyles service for patients with cancer, for example breast cancer weight loss and exercise programme (PC141508)
- Review provision of services for people with diabetes who have developed foot problems with the desired outcome of reducing the number of complications associated with foot problems in people with diabetes (PC141513)
- Securing 1 day service provision for people who have had a TIA (PC141510)

- Strengthen the GP's role at the heart of out of hospital care by identifying people at risk of hospital admission and introducing named accountable clinician (PCI141501)
- Explore the potential for introduction of a programme of care for Familial hypercholesterolemia. (PCI141512)
- Roll out learning disabilities physical health checks to under 16s (MHUC141510)
- Delivery of the Direct Enhanced Service for dementia within general practice, to increase awareness and screening for dementia (MHUC141511)
- Reduce the level of antibiotic prescribing (ADD141510)

10.4 – Harnessing transformational technologies

- Consider the use of technology to manage sleep apnoea in the community (PC141501)
- Implement the EPACCs IT system – Improve the use of special patient notes in end of life care (PC141506)
- Develop an integrated Health & Social care IM&T strategy & work plan (PCI141510)

10.5 – Reducing health inequalities

- Reviewing the phlebotomy and pathology provision to increase the equity of provision (PC141520)
- Increase access to and equity of provision of community gynae services (PC141517)
- Improve outcomes for people experiencing domestic abuse with a review of the Halton Women's centre (WCF141511)
- Supporting NHS England in ensuring quality in primary care, reducing the variation seen across membership practices. (PCI141508)
- Develop local services to reduce suicide attempts (MHUC141501)
- Review the AED liaison psychiatry model, ensuring that acute and emergency care for people in mental health crisis is as accessible and high quality as for physical health emergencies (MHUC141502)
- Develop and launch 'safe in town' initiative across Halton to increase the number of people in vulnerable groups feeling safe in their communities. (MHUC141503)
- Work with other North West CCG's to secure provision of an IAPT service for military veterans (MHUC141504)
- Review current eating disorder service to improve outcomes for patients (MHUC141506)
- Implement the action plan from the Health Needs Assessment for Learning Disabilities (MHUC141507)

- Develop alternative employment opportunities for vulnerable groups to improve the emotional wellbeing and support individual personal development (MHUC141508)
- Develop mechanisms to ensure we listen to the whole population, including young people and BME communities (ADD141502)

10.6 – Acute and specialist services will only be used by those with acute and specialist needs

- Procurement of community paediatric consultant service (WCF141502)
- Expand community provision for special schools orthoptic service (WCF141503)
- Review possible procurement of community midwifery service (WCF141504)
- Evaluate the Mersey QIPP pilot for children's community nursing service (WCF141510)
- Amend existing asthma care provision to divert emergency admissions and A&E presentations to the new Urgent care centres (WCF141512)
- Support the regional procurement of NHS 111 (MHUC141513)
- Implement the Urgent Care redesign preferred model to reduce inappropriate A&E attendances and subsequent admissions (MHUC141514)

10.7 – Enhancing practice based services around specialisms

- To support GP practices to deliver services over above their core contractual responsibilities (PCI141505)
- Develop the strategy for sustainable general practice in Halton (PCI141506)

10.8 – Providers working together across inter-dependencies to achieve real improvements in the health and wellbeing of our population

- Review pathways for patients with cancer attending hospital to explore alternative models of follow up i.e. telephone follow up or GP led. (PC141509)
- Increase integration in the musculoskeletal (MSK) pathway (PC141515)
- Review the design of community services to focus on outcome based services (PCI141503)
- Establish a single supplementary specialist service for dementia patients that is able to effectively respond and meet the multiple and complex needs of a care home population through the provision of enhanced support. (MHUC141515)

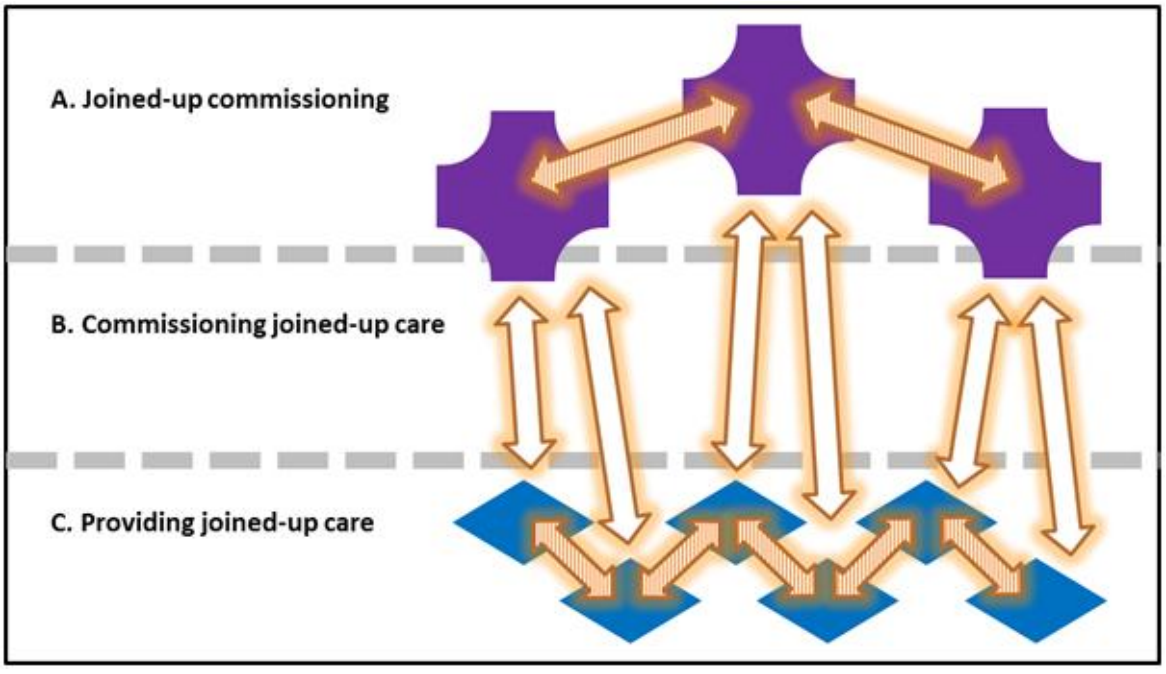
11. Contracting & Governance Overview

Success will be measured by NHS Halton CCG meeting its financial responsibilities, achieving service improvement and the move of activity away from acute settings and into the community. This will be measured by the views of the local population, providers, clinicians and the metrics highlighted both here and in the Better Care Fund Plan.

11.1 Contracting

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

A. Joined-up commissioning: Commissioners within the Clinical Commissioning Group and the local authority develop shared vision, plans and budget. Although this can present challenges, it is necessary to ensure that the large gaps that may have previously been visible between health and social care planning and provision is addressed. Halton are able to clearly demonstrate the benefits of developing shared vision, plans and budgets between the Clinical Commissioning Group and Halton Borough Council.
B. Commissioning joined-up care: Commissioners across sectors collaborate with providers to design coherent, reliable and efficient patient pathways, and ensure the incentives are right for providers to provide interoperable services within these pathways. Engaging patients and carers is a vital part of designing better systems and pathways of care.
C. Providing joined-up care: Providers ensure reliable and timely transitions, supported by a culture of inter-team collaboration and modern information systems.



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

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

Within 5 years the commissioning and delivery of all aspects of health, social care and well-being will be transformed within the borough of Halton. Building on our innovative solutions. The communities of Halton will have a fully integrated system that tailors its responses to their needs as individuals, members of families, carers and participants in their communities.

11.2 Managing Performance

Performance against the key milestones identified against each project will be reported in a performance dashboard. Regular review of this dashboard will allow effective and timely responses to manage situations as they arise.

In addition an early warning dashboard will provide an at-a-glance view of performance against a series of measures including, infection control, quality, risk and safety measures, these will provide effective early markers of possible provider problems or service failure and more can be added as and when appropriate.

Actions identified will also report to an oversight group or be part of a new or existing programme of work. Where this is the case the performance will be reviewed by this oversight group.

11.3 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.

11.3.1 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.

11.3.2 Internal governance

These arrangements are intended to ensure that decisions are properly considered and approved and that all the members of NHS Halton CCG can be 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.

11.3.3 Relationships and risk sharing

Examples of this include the creation of the pooled budget arrangements between NHS Halton CCG and Halton Borough Council for Continuing Health Care (CHC) adults and social care cases. Each party agrees to share the financial risk.

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

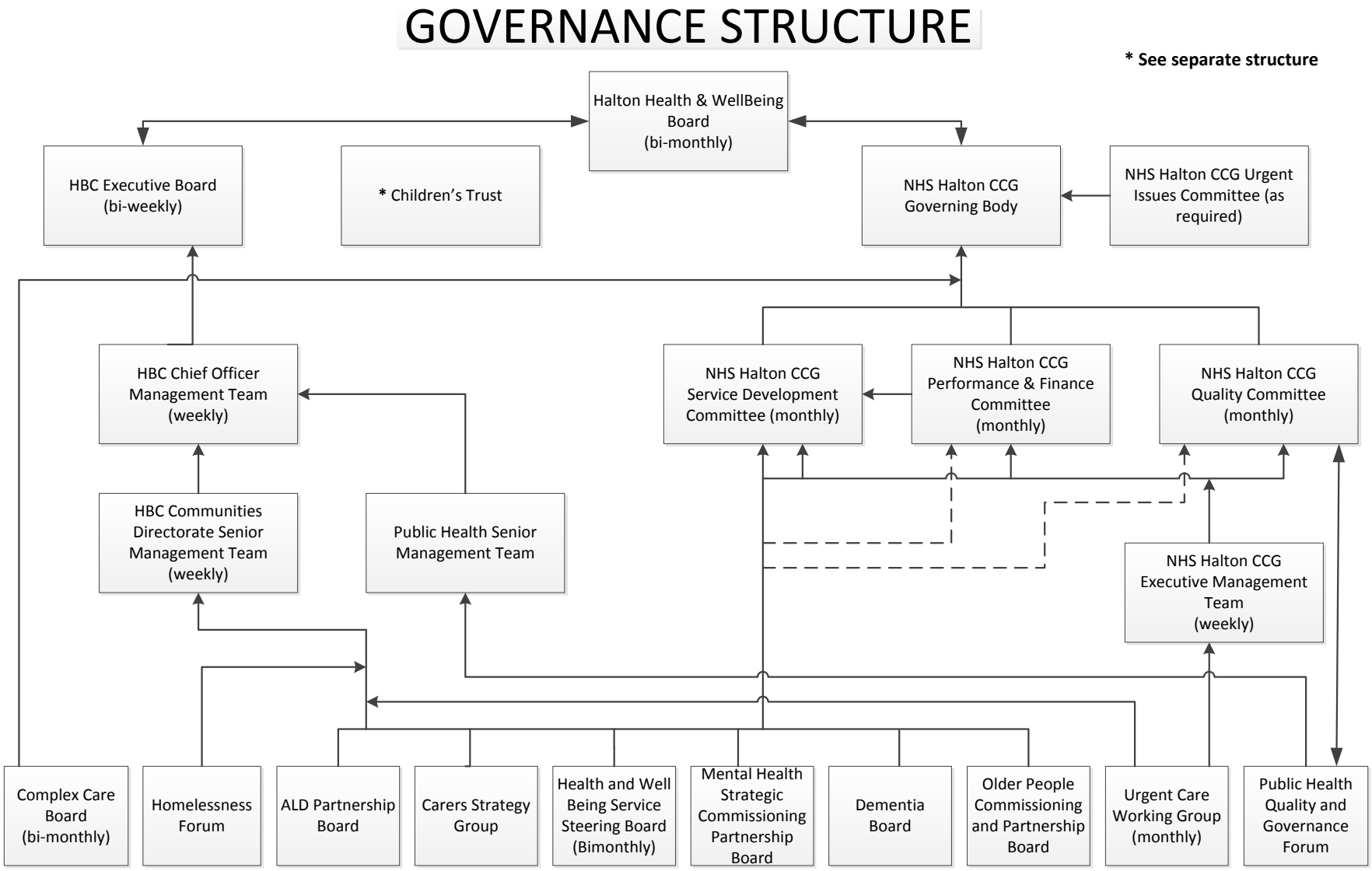
The close working between NHS Halton CCG and Halton Borough Council has led to the development of a list of shared risks to the delivery of the required changes

and the risk mitigations in place. The table below identifies a number of high level risks that we have identified as being the most significant.

Risk	Risk rating	Mitigating Actions
Improvements in the quality of care and in preventative services will fail to translate into the required reductions in the acute sector by 2015/16, impacting the overall funding available to support core services and future schemes.	High	Our integrated commissioning process is engaging a clinical lead and economist to work through the activity of all our provider trusts. This work will highlight further efficiencies by determining the activity that brings best value. Activity below the criteria of significant impact may need to stop to achieve this.
The introduction of the Care Bill 2013 will have implications in the cost of care provision, partnership working, policies, procedures and the skilled and informed workforce.	High	Strategic Group was established in October 2013 to begin to identify the implications of each element of the Care Bill.
Financial fragility	High	Work on-going to forecast financial situation and continue to identify efficiencies across both organisations.
Legal Challenge	High	Robust consultation processes in place, clear application of eligibility criteria, with policies and procedures in place to support decision-makers.
Failure to identify and deal with cultural issues across the HBC and NHS Halton CCG could result in staff feeling isolated; anxious and worried; and a reduction in job performance.	High	Building trust through effective communication, shared values, equal opportunities and effective leadership is crucial to the successful development of integrated teams.
Shifting of resources to fund new joint interventions and schemes will destabilise current service providers, particularly in the acute sector.	High	Our current plans are based on the strategies we have in place covering all service areas and linking in to the priorities of the Joint Health and Wellbeing Strategy and Joint Strategic Needs Assessment.
A lack of detailed baseline data and the need to rely on current assumptions means that our financial and performance targets for 2015/16 onwards are unachievable.	High	We are investing specifically in areas such as data management to ensure that we have up-to-date information around which we will adapt and tailor our plans throughout the next 2 years. This includes moving forward with data-sharing and developing a joint performance framework across all areas.
Operational pressures will restrict the ability of our workforce to deliver the required investment and associated schemes to make the vision of care outlined a reality.	High	Organisational development is an important factor in the successful delivery of the operational plan. On-going evaluation of the team and skill mix will ensure the infrastructure and capacity to deliver the schemes identified.
Communication	Medium	• Joint Local Authority and NHS Halton CCG commissioning team meetings take place on a bi-monthly basis communicating the vision and plans for the future and involving staff at the outset. • Communication and media tools have been identified as a future scheme to ensure the public are fully aware and involved in all aspects of the strategy and operational plan.

11.4 Whole System Governance

The governance structure within NHS Halton CCG fits within a wider system wide governance structure with the Halton Health and Wellbeing board at its head. This structure ensures that all parts of the Halton health economy are working towards the same goals and are aware of and contribute to the plans and actions of all parties in the wider health economy.



12. Reducing inequalities

The Halton Joint Strategic Needs Assessment (JSNA) identified 5 areas where outcomes could be improved, these are:

- People with cancer
- Child development
- Falls in adults
- Harm from Alcohol
- People with mental health conditions

Informed by the Joint Strategic Needs Assessment (JSNA) and in consultation with local residents, strategic partners and other stakeholders, the Halton Health & Wellbeing Strategy 2012-15 identified these as the five key priorities to help us to achieve our vision.

The Joint Health and Wellbeing Strategy sets the framework for the commissioning of health and wellbeing services in Halton with a particular emphasis on prevention and early intervention. This has been identified as an area of strategic focus for NHS Halton CCG.

The NHS E paper 'Promoting Equality and Tackling Health Inequalities' [17] highlighted the most cost-effective high impact interventions as recommended by the National Audit Office report into Health Inequalities, and the Public Accounts Committee Report into Tackling Inequalities in life expectancy, these are:

- Increased prescribing of drugs to control blood pressure;
- Increased prescribing of drugs to reduce cholesterol;
- Increase smoking cessation services;
- Increased anticoagulant therapy in atrial fibrillation;
- Improved blood sugar control in diabetes;

NHS Halton CCG with its partners in Public Health, Halton Borough Council and NHS England are developing a Cardiovascular strategy for Halton which will address some of the issues identified, including the prescribing of anti-hypertensives to patients at risk of or already diagnosed with cardiovascular disease, prescribing statins to patients at risk of or already diagnosed with cardiovascular disease. Working with colleagues in Public Health to review the support available for smoking cessation services.
NHS Halton CCG will work with the Mersey Diabetes Network to develop Merseyside pathways for diabetes as well as specific actions to review the provision of services for people with diabetes who have developed foot problems and reviewing the scope of the community diabetes provision with a desired outcome of reducing the amount of secondary care activity.

[17] http://www.england.nhs.uk/wp-content/uploads/2013/12/brd-dec-1.pdf

NHS Halton CCG will develop a new service specification for the Anticoagulation therapy service, Atrial Fibrillation is an integral part of the service specification for this service.

12.1 Equality Delivery System

The Equality Delivery System (EDS) was rolled out to the NHS in July 2011 and formally launched in November 2011. The EDS is currently being implemented by NHS Halton CCG.
The main purpose of the EDS was, and remains, to help local NHS organisations, in discussion with local partners including local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010. By using the EDS, NHS organisations can also be helped to deliver on the public sector Equality Duty (PSED). EDS2 is more streamlined and simpler to use compared with the original EDS. It is aligned to NHS England's commitment to an inclusive NHS that is fair and accessible to all.

12.1.1 Provider Equality Performance and EDS2

NHS Halton CCG has included the implementation of EDS 2 across its main providers and has stipulated this within the quality contract schedule for 2014/15. This performance measure requires Healthwatch Halton to play a quality assurance role on behalf of the CCG during 2014/15 EDS 2 self-assessments process. The key Providers include:

5 Boroughs Partnership NHS Foundation Trust
St Helens & Knowsely Hospitals NHS Trust
Warrington and Halton Hospitals NHS Foundation Trust
Bridgewater Community Healthcare NHS Trust

Other key trusts include
Liverpool Women's NHS Foundation Trust
Alder Hey Children's NHS Foundation Trust
Liverpool Heart and Chest NHS Foundation Trust

12.1.2 Halton CCG EDS2

Currently Halton CCG has assessed its self as developing across 18 outcomes. The CCG will formally report to the Integrated Governance Committee to formally approve a number of Stretch targets where the CCG intends to move from developing status to achieving status.
The CCG EDS2 self-assessment is a continuous evidence gathering process but CCG will formally self-assess and present its findings to Healthwatch Halton and other community representatives between January and March 2014/15.

To ensure Healthwatch Halton play a key quality assurance role the CCG will ensure their representatives receive training and briefings on EDS 2 and the Equality Act 2010 and monitor Healthwatch involvement in provider assessments. Furthermore Halton CCG will present its findings to the Healthwatch Management Committee between January and March 2015

Currently the CCG is graded at developing across all 18 outcomes.
The following stretch target has been identified to align with the actions contained within the Equality Objective Plan and CCG priorities for 2014/15. The outcomes highlighted for progression from developing status to achieving status are:

- Services are commissioned, procured, designed and delivered to meet the health needs of local communities

- 2.1 People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds

- Goal 3 -A representative and supported workforce- two targets to be proposed at Equality and HR meeting at Cheshire and Merseyside Commissioning Support Unit on the 7th February that align with the Equality Objective Plan and Wirral HR Business Manager who has the relevant links back into the HR and Remuneration Committee

- 4.1 Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations

- 4.2 Papers that come before the Board and other major committees identify equality-related impacts including risks, and say how these risks are to be managed

Grades will be agreed with Healthwatch Halton and other community representatives between January and March 2015. The measurement and grading is subject to CCG evidence and poof that

- People from most protected groups fare as well as people overall – Goals 1 and 2

- Staff members from most protected groups fare as well as the overall workforce- Goal 3

- Many of the examples show a strong and sustained commitment – Goal 4
    - This would include speeches given by Board members and senior leaders to various audiences; reports presented by Board members and senior leaders to various audiences; participation in Board Leadership Programmes for equality; and active promotion of equality-based initiatives for service

12.2 Parity of Esteem

NHS Halton CCG will continue to support recovery focussed mental health support services that are integrated across health, social care and the criminal justice system.

Services will be supported to develop innovation through organisational change and be commissioned to ensure meaningful outcomes are achieved such as:

- Reduce stigma and discrimination
- Reduce waiting times and ensure parity across services that will in turn support an integrated provision across cluster pathways
- Improve access
- Increases the level of involvement of services users in the quality agendas within the Trust – Such as serious untoward incident panels
- Sustaining and supporting Bridgewater Community Healthcare NHS Trust to be a pilot area for the Mental Health Friend and Family Test and continuing to support the Trust in the advancing quality agenda.

13. Citizen Participation

NHS Halton has a Comprehensive communication and engagement strategy which is reported via the quality committee to Governing Body. Communication and engagement was part of this year's internal audit annual assurance review, and communication and engagement was rated as "significant assurance" from audit. There are regular Board to Board meetings with providers, these are reported quarterly in the chief officers report to governing body. The health and wellbeing board is also keyed into this process and key issues / reports are included in Governing body.

The service development committee and membership forum a linked in the constitution, they are key stakeholders when making plans that fit with the strategy.

Healthwatch are a voting member of the quality committee and are also in attendance at governing body and the health and wellbeing board. Halton Healthwatch is a member of the NHS-E Quality surveillance group.

NHS Halton CCG chose to have a formal relationship with Halton Healthwatch, as part of this relationship there are four 'Halton Peoples Forum' events a year held at either the stadium or the town hall.

In association with Halton Healthwatch the Halton People's Forum have had several engagement events during the planning process both in developing commissioning intentions as part of the 'call to action' but also including development sessions with

respect to specific aspects of the plan such as the urgent care centres with feedback sessions built into the events as demonstrated in the image below.

In addition The Commissioning Intentions document clearly demonstrates which intentions were developed as part of the various engagement events which have taken place

14. NHS England Commissioning Intentions

NHS Halton CCG's commissioning Intentions do not operate in a vaccum, within the wider Halton health economy services are provided at many levels, in various settings by many different providers, some very specialised health care services are commissioned and funded by NHS England through 'Specilaised Commissoining' GP's are funded and commissioned through NHS England Primary Care.

14.1 NHS England Specialised Services Commissioning Intentions

NHS Halton CCG is aware of the plans by NHS England to concentrate specialised services in centres of excellence, linked to Academic Health Science Networks, Whilst NHS Halton CCG is not the co-ordinating commissioner for any of the specialised service providers we are conscious of the potential impact that the concentration of services in centres of excellence could have on Halton residents and will be fully involved partners with NHS E in the implementation of these changes.

14.2 NHS England Primary Care Commissioning Intentions

NHS Halton CCG is working with NHS England Primary Care Commissioning and has aligned its strategic intentions with some of the specific actions highlighted in "Primary care Commissioning Intentions 2014/15 – 2015/16 Merseyside"

Specific Service Issues raised by NHS England Primary Care Commissioning include;

- Personal Medical Services

NHS England seeks to align PMS contracts with local emerging primary care strategies. Locally in Merseyside this means a review of all PMS contracts for size and volume to align to national process in relation to equitable funding. The preferred model is for larger / federated PMS contractors to bring benefit and economies of scale. This should be linked to CCG and LA quality strategies where appropriate.

NHS Halton CCG are in the process of developing a Primary Care Strategy which will be led by the practice membership the aim of which is to agree a delivery model for primary care which will seek to support the governments drive to bring care closer to home, strengthen integration between services,; specifically community and social care whilst retaining the GP relationship that we know our patients value. The strategy will be developed with all key delivery partners and work will commence in May 2014 with a series of workshops to help facilitate delivery.

- APMS Contracts

NHS England will be engaging with APMS practices and their representatives to seek to agree the best way forward for APMS contracts, NHS England will be mindful of the impact of closures of these centres on patients and on choice and competitions. The Merseyside Area Team will systematically review its time limited APMS contract portfolio. For Halton this will include the Windmill Hill Practice in Runcorn. Any significant changes to services, both in terms of access and services provided will be subject to appropriate consultation and engagement of key local stakeholders and Equality Impact Assessment. The Area team will collaborate with CCG Primary Care colleagues in the development of local APMS service specifications.

NHS Halton CCG will work with NHS England to ensure the best possible outcome for the residents of Halton

- Local Enhanced Services

Any outstanding Local Enhanced Service (LESs) carried over by NHS England through transition will cease from 31 March 2014. Any remaining LESs will be migrated across to CCGs for future commissioning.

During transition, as directed by NHS England, NHS Halton undertook a full review of all Local Enhanced Services (LES) to ascertain whether they are clinically relevant in terms of supporting our commissioning intentions, review clinical outcomes and assess value for money. All LES' were evaluated against agreed criteria in line with national guidance and several including Anti-coagulation monitoring, Near Patient Testing, Palliative Care Drugs and Care at the Chemist will continue. The CCG have committed to reviewing all service specifications relating to these LES' to ensure they reflect latest clinical guidance and the appropriate procurement routes agreed. In addition, the CCG will continue to work with NHS England to support the implementation and monitoring of Directed Enhanced Services that are delegated to CCGs.

- GP IT Services and Care.Data

CCGs will continue to have delegated management for the delivery of GP IT Services and to set local strategies for strategic systems and technology.
By the summer of 2014 NHS England (Merseyside) anticipates that at least 5 per cent of GP practices will be linked to hospital data. By the end of March 2015 this will have increased to 90 per cent.
NHS Halton CCG is working closely with the Local Authority and other delivery partners to review its IM&T Strategy with the intention of developing a joint Health & Social Care Informatics Strategy that will be delivered across the Local Health Economy. We will continue to build on the good work we have progressed to date with 100% of practices receiving e-Discharge letters and A&E activity data and will continue to look at ways to promote ways to increase the uptake of Choose & Book which will support e-Referral when it becomes live. Currently over 60% of practices are using the Summary Care Record and the CCG has a work programme in place to ensure 100% uptake by December 2014.

NHS
Halton Clinical Commissioning Group

NHS Halton CCG
2 Year Operational Plan
Measures & Targets
2014/15 – 2015/16

15. Operational Plan Outcome Measures & Targets

This section goes into some detail about current and expected levels of performance across a range of different performance measures. Some statistical terminology is used to describe where performance is good or bad in relation to benchmarks.

It is useful to have an understanding of some of the commonly used terms to help interpret the data. Appendix D lists some of the common terms used, how they are calculated and what they mean.

The 5 year strategy and 2 year operational plan detail both the vision for where the Health economy in Halton needs to be in five years and the methods and schemes that need to be in place to achieve that vision. This section of the plan gives some detail on the metrics that will be used to demonstrate that the schemes are having the desired effect, the level of ambition for those metrics and how Haltons performance compares over time, with both national and regional comparitors.

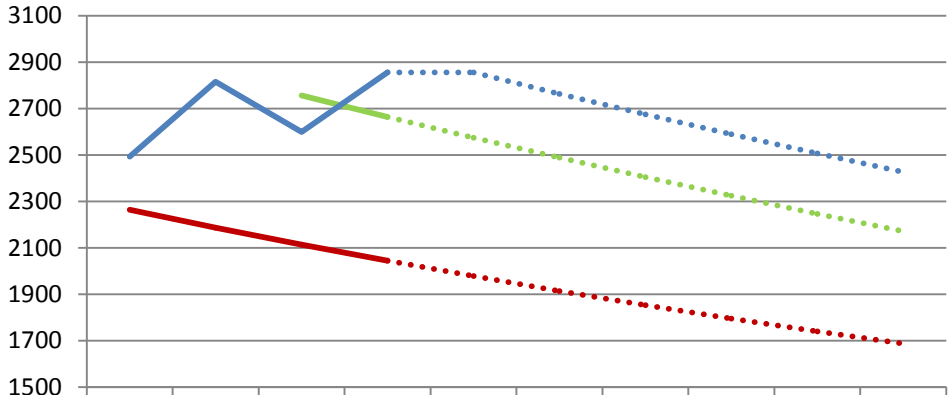
15.1 Securing additional years of life for the people of Halton with treatable mental and physical health conditions

Based on national and local intelligence NHS Halton CCG has developed a number of schemes for implementation over the next 2 years which have the intention of securing additional years of life for the people of Halton. Overall this improvement has been set at 3.2% in both 14/15 and 15/16 for both males and females.
The schemes identified for implementation are;

Reference	Description
PC141505	Review pathway around cancer presentations. This will look at the evidence across all pathways, and will include examining the evidence to introduce a targeted screening programme to increase early detection rates of lung cancer
PC141510	Develop a Cardiovascular strategy for Halton and implement actions arising from the strategy. To include 1) Securing 1 day service provision for people who have had a TIA
PCI141512	Explore the potential for introduction of a programme of care for Familial hypercholesterolemia
MHUC141501	Develop local services to reduce suicide attempts

For full details of the individual schemes please see appendix A.

C1.1 Potential years of life lost from causes amenable to health care in Halton



	Actual 2009	Actual 2010	Actual 2011	Actual 2012	Plan 2013	Plan 2014	Plan 2015	Plan 2016	Plan 2017	Plan 2018
National*	2264.3	2187.7	2115	2045	1979	1915	1854	1796	1741	1688
Local Trajectory*			2757	2665	2576	2489	2406	2325	2247	2172
Halton CCG	2493	2816	2600	2856	2856	2765	2676	2591	2508	2427

Source Data: http://ccgtools.england.nhs.uk/opa/flash/atlas.html on 16/06/2014

** Taken from Potential years of Life lost from causes considered amenable to healthcare - A Public Health tool to facilitate comaprison of CCG plans against relavent trends*

This measure has been selected as a 2014/15 Quality Premium Measure with a nationally set target for the calendar year 2014 of a 3.2% reduction based on the directly standardised rate from a 2013 baseline. NHS Halton CCG has worked closely with the Halton Public Health team to model the elements within PYLL to determine where the greatest gains can be made to achieve a real reduction in the number of years of life lost by Halton residents.

The table below shows the areas identified by Public Health Halton. Those sections in red show where improvements can be made, with dark red showing the areas of greatest potential gain.

The table shows that the greatest gain can be made in Cardio Vascular Disaease (CVD) and Nesoplasms, especially in age ranges of 50-69.

CVD has been recognised as an area for improvement in Halton, and alongside long term ambitions of improving the lifestyle factors associated with CVD (smoking, obesity, exercise) there are also some short-term measures identified that could have an impact, these are centred around early identification, optimising medication and ensuring a concordance between patient and practice around the medication regime.

Years of life lost 2013

Area identified where years of life lost

Area identified where greatest number of years of life lost

	Age Group	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74
Infections	Tuberculosis										
	Selected invasive bacterial and protozoal infections										
	Hepatitis C										
	HIV/AIDs										
Neoplasms	Malignant neoplasm of colon and rectum										
	Malignant melanoma of skin										
	Malignant neoplasm of breast										
	Malignant neoplasm of cervix uteri										
	Malignant neoplasm of bladder										
	Malignant neoplasm of thyroid gland										
	Hodgkin's disease										
	Leukaemia										
	Benign neoplasms										
Nutritional, endocrine & metabolic	Diabetes mellitus										
Neurological disorders	Epilepsy and status epilepticus										
CVD	Rheumatic and other valvular heart disease										
	Hypertensive diseases										
	Ischaemic heart disease										
	Cerebrovascular diseases										
Respiratory diseases	Influenza (including swine flu)										
	Pneumonia										
	Asthma										
Digestive disorders	Gastric and duodenal ulcer										
	Acute abdomen, appendicitis, intestinal obstruction, cholecystitis / lithiasis, pancreatitis, hernia										
Genitourinary disorders	Nephritis and nephrosis										
	Obstructive uropathy & prostatic hyperplasia										
Maternal & infant	Complications of perinatal period										
	Congenital malformations, deformations and chromosomal anomalies										
Injuries	Misadventures to patients during surgical and medical care										

For Diabetes mellitus and Leukaemia the Potential Years of Life Lost (PYLL) is not included for deaths after the ages of 50 and 45 respectively

The 2013 baseline will be available in the Summer of 2014, the figure used in this report is the 2012 baseline. For figures post 2014 a further 3.2% has been applied to each year, however targets post 2014 have not been specified by NHS England.

By continuing a year on year reduction of 3.2% on the potential years of life lost (PYLL) this would bring NHS Halton CCG's figure for PYLL from causes amenable to health care to the 4th Quintile nationally from the 5th currently (based on 2012 quintile boundaries). It should however be noted that as this measure is a quality premium measure with a target attached to it of 3.2% most CCG's will be aiming for a smililar level of improvement.

15.2 Improving the health related quality of life of the people of Halton with one or more long-term conditions, including mental health conditions

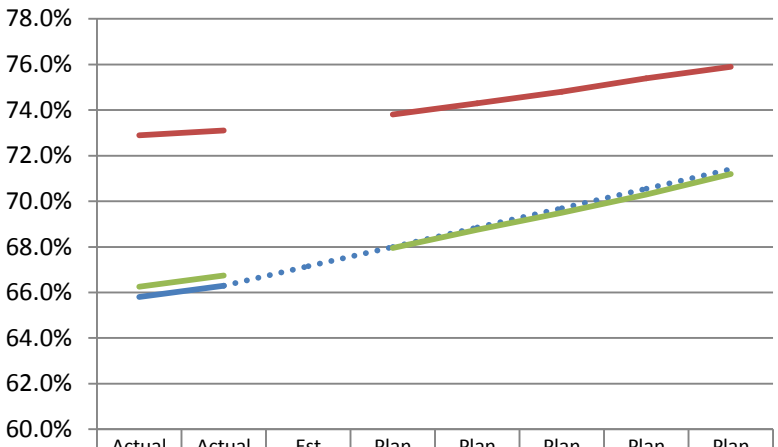
Based on national and local intelligence NHS Halton CCG has developed a number of schemes for implementation over the next 2 years which have the intention of improving the health related quality of life of the people of Halton with one or more long term conditions.

The schemes identified are;

Reference	Description
PC141508	To review access to lifestyles services for patients with cancer, for example breast cancer, weight loss and exercise programme
PC141514	Review the scope of the community diabetes provision
PCI141503	Review the design of community services to focus on outcome based services
MHUC141504	Work with other North West CCGs to secure provision of an IAPT service for military veterans
MHUC141506	Review and redesign current eating disorder service
MHUC141507	Implement the action plan from the Health Needs Assessment for Learning Disabilities
MHUC141508	Develop alternative employment opportunities for vulnerable groups
MHUC141510	Roll out of learning disabilities health checks to under 16s
MHUC141511	Delivery of Direct Enhanced Service for Dementia within general practice, to increase awareness and screening for dementia

For full details of the individual schemes please see Appendix A.

C2.1 Enhancing quality of life for people with long-term conditions (Average EQ5D score)



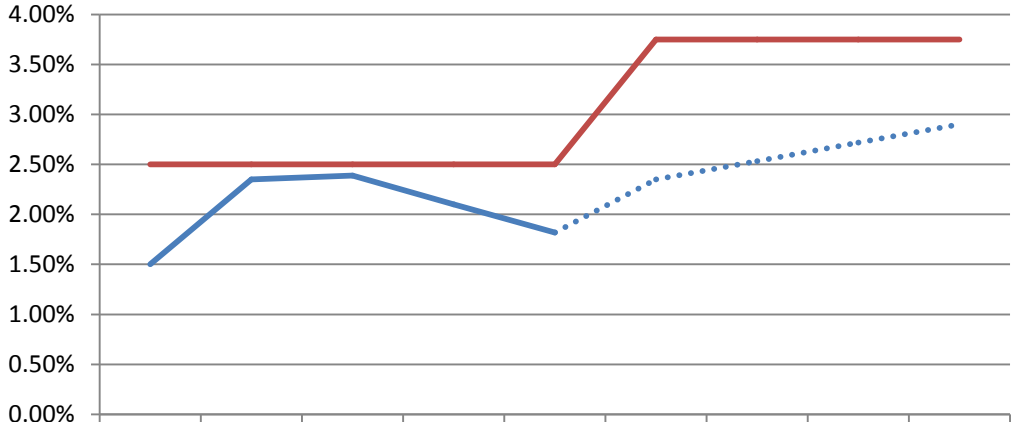
	Actual 11/12	Actual 12/13	Est 13/14	Plan 14/15	Plan 15/16	Plan 16/17	Plan 17/18	Plan 18/19
Halton average health status score	65.8%	66.3%	67.2%	68.0%	68.9%	69.7%	70.6%	71.4%
England Average	72.9%	73.1%		73.8%	74.3%	74.8%	75.4%	75.9%
NHS Merseyside Area (median)	66.3%	66.8%		68.0%	68.8%	69.5%	70.3%	71.2%

Source Data: http://ccgtools.england.nhs.uk/opa/flash/atlas.html on 16/06/2014

The graph above shows the average health status (EQ-5D) score for individuals who identify themselves as having a long-term condition,

A 0.5% increase has been seen in the average health status score between 2011 and 2012 in Halton. This places Halton in the lowest 20% of CCG's nationally and slightly below average when looking at CCG's in Merseyside. Given the rate of improvement needed to reach the England 2012 average score by 2015/16 this looks unrealistic. A more realistic target of a 0.8% Year on Year improvement is both stretching, given historical rates of improvement, and achievable, given the improvement schemes being put into place. This level of improvement would place NHS Halton CCG slightly above average in the Merseyside Area team by 2015/16 This would represent a statistically significant level of improvement on the 2012/13 figure regardless of regional or national improvements.

C2.2 IAPT roll out - Proportion of people that enter treatment against the level of need in the general population



	2012/13 Q4 Actual	2013/14 Q1 Actual	2013/14 Q2 Actual	2013/14 Q3 Actual	2013/14 Q4 Actual	2014/15 Q1 Plan	2014/15 Q2 Plan	2014/15 Q3 Plan	2014/15 Q4 Plan
Halton	1.50%	2.35%	2.39%	2.10%	1.82%	2.35%	2.53%	2.72%	2.90%
England	2.50%	2.50%	2.50%	2.50%	2.50%	3.75%	3.75%	3.75%	3.75%

Source Data 2012/13 Q4 Actual: *http://www.hscic.gov.uk/catalogue/PUB11365* on 09/01/2014

The 2012/13 Q4 actual performance is based on the Halton & St Helens PCT figure, There are two IAPT providers in Halton, Self Help and Bridgwater Community Health Care Trust. This is due to change shortly and the IAPT service will be provided through 5 Boroughs Partnership.
To achieve the 2014/15 Quality Premium NHS Halton CCG will need to achieve an Improving Access to Psychological Therapies (IAPT) annual access level of at least 15% by 31/03/2015

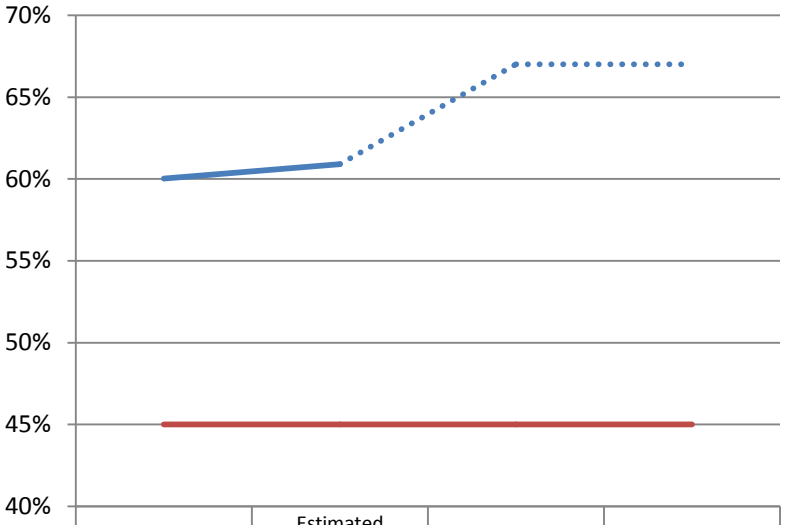
Halton's historical performance with St Helens as a PCT and NHS Halton CCG's performance in 2013/14 (8.66%) is below the England average. Plans highlighted in the table above and in Appendix A will have a positive impact on the number of people accessing IAPT services

The current estimated performance for 2013/14 is 8.66%

The trajectory set in chart C2.2 above demonstrates the quarterly planned figures to achieve a 10.5% annual figure for 2014/15 this is below the National Quality Premium target, however it is not thought possible that given the current levels of performance that a near doubling of the number of people accessing the service during 2014/15 was realistic.

For 2015/16 the intention is to increase performance and ultimately achieve the 15% IAPT access level. This is equal to 2460 people based on a Halton prevalence of 16401.

C2.13 Estimated diagnosis rate for people with dementia

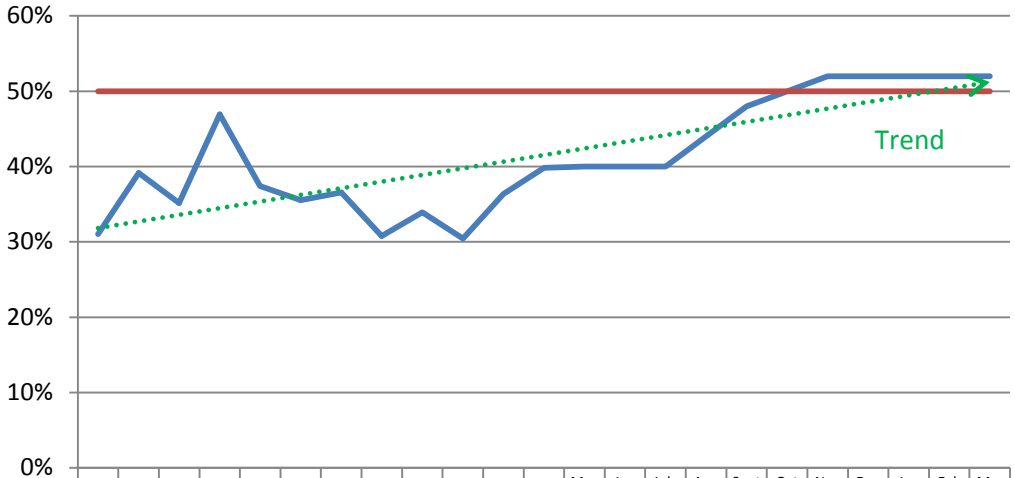


	Actual 2012/13	Estimated 2013/14	Plan 2014/15	Plan 2015/16
Halton Estimated diagnosis rate	60%	61%	67%	67%
England CCG Ave.	45%	45%	45%	45%

Source Data – Halton CCG: http://dementiapartnerships.com/diagnosis/dementia-prevalence-calculator// on 17/06/2014
England CCG Ave: https://www.gov.uk/government/policies/improving-care-for-people-with-dementia
Halton CCG Target: http://www.england.nhs.uk/wp-content/uploads/2013/12/every-count-tech-def.pdf

The NHS Halton CCG estimated diagnosis rate for 2012/13 was 60.02% this is the 16th highest rate in the country (out of 210 CCG's). The provisional 2013/14 results showed a further improvement and an estimated final year position of 60.9%. The plan is to reach the regionally set target of 67% by 31 March 2015 and to at least maintain that level of performance for 2015/16.

C2.11 Recovery following talking therapies for people of all ages



	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May 14 plan	Jun 14 Plan	July 14 Plan	Aug 14 Plan	Sept 14 plan	Oct 14 Plan	Nov 14 Plan	Dec 14 Plan	Jan 15 Plan	Feb 15 Plan	Mar 15 Plan
Actuals	31%	39%	35%	47%	37%	36%	37%	31%	34%	30%	36%	40%	40%	40%	40%	44%	48%	50%	52%	52%	52%	52%	52%
Plan	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%

A major restructure of how IAPT services are offered from August 2014 onwards will have a significant impact on the recovery rates recorded. Based on historical trend performance and the move to a single provider to enable best practice across the whole population, the expectation is that NHS Halton CCG will achieve the 50% IAPT recovery rate by the end of March 2015.

15.3 Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.

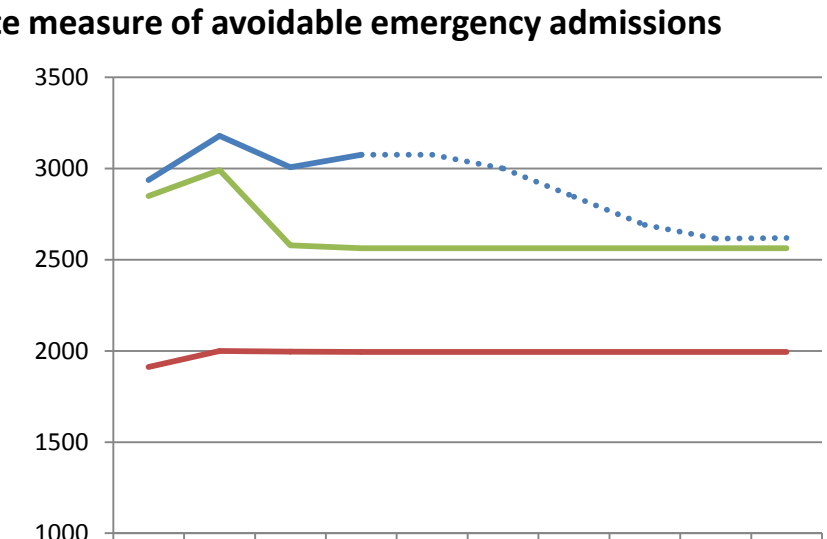
Based on national and local intelligence NHS Halton CCG has developed a number of schemes for implementation over the next 2 years which have the intention of reducing the amount of time people spend avoidably in hospital.

The schemes identified are;

Reference	Description
PC141501	Develop a respiratory strategy for Halton and implement actions from the strategy. To include: 1) reviewing the pathway for people with sleep apnoea. This will include the possibility of using technology to manage sleep apnoea in the community, and considering whether weight management is part of the pathway 2) Reviewing the provision of spirometry services in Halton
PC141506	Implement tools to improve the sharing of information at the end of life: - Work towards implementing the EPACCs IT system - Improve the use of special patient notes in end of life care
PCI141501	Strengthen the GPs role at the heart of out of hospital care and supporting people to stay healthy by identifying people at risk of hospital admission including the introduction of a named accountable clinician
PCI141505	To support GP practices and other providers where appropriate to deliver services over and above their core contractual responsibilities (Local Commissioning Schemes – previously known as Enhanced Services)
PCI141506	A strategy for sustainable general practice services in Halton
PCI141508	Support NHS England in ensuring quality in primary care
PCI141510	Develop an Integration Health & Social Care IM&T Strategy & work plan to include; 1) exploring ways for clinicians and carers to have access to the same information regardless of setting, 2) explore opportunities for OOH providers to have access to primary care record OOH, 3) use of Telehealth and telemedicine to improve patient care, 4) identify the benefits and possibly introduction of Map of Medicine and 5) extending the uptake and use of Choose & Book to improve pathways to hospital and patient choice
PCI141514	Secure provision of community services from 2015
WCF141504	Continue to review with possible procurement community midwifery service
WCF141510	Evaluate the Mersey QIPP pilot for children's community nursing service.
WCF141512	Amend existing care provision for children to build on work done currently to divert emergency admissions and A&E presentations to the new Urgent care centre
MHUC141514	Implement the Urgent Care redesign preferred model

For full details of the individual schemes please see appendix A.

15.3.1 Annual Composite Measure



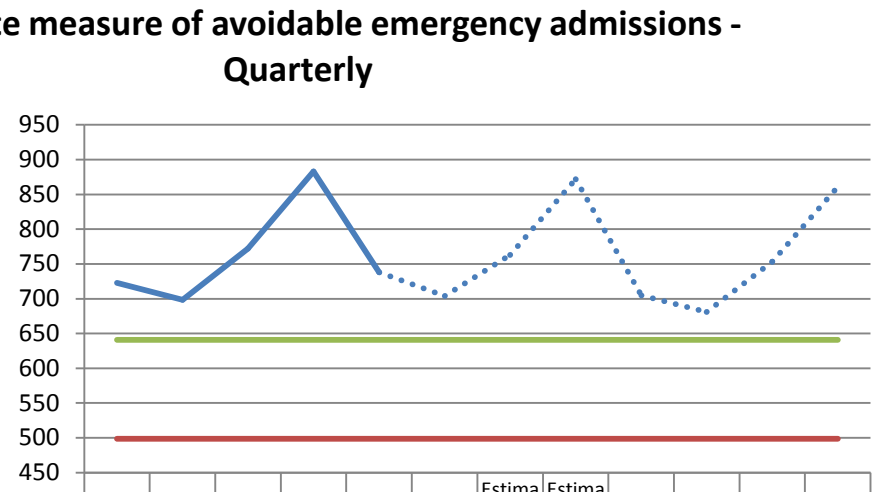
	Actual 09/10	Actual 10/11	Actual 11/12	Actual 12/13	Est. 13/14	Plan 14/15	Plan 15/16	Plan 16/17	Plan 17/18	Plan 18/19
Halton Annual	2936	3179	3007	3076	3076	2999	2845	2692	2615	2619
NHS England Average	1912	2000	1996	1994	1994	1994	1994	1994	1994	1994
Merseyside Area CCG's Median	2848	2991	2579	2563	2563	2563	2563	2563	2563	2563

Source data: http://ccgtools.england.nhs.uk/loa/flash/atlas.html on 17/06/2014

This measure has been identified as a quality premium measure. A reduction or zero percent change is required to earn this portion of the quality premium.

There is an expectation for NHS Halton CCG to achieve 15% of savings over the next five years. The schemes identified in the table above will contribute towards this saving and have been assessed as a realistic level by two independent economic reports by i5 Health and Capita. The plan is to reduce the number of avoidable emergency admissions by 15% over four years. This will be achieved in part by the development of the urgent care centre however this will only become fully operational part way through 2014/15. A 2.5% reduction is planned (from the revised 2012/13 figure) for 2014/15, this would reduce the number of emergency admissions per 100,000 to 2999; Further 5% reductions (on the 12/13 baseline) are expected to be seen in both 15/16 and 16/17. Beyond 16/17 the current expectation is that there will be continued innovation and development of the service and a further 2.5% reduction is anticipated. Beyond 2017/18 an age standardised demographic increase of 0.17% is forecast, however development in services over the next four years may impact on this.
The 14/15 Quality premium is based on a reduction being seen between 13/14 and 14/15 or a rate below 1,000 per 100,000. The Baseline data for 2013/14 will not be available until summer 2014 the figures above are based on the 2012/13 actual

15.3.2 Quarterly composite measure



	Actual 12/13 Q1	Actual 12/13 Q2	Actual 12/13 Q3	Actual 12/13 Q4	Actual 13/14 Q1	Actual 13/14 Q2	Estimated 13/14 Q3	Estimated 13/14 Q4	Plan 14/15 Q1	Plan 14/15 Q2	Plan 14/15 Q3	Plan 14/15 Q4
Halton Annual	723	698	772	883	738	704	763	872	705	681	753	861
NHS England Average	499	499	499	499	499	499	499	499	499	499	499	499
Merseyside Area CCG's Median	641	641	641	641	641	641	641	641	641	641	641	641

Source Data: http://ccgtools.england.nhs.uk/opa/flash/atlas.html on 17/06/2014

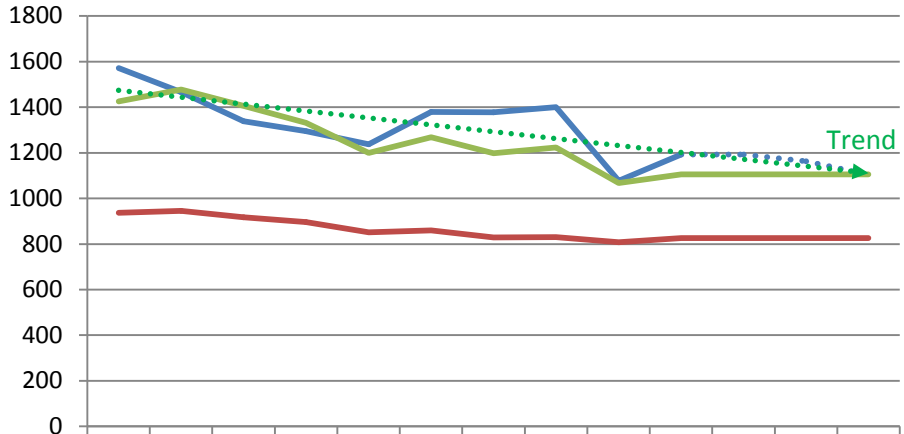
This measure is a composite of four separate measures. These are;

- Unplanned hospitalisation for chronic ambulatory care sensitive conditions
- Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s
- Emergency admissions for acute conditions that should not usually require hospital admission
- Emergency admissions for children with lower respiratory tract infections (LRTI)

Separate plans have been made of each of these measures. For the composite measure quarterly plans are required for 14/15, the figures based in the chart above are based on the 2.5% reduction on the 12/13 baseline. This have been split across the year based on the seasonal pattern seen in both 12/13 and 13/14 YTD

15.3.3 Unplanned hospitalisation for chronic ambulatory care conditions

C2.6 Unplanned hospitalisation for chronic ambulatory care (ACS) conditions (adults)



	Actual 03/04	Actual 04/05	Actual 05/06	Actual 06/07	Actual 07/08	Actual 08/09	Actual 09/10	Actual 10/11	Actual 11/12	Actual 12/13	Est 13/14	Plan 14/15	Plan 15/16
Halton per 100,000	1572	1466	1338	1295	1237	1379	1378	1401	1078	1193	1193	1163	1103
England	937	945	918	896	852	860	829	831	808	827	827	827	827
Northwest	1425	1478	1406	1332	1200	1269	1198	1224	1068	1105	1105	1105	1105

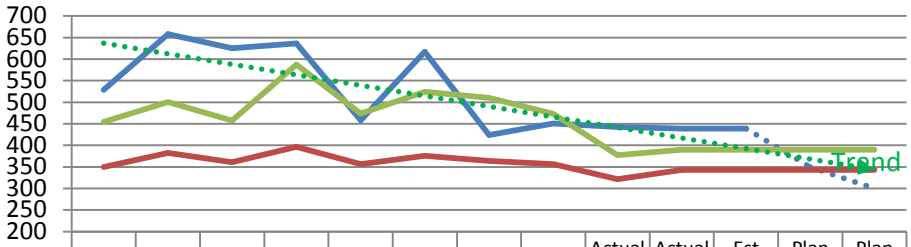
Source data: http://ccgtools.england.nhs.uk/loa/flash/atlas.html on 10/01/2014

This is one of the measures included in the composite measure on emergency admissions

For 2014/15 a 2.5% reduction has been planned based on 12/13 Actuals. 13/14 baseline is not yet known. A further 5% reduction on the 12/13 baseline is planned for 2015/16. This is a statistically significant reduction, would bring Halton's performance below the Northwest 12/13 baseline and is in line with the long-term historical trend from 2003.

15.3.4 Unplanned hospitalisation for asthma, diabetes and epilepsy

C2.7 Unplanned hospitalisation for asthma, diabetes and epilepsy (under 19's)



	Actual 03/04	Actual 04/05	Actual 05/06	Actual 06/07	Actual 07/08	Actual 08/09	Actual 09/10	Actual 10/11	Actual 2011/12	Actual 2012/13	Est 2013/14	Plan 2014/15	Plan 2015/16
Halton (per 100,000)	529	658	626	637	458	617	424	451	443	439	439	350	300
England	350	383	361	396	357	375	364	356	322	343	343	343	343
North west (2nd Quintile)	454	501	458	588	474	525	510	473	377	390	390	390	390

Source data: http://ccgtools.england.nhs.uk/loa/flash/atlas.html on 10/01/2014

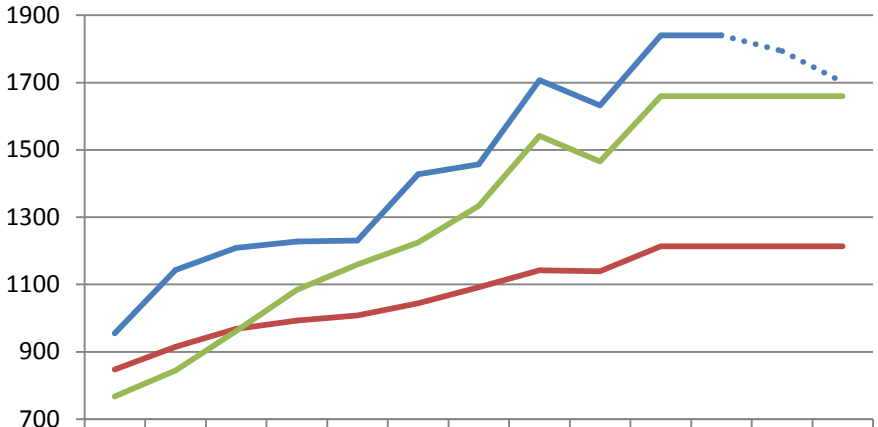
This is one of the measures included in the composite measure on emergency admissions

Significant progress has been made with regard to unplanned hospitalisation for asthma, diabetes and epilepsy. It is expected that 2013/14 will be lower than 2012/13. Based on trend forecasting a reduction to 350 per 100,000 is expected by 2014/15 this is a statistically significant reduction below the Lower level confidence interval of the 2012/13 baseline. Further improvements are expected in 2015/16 which will bring the number of admissions down to 300 per 100,000 which will be below the England 12/13 average.

Based on current intelligence if current improvements in performance can be maintained an out-turn rate of 300 is predicted for 2015/16

15.3.5 Emergency admissions for acute conditions that should not usually require hospital admission

C3.1 Emergency admissions for acute conditions that should not usually require hospital admission



	Actual 03/04	Actual 04/05	Actual 05/06	Actual 06/07	Actual 07/08	Actual 08/09	Actual 09/10	Actual 10/11	Actual 2011/12	Actual 2012/13	Est 2013/14	Plan 2014/15	Plan 2015/16
Halton (per 100,000)	955	1143	1209	1228	1231	1428	1457	1707	1632	1840	1840	1794	1702
England	847	915	968	993	1008	1044	1092	1142	1139	1214	1214	1214	1214
North west (3rd Quintile)	768	845	962	1084	1159	1225	1333	1542	1466	1660	1660	1660	1660

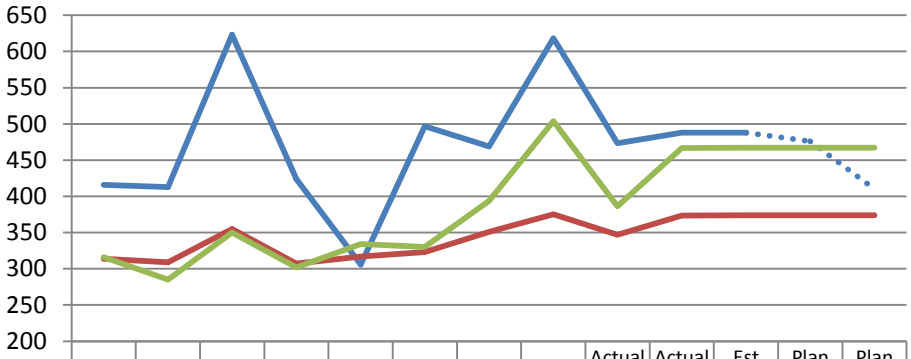
Source Data: http://ccgtools.england.nhs.uk/loa/flash/atlas.html on 10/01/2014

This is one of the measures included in the composite measure on emergency admissions

The plan over the next two years is through transformation of services to make a statistically significant reduction in the number of these admissions with a 2.5% reduction on the 12/13 baseline in 2014/15 and a further 5% on the 12/13 baseline by 2015/16. This will also bring NHS Halton CCG close to the North West 2012/13 3rd quintile boundary.

15.3.6 Emergency admissions for children with lower respiratory tract infections (LRTI's)

C3.4 Emergency admissions for children with lower respiratory tract infections (LRTI's)



	Actual 03/04	Actual 04/05	Actual 05/06	Actual 06/07	Actual 07/08	Actual 08/09	Actual 09/10	Actual 10/11	Actual 2011/12	Actual 2012/13	Est 2013/14	Plan 2014/15	Plan 2015/16
Halton (per 100,000)	416	413	623	424	306	497	469	618	473	488	488	476	410
England	314	309	355	307	317	323	351	375	347	374	374	374	374
North west (2nd Quintile)	316	285	350	302	334	330	394	504	386	467	467	467	467

Source data: http://ccgtools.england.nhs.uk/loa/flash/atlas.html on 10/01/2014

This is one of the measures included in the composite measure on emergency admissions

Targets have been set for a 2.5% reduction on the 12/13 baseline for 2014/15 and a further reduction to 410 per 100,000 for 2015/16.

The 410 per 100,000 target has been chosen as slightly higher level of improvement than other types of emergency admissions as schemes planned over the next two years are expected to have a larger impact including 'Paediatric attendance at A&E'

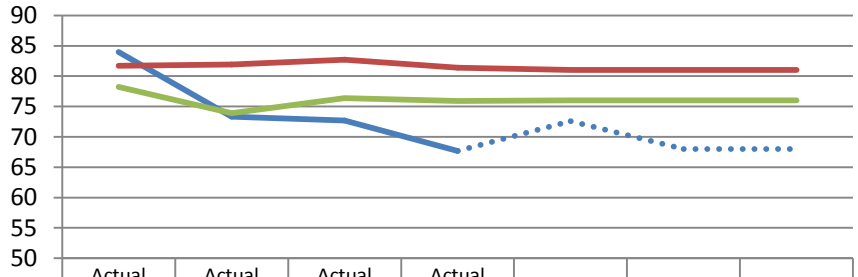
NHS Halton CCG aim to reduce the utilisation of A&E by children by 16% over 2 years by ensuring that there are paediatric specific services, using agreed care pathways available within the community at the two Urgent Care centres to be established within Halton, for the most common conditions which cause children to present at A&E. These services will be underpinned by the availability of appropriate diagnostic/facilities e.g. cold room to ensure the services can deal with a range of children's conditions effectively. It is also expected that the reduction in the number of A&E attendances will also result in a reduction in the number of emergency admissions, especially in St Helens. This has been calculated at between 3% and 5%.

15.4 Increasing the proportion of older people living independently at home following discharge from Hospital

NHS Halton CCG has worked in partnership with Halton Borough Council in the development of the Better Care Fund plan. Full details of the schemes in place and planned improvements to increase the proportion of older people living independently at home following discharge from hospital are available in this plan.

Although estimated performance for 13/14 is 72.6% the BCF requires 2 year plan figures based on the 2012/13 actual, for Halton this was 68%, this level of performance is planned to be maintained to 2015/16.

ASCOF 2B - Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

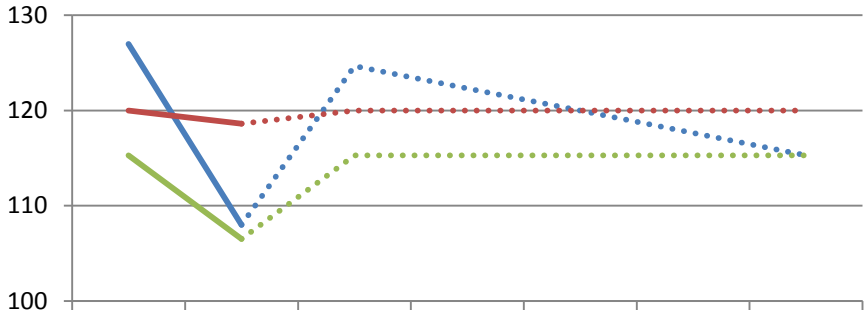


	Actual 09/10	Actual 10/11	Actual 11/12	Actual 12/13	Est 13/14	Plan 14/15	Plan 15/16
Halton	84	73	73	68	73	68	68
England	82	82	83	81	81	81	81
North West 2nd Quintile	78	74	76	76	76	76	76

Data Source: http://ccgtools.england.nhs.uk/loa/flash/atlas.html on 10/01/2014

15.5. Increasing the number of people having a positive experience of hospital care

C4.2.1 Patient experience of hospital care - number of 'poor' responses per 100 patients



	2012 Actual	2013 Actual	2014 Plan	2015 Plan	2016 Plan	2017 Plan	2018 Plan
Halton	127	108	124.66	122.32	119.98	117.64	115.3
NHS England 2012 Ave.	120	118.6	120	120	120	120	120
Merseyside 2012 Median	115.3	106.5	115.3	115.3	115.3	115.3	115.3

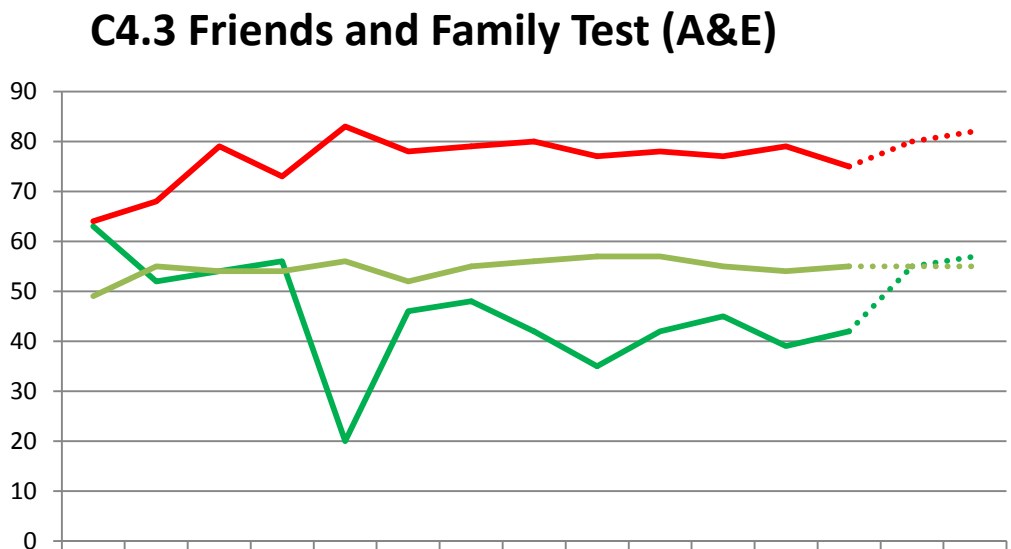
Source Data: http://ccgtools.england.nhs.uk/loa/flash/atlas.html on 17/06/2014

Data is available for 2012 and 2013 however following guidance from NHS England Merseyside Area Team. Only the 2012 figure has been used for benchmarking purposes. This shows NHS Halton CCG with a performance of 127 'poor' responses per 100 patients (a person can have a 'poor' response to more than one question in the survey).

By working together with the Acute Trusts, regularly reviewing performance through the Quality committee and by providing more streamlined & reduced care pathways to reduce lengths of stay and prevent delayed discharge this should provide a better experience for a patient receiveing hospital care and this will be reflected in these survey results.

Taking into account the very good improvement in survey responses in 2013 but using 2012 as the benchmark a target has been set to achieve the Merseyside 2012 median value by 2018 this would improve NHS Halton CCG's performance from worse than the national average to better than average.

15.5.1 Friends and Family Test A&E.



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	14/15 Plan	15/16 Plan
Warrington	63	52	54	56	20	46	48	42	35	42	45	39	42	55	57
St Helens	64	68	79	73	83	78	79	80	77	78	77	79	75	80	82
England	49	55	54	54	56	52	55	56	57	57	55	54	55	55	55

Source[18]

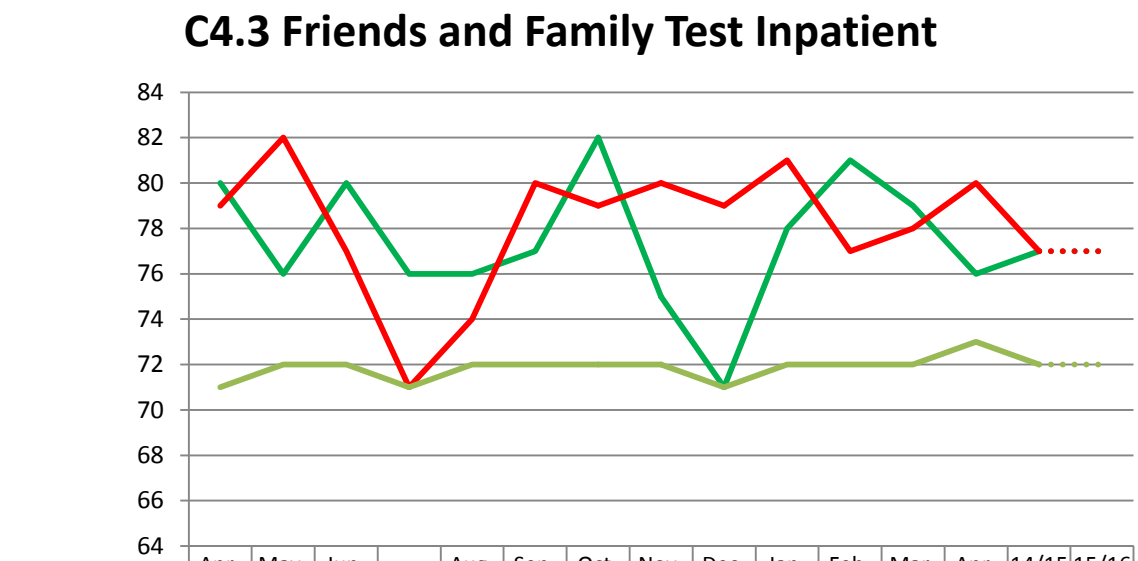
There are significant differences in performance in the Friends and Family test (A&E) between St Helens & Knowsley NHS Trust and Warrington & Halton Hospitals NHS Foundation Trust.

By working together with the Acute Trusts, regularly reviewing performance through the Quality committee and by providing more streamlined services with genuine alternatives to A&E this should have an impact on waiting times and only patients with genuine acute needs attending the Type 1 A&E centres. This should provide a better experience for a patient receiveing Accident and Emergency care and this will be reflected in these survey results.

The plan is to improve performance in both Trusts. For Warrington & Halton Hospitals NHS Foundation Trust the plan is to bring performance in line with the England average by 2014/15 and a further improvement to exceed England average by 2015/16. For St Helens & Knowsley NHS Trust the plan for 14/15 and 15/16 is for continuous improvement based on a linear trend forecast.

[18] http://www.england.nhs.uk/statistics/statistical-work-areas/friends-and-family-test/friends-and-family-test-data/

15.5.3 Friends and Family Test - Inpatient.



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	14/15 Plan	15/16 Plan
Warrington	80	76	80	76	76	77	82	75	71	78	81	79	76	77	77
St Helens	79	82	77	71	74	80	79	80	79	81	77	78	80	77	77
England	71	72	72	71	72	72	72	72	71	72	72	72	73	72	72

Source[19]

With regards to the Friends and Family Test (Inpatient) both Warrington & Halton Hospitals NHS Foundation Trust and St Helens & Knowsley NHS Trust perform much higher than the England average. The plan for 14/15 and 15/16 are to maintain this excellent level of performance at the average of the period April 13 to April 14, 77% compared with the England averge of 72% over the same period

[19] http://www.england.nhs.uk/statistics/statistical-work-areas/friends-and-family-test/friends-and-family-test-data/

15.6. Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community

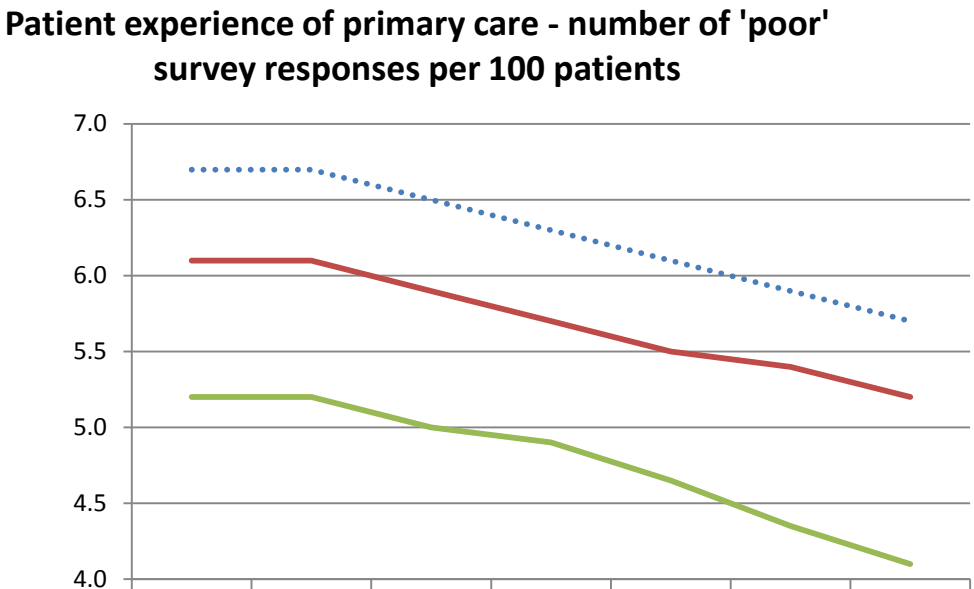
Based on national and local intelligence NHS Halton CCG has developed a number of schemes for implementation over the next two years which have the intention of increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.

The schemes identified are;

Reference	Description
WCF141503	Move to local community tariff basis for special schools orthoptic service and expand community provision on a tariff basis
WCF141505	Undertake joint review of Children's Speech & Language services with LA to deliver single specification and single budget through 'pooled' arrangements with subsequent procurement during 2014/15
WCF141508	To support delivery of the Halton's mental Health Strategy in relation to young people including; 1) Continue review of emotional wellbeing and psychological pathway for young people with a view to delivering revised Integrated Tier 2 CAMHS specification as a joint project with the LA and procurement during 2014/15
WCF141511	Review of the Halton Women's centre
ADD141503	Work towards reporting on the quality of services at GP practice level and also at the level of consultant-led teams for a number of specific specialties
ADD141504	Extend the friends and family test in line with national timescales, including Mental Health and Community based services from April

For full details of the individual schemes please see appendix A.

15.6.1 Composite indicator of i) GP Services and ii) GP out-of hours services



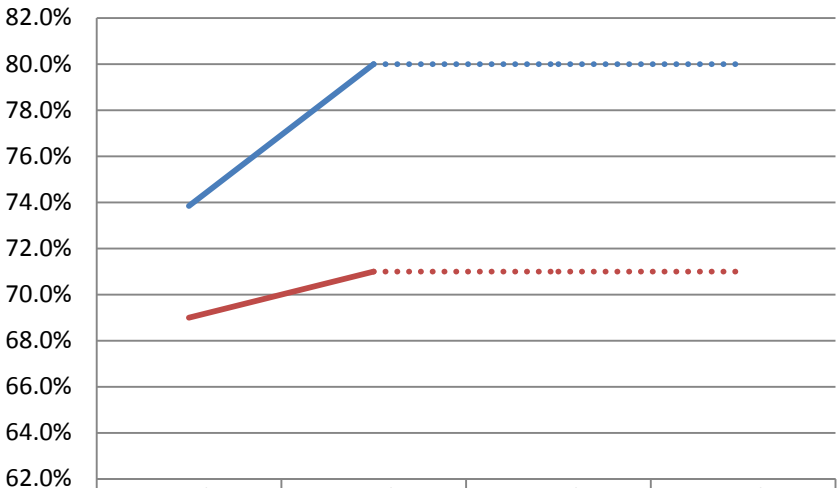
	2012 Actual	2013 Est	2014 Plan	2015 Plan	2016 Plan	2017 Plan	2018 Plan
Halton	6.7	6.7	6.5	6.3	6.1	5.9	5.7
NHS England	6.1	6.1	5.9	5.7	5.5	5.4	5.2
NHS Merseyside	5.2	5.2	5.0	4.9	4.7	4.4	4.1

Source Data: http://ccgtools.england.nhs.uk/loa/flash/atlas.html on 16/06/2014

The data above is a composite indicator of results from both GP services and GP out of hours services. In 2012 Halton's performance of 6.7 'poor' survey responses per 100 patients was higher than both the England and Merseyside average, Improvements are expected in this performance measure both nationally and locally. NHS Halton CCG's targeted improvement is realistic in terms of relecting the level of ambition both regionally and nationally however NHS Halton is starting from a slightly worse position. It is anticipated that by 2016 NHS Halton CCG's performance in terms of GP patient experience will be better than the levels currently experienced nationally.

15.6.2 Patient Experience - GP Out of Hours

(C4.1) Patient experience of GP out of hours services

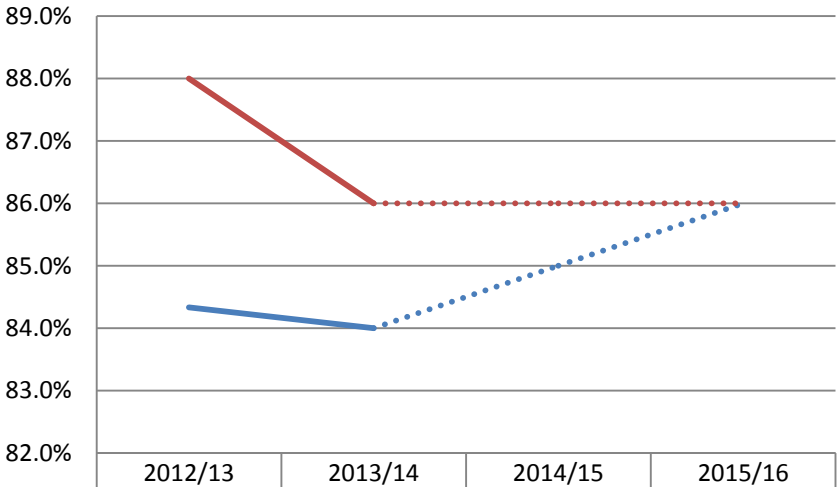


	2012/13	2013/14	2014/15	2015/16
% of people answering 'good' or 'very good' in the GPPS survey	73.8%	80.0%	80.0%	80.0%
England average	69.0%	71%	71.0%	71.0%

NHS Halton CCG's performance in the GPPS survey for patient experience of GP out of hours services is significantly higher than the England average. The plan for 2014/15 and 15/16 is to maintain this high level of performance.

15.6.3 Patient Expereince – GP Overall Experience

GPPS Survey Q28 'Overall, how would you describe your experience of your GP Surgery



	2012/13	2013/14	2014/15	2015/16
% of people answering 'good' or 'very good' in the GPPS survey	84.3%	84.0%	85.0%	86.0%
England Average	88.0%	86.0%	86.0%	86.0%

Current performance across Halton practices has remained constant from the Oct-March 13 results to the Jul-Sept results at 84% for those patients answering 'fairly good' or 'very good' to their experience of the GP surgery. NHS Halton CCG are committed to not reducing the quality of services for its residents and aim to bring the overall satisfaction to GP practices to at least the England average of 86% by 2015/16

15.7 Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

Based on national and local intelligence NHS Halton CCG has developed a number of schemes for implementation over the next two years which have the intention making significant progress towards eliminating avoidable deaths in hospital caused by problems in care.

The schemes identified are;

Reference	Description
ADD141505	Implement the commissioning outcomes of both the Francis report and the government response
ADD141506	Develop process to monitor and improve SHMI and HSMR mortality figures in secondary care
ADD141510	Ensure appropriate prescribing of antibacterials

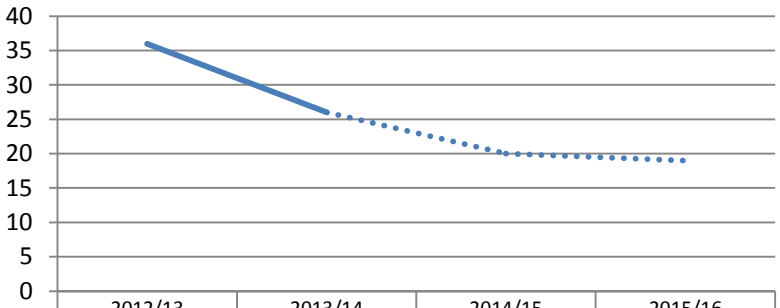
15.7.1 MRSA Zero tolerance

NHS Halton CCG has a zero tolerance approach to MRSA (meticillin-resistant staphylococcus aureus). In the period April to December 2013 there have been no HCAI reported incidences of MRSA for Halton GP registered patients. NHS Halton CCG is committed to maintaining this level of performance for 2014/15 and 2015/16

15.7.2 Clostridium Difficile

NHS Halton CCG had a very good year in 2013/14 in terms of the number of people reported with HCAI Clostidium Difficile, the Acutal (26) was much lower than the target set for the CCG of 33. In light of this NHS E have set the NHS Halton CCG a challenging target for 2014/15 of just 20 cases, with a further reduction expected to be seen in 2015/16.

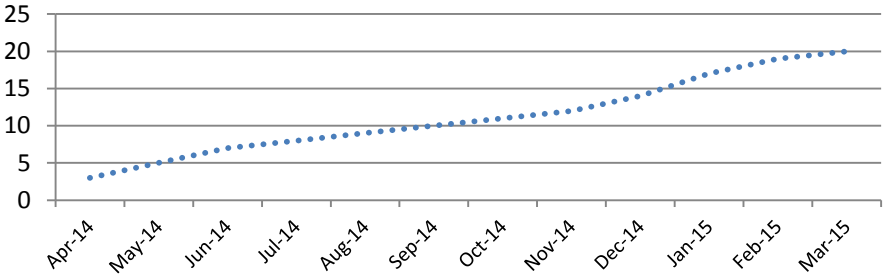
(C5.4) Incidence of healthcare associated infection (HCAI) Clostridium Difficile (c.difficile)



	2012/13 Actual	2013/14 Actual	2014/15 Plan	2015/16 Plan
The number of C.difficile infections reported in people aged 2 and over	36	26	20	19

15.7.3 Clostridium Difficile monthly plan

(C5.4) Incidence of healthcare associated infection (HCAI) Clostridium Difficile



	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
C-diff cases (cumulative)	3	5	7	8	9	10	11	12	14	17	19	20

The seasonal variation of C-Difficile infections has been taken into account when planning monthly figures for 2014/15.The percentages applied are 33% of cases expected between Jan to March, with the peak for infections being in January, 27% for April to June, 20% for July to September and 20% for October to December. These estimates were taken from 'English voluntary surveillance scheme for C. Difficile infections'[20]

[20] http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317132089343

16. Operational Plan NHS Constitution measures

For the next two years NHS Halton CCG has set the following targets to meet or exceed the NHS constitution measures

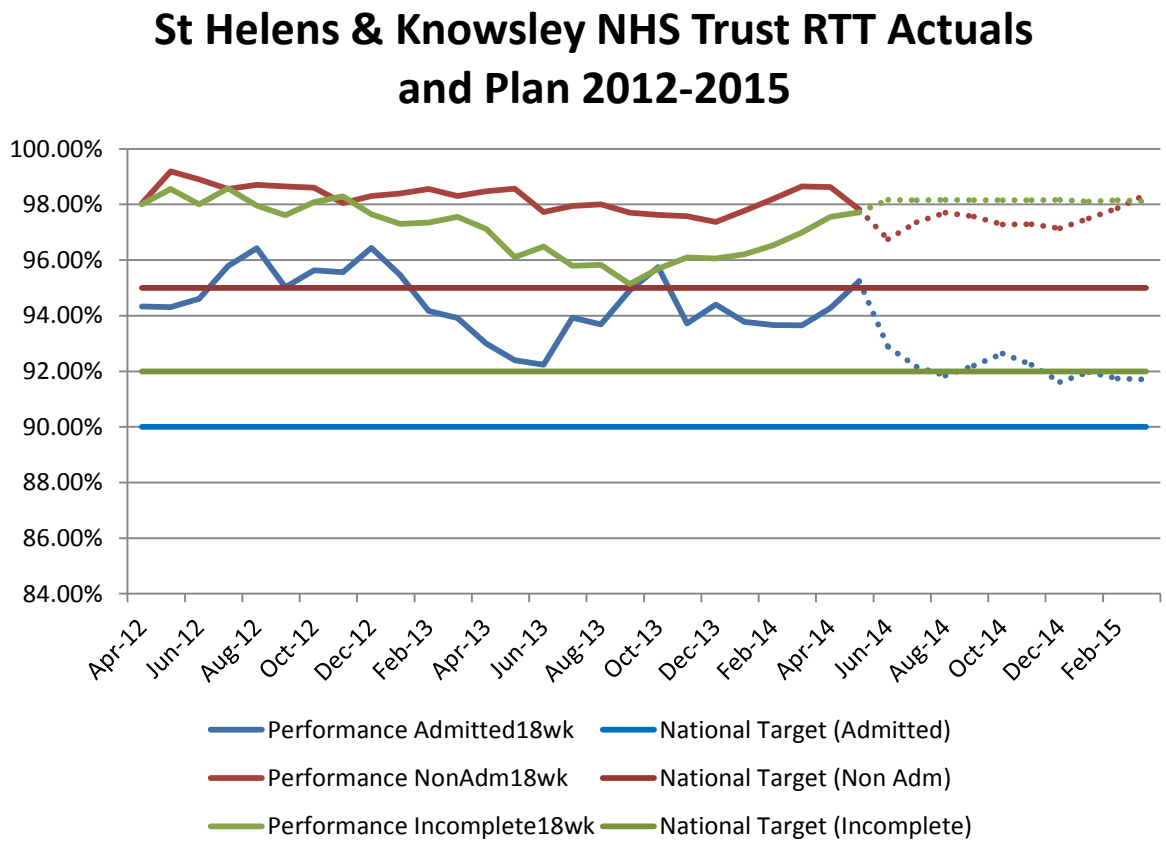
Description	Standard	Halton 14/15 Target	Halton 15/16 Target
Referral to Treatment waiting times for non-urgent consultant–led treatment			
Admitted patients to start treatment within a maximum of 18 weeks from referral	90%	90%	90%
Non-admitted patients to start treatment within a maximum of 18 weeks from referral	95%	95%	95%
Patients of incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral	92%	92%	92%
Diagnostic test waiting times			
Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral	99%	99%	99%
A&E Waits			
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department	95%	95%	95%
Cancer waits – 2 week wait			
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93%	93%	93%
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer not initially suspected)	93%	93%	93%
Cancer waits – 31 days			
Maximum one month (31 day) wait from diagnosis to first definitive treatment for all cancers	96%	96%	96%
Maximum 31-day wait for subsequent treatment where that treatment is surgery	94%	94%	94%
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	98%	98%	98%
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	94%	94%	94%
Cancer waits – 62 days			
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer	85%	85%	85%
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	90%	90%	90%
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set	n/a	90%	90%
Category A ambulance calls			
Category A calls resulting in an emergency response arriving within 8 minutes (Red 1)	75%	75%	75%
Category A calls resulting in an emergency response arriving within 8 minutes (Red 2)	75%	75%	75%
Category A calls resulting in an ambulance arriving at the scene within 19 minutes	96%	95%	95%

NHS Halton CCG is committed to maintaining its excellent performance against the NHS constitution measures and achieving or exceeding the standards set.

16.1 RTT (Referral to Treatment)

NHS Halton CCG has acknowledged that there is significant pressure across the health economy in achieving the 18-week referral to treatement timescale, especially within the Acute providers. In Halton, Bridgewater Community NHS Trust has provided assurance that it will continue to meet its 18-week timescales for the small amount of consultant led services which it provides.

St Helens & Knowsley NHS Trust has also provided Trust level figures of the expected level of RTT performance



Against all three RTT measures St Helens & Knowsely NHS Trust plans to exceed the national target.

NHS Halton CCG has planned for growth in the activity in each of the providers, both acute and community, a contingency has been put aside to deal with overperformance, however where this occurs providers will be held to account and access will be requested to the patient tracking lists, consultant productivity and Theatre utilisation.

16.2 NHS Constitution support measures

Description	Standard	Halton 14/15 Target	Halton 15/16 Target
Mixed Sex Accommodation Breaches[21]			
Minimise breaches (rate per 1,000 FCEs)	0.1	0.1	0.1
Cancelled Operations			
All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patients treatment to be funded at the time and hospital of the patient's choice	100%	100%	100%
Mental Health			
Care Programme Approach (CPA): the proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period	95%	95%	95%
Referral to Treatment waiting times for non-urgent consultant-led treatment			
Zero tolerance of over 52 week waiters	0	0	0
A&E waits			
No waits from decision to admit to admission (trolley waits) over 12 hours	0	0	0
Cancelled Operations			
No urgent operation to be cancelled for a 2nd time	0	0	0
Ambulance Handovers			
All handovers between ambulance and A&E must take place within 15 minutes and crews should be ready to accept new calls within a further 15 minutes. Financial penalties, in both cases, for delays over 30 minutes and over an hour.	0	0	0

16.2.1 Mixed Sex Accommodation

NHS Halton CCG usually has a very good record with regards to mixed sex accommodation breaches, with no breaches at all recorded between April and August 2013. However 2 breaches were reported in September and 3 in October (rate of 0.7 per 1000 FCE's) this has since returned back to 0 in November. The plan is to minimise the number of breaches to at least the national average and ultimately zero.

16.2.2 Ambulance Handovers

NHS Halton CCG recognises that this national standard is an ambitious target to achieve, however we aspire to meet this standard and will work with the Acute Trusts and the North West Ambulance Service NHS Trust (NWAS) to move towards this.

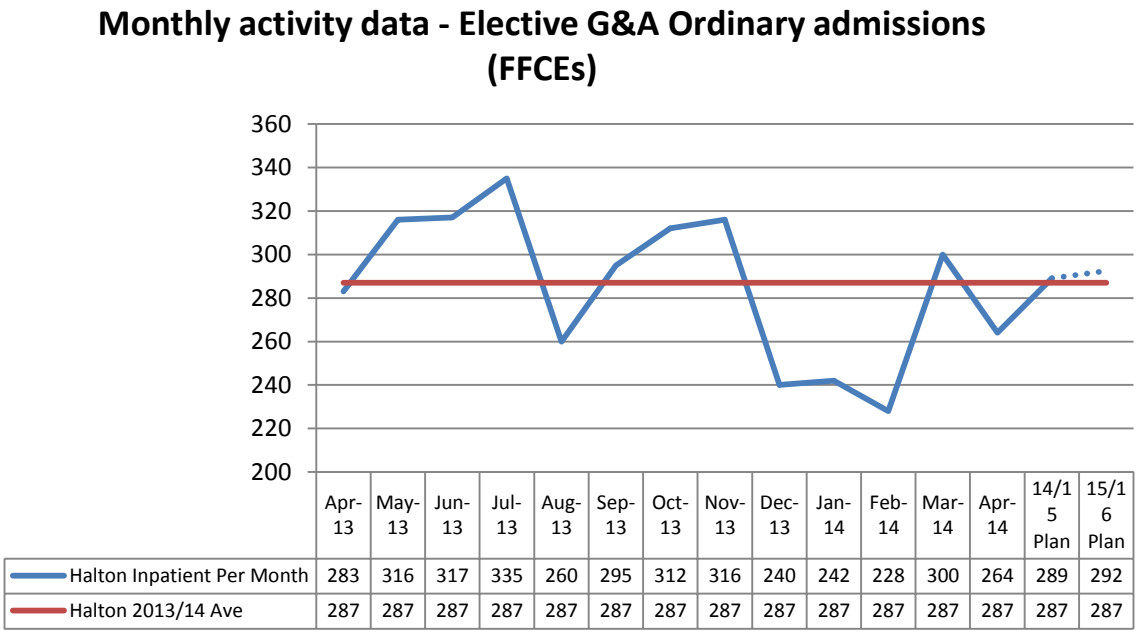
[21] http://www.england.nhs.uk/statistics/statistical-work-areas/mixed-sex-accommodation/msa-data/

17. Operational Plan Activity

The charts below show actual and projected activity for a range of measures as highlighted in the NHS England Planning guidance.

17.1 Elective[22]

17.1.1 Elective G&A Ordinary Admissions (FFCEs)



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	14/15 Plan	15/16 Plan
Halton Inpatient Per Month	283	316	317	335	260	295	312	316	240	242	228	300	264	289	292
Halton 2013/14 Ave	287	287	287	287	287	287	287	287	287	287	287	287	287	287	287

A small increase in activity is expected due to demographic changes in the population of Halton

Growth has been calculated using the growth table as discussed in section 9.1

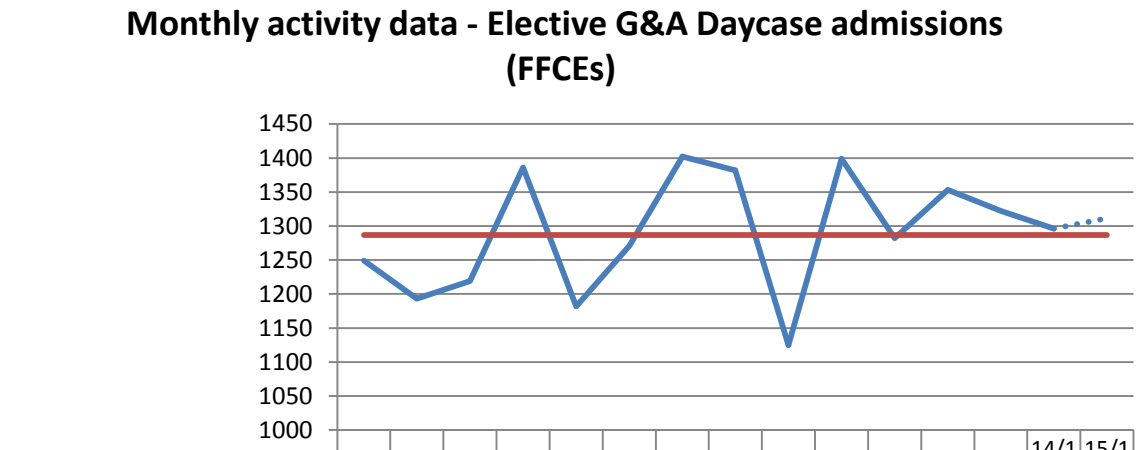
0.74% (age standardised activity increase for 2014/15)
1.16% (age standardised increase for 2015/16)

The average number of G&A ordinary admissions per month in 2013/14 is estimated to be 287; by 14/15 this is expected to have increased to 289 and by 2015/16 to 292 per month.

The 14/15 plan and 15/16 plan figures are the monthly average for those years.

[22] http://www.england.nhs.uk/statistics/statistical-work-areas/hospital-activity/monthly-hospital-activity/mar-data/

17.1.2 Elective G&A Day case Admissions (FF CEs)



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	14/15 Plan	15/16 Plan
Halton Daycase Per Month	1249	1193	1219	1386	1182	1271	1402	1382	1125	1399	1282	1353	1322	1296	1311
Halton 2013/14 Ave	1287	1287	1287	1287	1287	1287	1287	1287	1287	1287	1287	1287	1287	1287	1287

A small amount of increased activity is expected due to the changes in the population of Halton, the calculations behind how this has been done are described in section 9.1

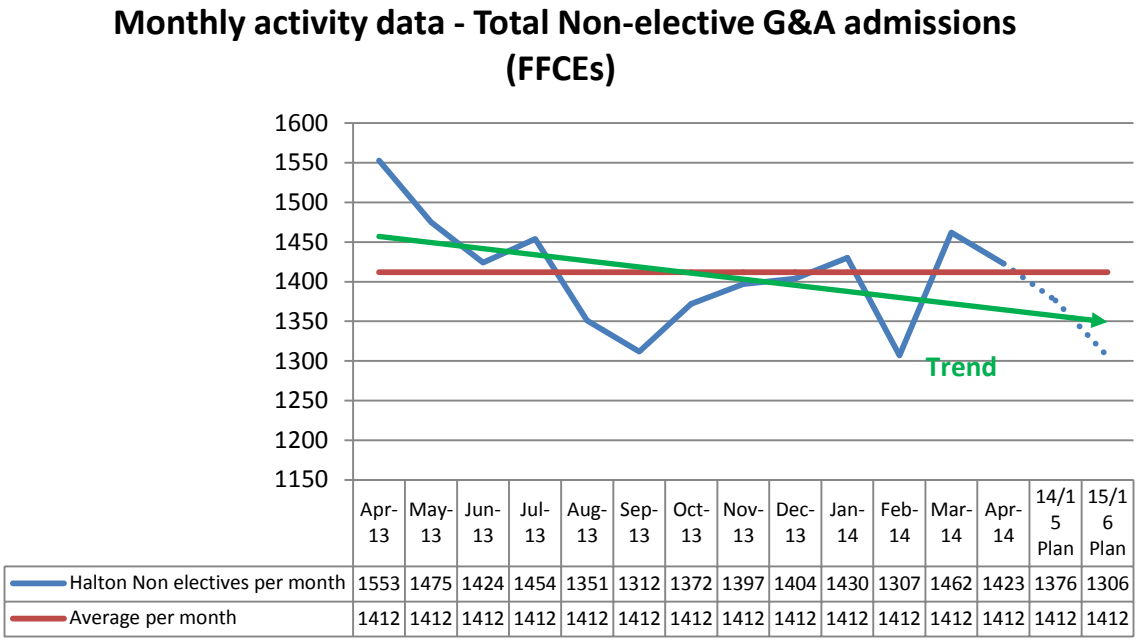
0.74% (age standardised activity increase for 2014/15)
1.16% (age standardised increase for 2015/16)

For the number of elective G&A day case admissions the average number of admissions per month in 2013/14 is expected to be 1287, for 14/15 this is expected to have increased to 1296 and for 2015/16 an increase to 1311 per month.

The 14/15 plan and 15/16 plan figures are the monthly average for those years.

17.2 Non Elective Admissions

17.2.1 Total Non-elective G&A Admissions (FFCEs)



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	14/15 Plan	15/16 Plan
Halton Non electives per month	1553	1475	1424	1454	1351	1312	1372	1397	1404	1430	1307	1462	1423	1376	1306
Average per month	1412	1412	1412	1412	1412	1412	1412	1412	1412	1412	1412	1412	1412	1412	1412

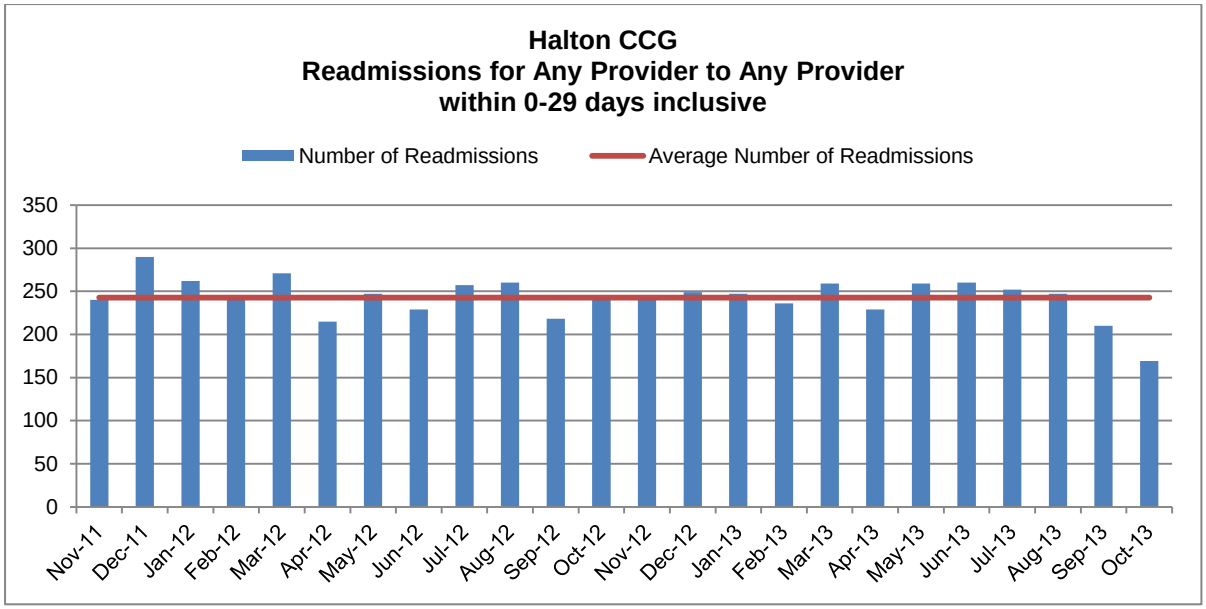
The actions being put into place as part of the 5-year strategy and 2-year operational plan are forecast to have the impact of reducing the number of non-elective admissions by 2.5% (based on 13/14 estimate) for 2014/15 then a further 5% in 2015/16 and 2016/17.

For 2013/14 the estimate has been calculated as the April to November average of 1412. A 2.5% reduction equates to 35 cases per month. The 14/15 plan is 1376 per month and 15/16 plan of 1306 per month.

The 14/15 and 15/16 plans shown in the chart above are the monthly averages.

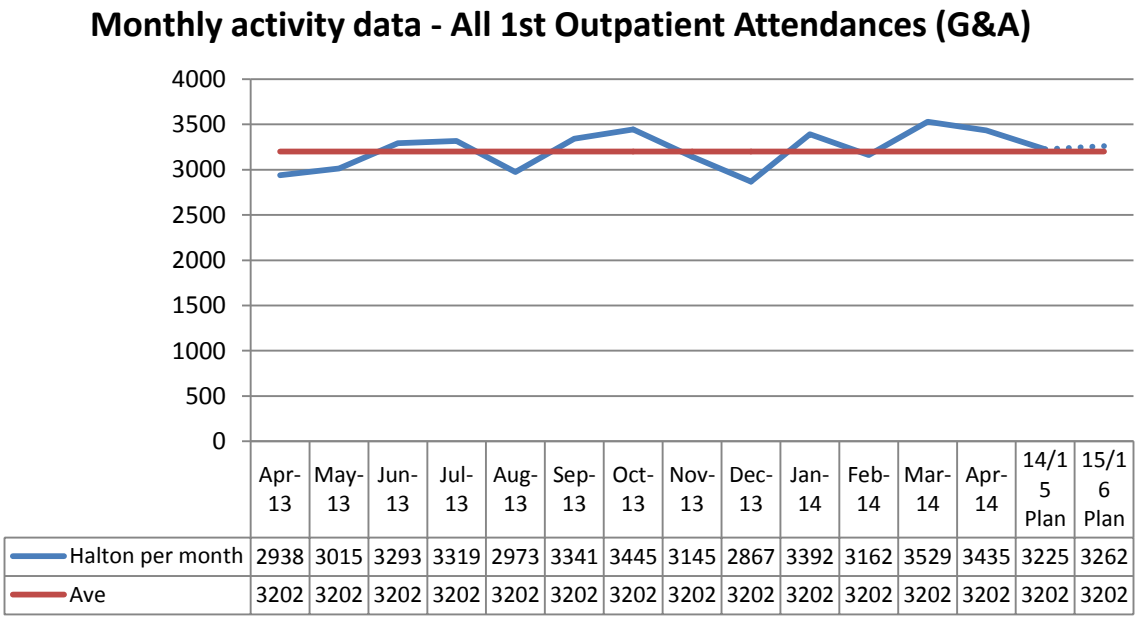
17.2.2 Readmissions 0-28 days

As represented in the chart below, readmissions across all trusts for Halton residents are improving. The schemes and attention paid to ensuring quality care outside of hospital is paying dividend. We aim to continue to drive this direction of travel and maintain at a safe and affordable level. At this trajectory at the end of 2015/16 Halton will have moved into all areas of green activity based on the ADASS National Scorecard



17.3 Outpatient Attendances

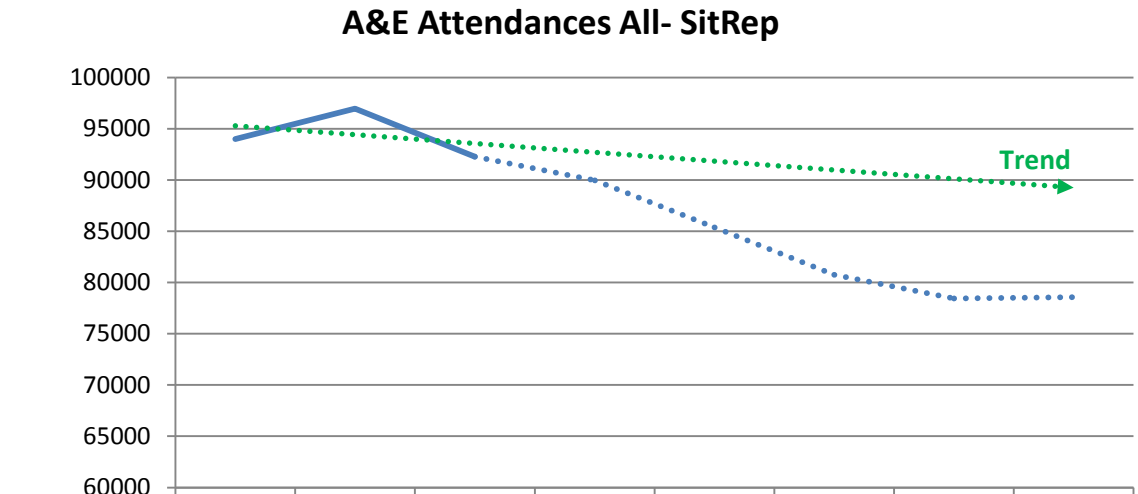
17.3.1 All first outpatient attendances in general & acute specialties



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	14/15 Plan	15/16 Plan
Halton per month	2938	3015	3293	3319	2973	3341	3445	3145	2867	3392	3162	3529	3435	3225	3262
Ave	3202	3202	3202	3202	3202	3202	3202	3202	3202	3202	3202	3202	3202	3202	3202

Increases in the number of outpatient attendances recorded at the general and acute trusts are expected in both 2014/15 and 15/16. These increases have been calculated in line with the different rates of demographic change differing age groups and the proportion of activity that is made up from those age groups. This equates to a small increase of 0.74% in the overall total number of outpatient admissions for 14/15 and a slightly larger increase of 1.16% for 2015/16

17.4 A&E Attendances[23]



	2011/12	2012/13	2013/14 Forecast	14/15 Plan	15/16 Plan	16/17 Plan	17/18 Plan	18/19 Plan
Halton CCG	94016	96959	92293	89985	85371	80756	78449	78582
Trend	94016	96959	92293					

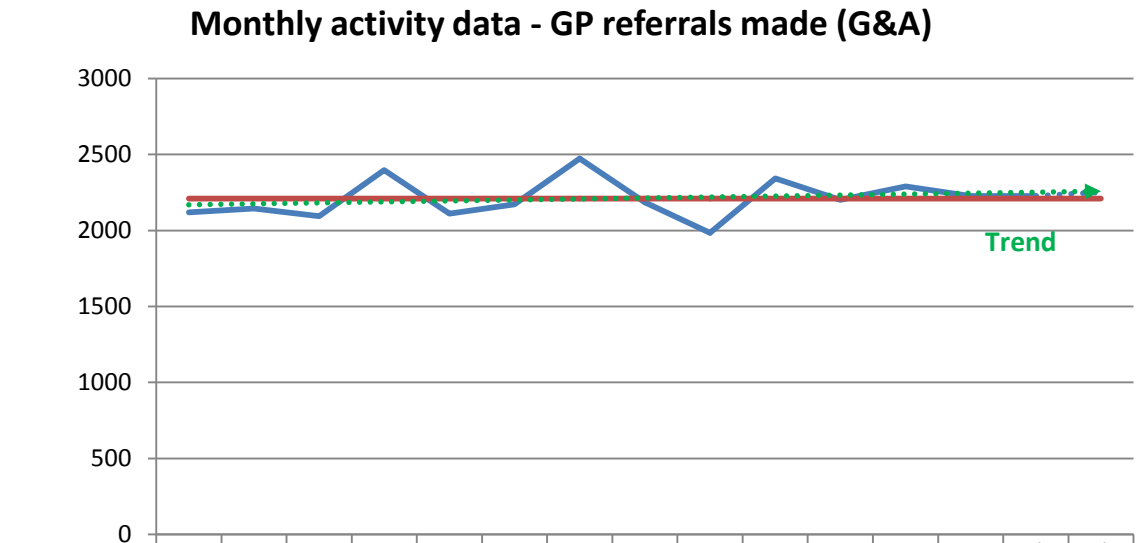
By implementing the commissioning intentions, including developing the Urgent Care Centres in Widnes and Runcorn the plan is to reduce A&E attendances by 2.5% in 14/15, 5% in both 15/16 and 16/17 and 2.5% in 17/18. This is significantly lower than would be expected by looking at the trend over the last three years (shown as the green dotted line in the chart above, it is also a planned reduction when demographic changes are forecasting an increase over the next five years.

This is a challenging but achievable goal. Independent economic analysis by i4 Health and Capita confirm that the scale of the ambition is achieveable.

[23] http://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/weekly-ae-sitreps-2012-13/

17.5 Referrals

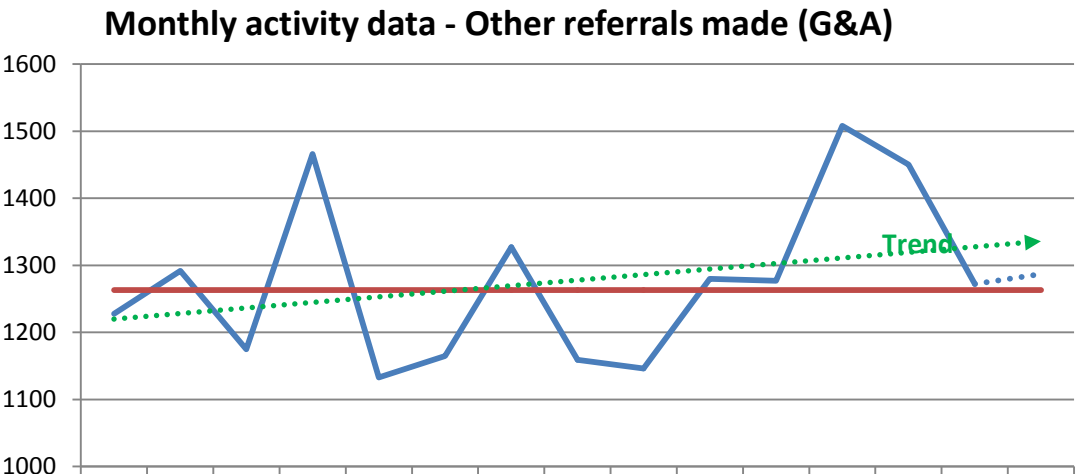
17.5.1 GP Referrals made (G&A)



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	14/15 Plan	15/16 Plan
Actual	2119	2144	2094	2397	2110	2173	2473	2184	1985	2343	2202	2289	2227	2226	2252
Average	2209	2209	2209	2209	2209	2209	2209	2209	2209	2209	2209	2209	2209	2209	2209

Small increases in activity have been planned for 14/15 and 15/16, these have been calculated based on demographic changes and the age breakdown in service use. This has been calculated as a 0.74% increase in 2014/15 and a further 1.16% increase in 15/16. This increase in activity is below the trend since April 2013 but follows the same trajectory.

17.5.2 Other referrals made (G&A)



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	14/15 Plan	15/16 Plan
Actual	1228	1292	1175	1466	1133	1165	1327	1159	1146	1280	1277	1508	1450	1272	1287
Average	1263	1263	1263	1263	1263	1263	1263	1263	1263	1263	1263	1263	1263	1263	1263

There have been large variations in the monthly figures available for Halton from April 2013. Over the last seven moths the average is 1263 per month and the trend is for an increasing number of other referrals

Small increases are planned for 2014/15 and 2015/16 based on anticipated increase in demand from demographic changes and the age profile of service users. This has been calculated as 0.74% for 2014/15 and 1.16% for 2015/16. The figures reported in the chart for these two years are the average number of 'other referrals' per month in that year.

18. Better Care Fund Plan

The 5 year strategic plan and 2 year operational plans have been developed alongside the Better Care Fund plan. The work that both NHS Halton CCG and Halton Borough Council are doing to integrate commissioning and service provision has identified 6 measures which provide good indications of the success of this integrated working. These are identified below.

18.1 Permanent admissions of older people (aged 65 and over) to residential and nursing care homes per 100,000 population.

Metrics		Current Baseline (as at….)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	439.7		816.2 (target)
	Numerator	82		N/A
	Denominator	18,648		N/A
		(April 2012 - March 2013)		(April 2014 - March 2015)

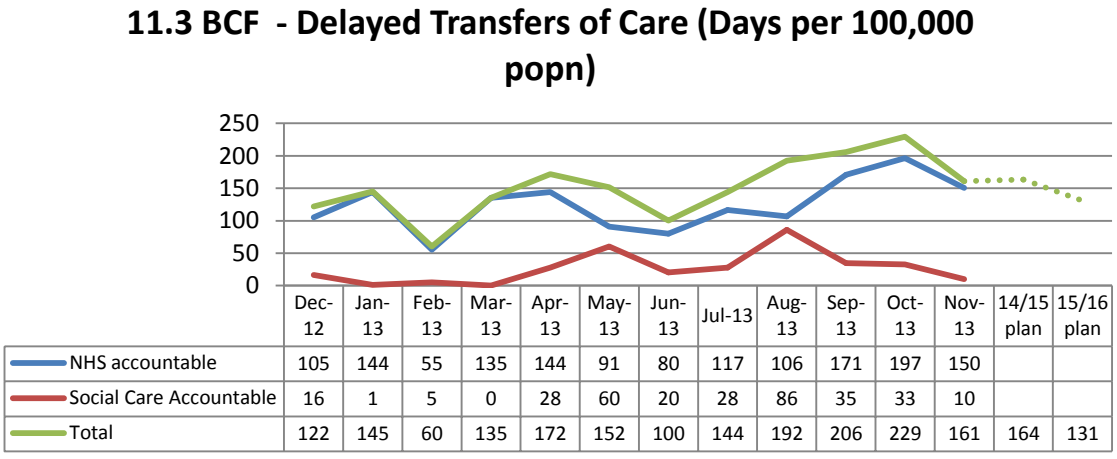
As a part of this scheme, there is a strong focus on assessing and intervening with people with complex needs, and their carers, at an earlier stage, providing care and support in the community for as long as possible. Expected outcomes and benefits include a reduction in the proportion of people requiring residential or nursing care, more people being supported to live at home, a reduction in the numbers of people requiring inpatient services, and improved reported quality of life.

18.2 Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services.

Metrics		Current Baseline (as at….)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	72.63%	N/A	68% (target)
	Numerator	69		N/A
	Denominator	95		N/A
		(April 2012 - March 2013)		(April 2014 - March 2015)

Continued developments of the intermediate care and reablement services will deliver a greater proportion of people who remain at home beyond 91 days of discharge from hospital. Additional benefits will include improved health outcomes, greater levels of personal independence and improved quality of life. These will be measured by the recorded national data sets on intermediate care and rehabilitation services, and by surveys which measure quality of life and satisfaction with services.

18.3 Delayed transfers of care from hospital per 100,000 population (average per month)



	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	14/15 plan	15/16 plan
NHS accountable	105	144	55	135	144	91	80	117	106	171	197	150		
Social Care Accountable	16	1	5	0	28	60	20	28	86	35	33	10		
Total	122	145	60	135	172	152	100	144	192	206	229	161	164	131

This measure has been calculated as the number of delayed transfers of care days per 100,000 18+ LA population. The number of patients per month is not available other than as a snapshot on the last Thursday of the month and this method of calculation has been specifically excluded in the technical guidance.

The baseline has been calculated as 172 days per 100,000 per month based on the most recent six month average (Jun 13 to Nov 13) and a mid 2012 18+ pop estimate of 97,677

The Plan for 14/15 is for a 5% reduction from 172 to 164.

The plan for 15/16 is for a return to the average seen between Dec 12 and May 2013. Calculated as 131 days per 100,000 per month.

18.4 Avoidable emergency admissions (composite measure)

Metrics		Current Baseline (as at….)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Avoidable emergency admissions (composite measure)	*Metric Value*	1561	1522	1483
	Numerator	1962	1913	1864
	Denominator	125,692	125,692	125,692
		(March 2013 - Aug 2013)	(April - September 2014)	(October 2014 - March 2015)

This measure is a composite of 4 emergency admission measures. The data has been taken from the Operational Planning Atlas tool[24]

NHS England will provide the baseline in January 2014, however there is little difference in looking at the performance over the last 6 month or 12 month period so a baseline of 260 per 100,000 has been used.

The plan for 14/15 is for a 2.5% reduction in admissions on the baseline.

The plan for 15/16 is for a 5% reduction on the baseline.

The redesign of the Urgent Care pathway (and in particular the development of the Urgent Care Centres), developments in preventive and early intervention services including Community Multidisciplinary Teams, and further developments with partners in diverting people with mental health needs from emergency care, will all result in a reduction in emergency admissions to hospital. This will be measured through the development of integrated performance measures with health service partners.

[24] http://ccgtools.england.nhs.uk/opa/flash/atlas.html

18.5 Patient / service user experience

The national metric will be used, this has yet to be developed but will be in place for 2015

18.6 Local Measure

Hospital readmissions where original admission was due to a fall (65+)

Metrics		Current Baseline (as at….)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Hospital readmissions where original admission was due to a fall (65+)	*Metric Value*	809.8	769.8	734.8
	Numerator	162	154	147
	Denominator	20,005	20,005	20,005
		(April 2012 - March 2013)	(April 2013 - March 2014)	(April 2014 - March 2015)

One of the areas of focus in the Health and Wellbeing Plan is the reduction in the number of falls. This has been selected as one of the local measures in the better care fund plan, it has also been selected as a CCG quality premium indicator.

Appendix A - Operational Plan Schemes

A1 Planned Care

Project Description		Develop a respiratory strategy for Halton and implement actions from the strategy. To include: 1) reviewing the pathway for people with sleep apnoea. This will include the possibility of using technology to manage sleep apnoea in the community, and considering whether weight management is part of the pathway 2) Reviewing the provision of spirometry services in Halton			
Ref	PC141501	Commissioning Area	Planned Care	Programme / Project	Respiratory
				Oversight Group	Respiratory Group
Desired Outcome		Completion of respiratory strategy (which will support the CCG in its work to reduce the likelihood of people developing a respiratory condition and improve outcomes for people who have a respiratory condition). This will be supported by an action plan, the actions from this will form a part of the 2014/15 commissioning plan once agreed.		Commissioning Lead	Steve Eastwood
				Clinical Lead	Dr Chris Woodforde
				Integrated Commissioning Partners	LA, PH, NHSE
				Better Care Fund Plan	No
Financial Impact		Informed by the Action plan, will expect to see an increase in prescribing but a reduction in the length of stay and a reduction in admissions. Overall expect to be cost neutral in the medium term with the potential for savings in the long term. Likely to be additional cost in relation to the provision of spirometry services		Strategic Objectives supported	CCGICS1, CCGICS3, NHSOF1, NHSOF2, NHSOF3

Milestones		
2014/15		2015/16
Q1	Strategy and action plan in place	Commissioning intentions implemented
Q2	Commissioning intentions developed from action plan	
Q3	Commissioning intentions implemented	
Q4	Commissioning intentions implemented	
Supporting measures	Prescribing spend, reduction in admissions, reduction in length of stay	

Project Description		Review pathway around cancer presentations. This will look at the evidence across all pathways, and will include examining the evidence to introduce a targeted screening programme to increase early detection rates of lung cancer			
Ref	PC141505	Commissioning Area	Planned Care	Programme / Project	Cancer & EOL
				Oversight Group	none
Desired Outcome		Increased early detection of cancer, reduced mortality from cancer		Commissioning Lead	Emma Alcock
				Clinical Lead	Dr Mel Forrest
				Integrated Commissioning Partners	PH
				Better Care Fund Plan	No
Financial Impact		External funding is available to support audit. Possibly increased costs following increased levels of diagnosis for increased scanning, increased treatment costs as more lung cancer detected.		Strategic Objectives supported	HHAWS1, NHSOF1, CCGICS1

Milestones		
2014/15		2015/16
Q1	Complete Primary Cancer Audit	Full roll out (if appropriate)
Q2	Completion of action plan / strategy & Business plan	
Q3	Potential pilot projects (if appropriate) begin	
Q4	Evaluation of pilot projects (if appropriate)	
Supporting measures	Long term- reduced mortality, short term - increased lung cancer staging data. (Primary lung cancers)	

Project Description		Implement tools to improve the sharing of information at the end of life: - Work towards implementing the EPACCs IT system - Improve the use of special patient notes in end of life care			
Ref	PC141506	Commissioning Area	Planned Care	Programme / Project	Cancer & EOL
				Oversight Group	None
Desired Outcome		Increased sharing of information at the end of life.		Commissioning Lead	Emma Alcock
				Clinical Lead	Dr Mel Forrest
				Integrated Commissioning Partners	NHSE
				Better Care Fund Plan	No
Financial Impact		Potential savings with regard to unplanned admissions		Strategic Objectives supported	NHSOF4, CCGOIS1, CCGICS4

Milestones		
2014/15		2015/16
Q1	Options paper available Jan 14. Possible development of interim viewer.	Should be available nationally by December 15.
Q2		
Q3		
Q4		
Supporting measures	Improvement seen in preferred place of care, reduced unplanned admissions in last 12 months of life	

Project Description		Implement the replacement for the Liverpool Care Pathway			
Ref	PC141507	Commissioning Area	Planned Care	Programme / Project	Cancer & EOL
				Oversight Group	None
Desired Outcome		Increased quality of care at the end of life		Commissioning Lead	Emma Alcock
				Clinical Lead	Dr Mel Forrest
				Integrated Commissioning Partners	LA, NHSE
				Better Care Fund Plan	No
Financial Impact		Possible small amount of additional costs relating to additional training,		Strategic Objectives supported	NHSOF4, CCGICS1

Milestones		
2014/15		2015/16
Q1	National guidance issued February. Task and finish group set up	
Q2	Actions dependent on requirements of national guidance	
Q3		
Q4		
Supporting measures		

Project Description		To review access to lifestyles services for patients with cancer, for example breast cancer weight loss and exercise programme			
Ref	PC141508	Commissioning Area	Planned Care	Programme / Project	Cancer & EOL
				Oversight Group	None
Desired Outcome		Improved quality of life, increased life expectancy		Commissioning Lead	Emma Alcock
				Clinical Lead	Dr Mel Forrest
				Integrated Commissioning Partners	PH
				Better Care Fund Plan	No
Financial Impact		Potential increase in costs in the short term, dependent on increased uptake. Should enable longer term cost savings		Strategic Objectives supported	NHSOF1, NHSOF2, CCGICS1

Milestones		
2014/15		2015/16
Q1	Plan in place	Roll out of services
Q2	Pilot begins	
Q3	Pilot evaluated	
Q4	Roll out of services	
Supporting measures		

Project Description		Review pathways for patients with cancer attending hospital to explore alternative models of follow up e.g. telephone follow up or GP Led			
Ref	PC141509	Commissioning Area	Planned Care	Programme / Project	Cancer & EOL
				Oversight Group	None
Desired Outcome		Reduced hospital based follow up for people with cancer		Commissioning Lead	Emma Alcock
				Clinical Lead	Dr Mel Forrest
				Integrated Commissioning Partners	None
				Better Care Fund Plan	No
Financial Impact		Should result in financial savings for hospital follow ups for prostates		Strategic Objectives supported	NHSOF2, CCGICS1

Milestones		
2014/15		2015/16
Q1	Initially looking at prostate. Pathway review & plan in place	Full rollout
Q2	Pilot begins	
Q3	Pilot	
Q4	Evaluation of pilot	
Supporting measures	Reduction in hospital follow ups – initially for prostate cases	

Project Description		Develop a Cardiovascular strategy for Halton and implement actions arising from the strategy. To include 1) Securing 1 day service provision for people who have had a TIA			
Ref	PC141510	Commissioning Area	Planned care	Programme / Project	CVD
				Oversight Group	CVD Board
Desired Outcome		Cardiovascular strategy which will support the CCG in its work to reduce the likelihood of people developing cardiovascular disease and improve outcomes for people who have cardiovascular disease. This will be supported by an action plan, the actions from this will form a part of the 2014/15 commissioning plan once agreed.		Commissioning Lead	Mark Holt
				Clinical Lead	Dr Mick O'Connor / Dr Damian McDermott
				Integrated Commissioning Partners	PH, LA, NHSE
				Better Care Fund Plan	No
Financial Impact		Expect to be cost neutral, but exact costing will be informed by the action plan.		Strategic Objectives supported	CCGICS1, NHSOF1, NHSOF2, NHSOF3

Milestones		
2014/15		2015/16
Q1	Strategy and action plan in place. Recommendations for TIA service in place for end of June 2014	To be informed by action plan
Q2	Commissioning intentions from action plan. TIA service in place	
Q3	To be informed by action plan	
Q4	To be informed by action plan	
Supporting measures	Reduction seen in under 75 mortality rate from CVD. Others informed by strategy. % of people seen by TIA service within 24 hours of stroke.	

Project Description		Review the cardiology direct access service			
Ref	PC141512	Commissioning Area	Planned Care	Programme / Project	CVD
				Oversight Group	CVD Board
Desired Outcome		Improved interpretation of echocardiogram results		Commissioning Lead	Steve Eastwood
				Clinical Lead	Mike Chester
				Integrated Commissioning Partners	None
				Better Care Fund Plan	No
Financial Impact		None		Strategic Objectives supported	CCGICS1, NHSOF1

Milestones		
2014/15		2015/16
Q1	Planning – need to baseline current level of dissatisfaction	
Q2	Improved reporting in place	
Q3	Review of new service. Has satisfaction increased?	
Q4		
Supporting measures	Increased GP satisfaction of echo results (from Hospital) from Baseline.	

Project Description		Review provision of services for people with diabetes who have developed foot problems			
Ref	PC141513	Commissioning Area	Planned Care	Programme / Project	CVD
				Oversight Group	CVD Board
Desired Outcome		Reduction in complications associated with foot problems in people with diabetes		Commissioning Lead	Emma Alcock
				Clinical Lead	Dr Damian McDermott
				Integrated Commissioning Partners	None
				Better Care Fund Plan	No
Financial Impact				Strategic Objectives supported	CCGICS1, NHSOF2

Milestones		
2014/15		2015/16
Q1	Review current pathways, services & outcomes (baseline foot checks at GP)	Review & monitor service
Q2	Develop foot care pathway	
Q3	Launch	
Q4		
Supporting measures	Improved performance in foot checks at GP. Reduction in amputations	

Project Description		Review the scope of the community diabetes provision			
Ref	PC141514	Commissioning Area	Planned Care	Programme / Project	CVD
				Oversight Group	CVD Board
Desired Outcome		Reduction in secondary care activity, improved outcomes for people with diabetes.		Commissioning Lead	Emma Alcock
				Clinical Lead	Dr Damian McDermott
				Integrated Commissioning Partners	Leslie Mills, Community Diabetes Nurse.
				Better Care Fund Plan	No
Financial Impact		Cost neutral or possible reduction in secondary spend		Strategic Objectives supported	CCGICS1, NHSOF1, NHSOF2, NHSOF3

Milestones		
2014/15		2015/16
Q1		Implement recommendations
Q2	Review the scope of the current service & develop recommendations	
Q3	Review the scope of the current service & develop recommendations	
Q4		
Supporting measures	Reduction in outpatient appointments at hospital. Fewer Hypo'. Improved measures QOF around blood & Cholesterol	

Project Description		Continue work on increasing integration in the Musculoskeletal (MSK) pathway			
Ref	PC141515	Commissioning Area	Planned Care	Programme / Project	Planned care general
				Oversight Group	None
Desired Outcome		Improved access to services, increased integration of services. Maintain/improve position on SPOT tool (lower spend, better outcomes) – Source NHS PH England		Commissioning Lead	Lyndsey Abercromby
				Clinical Lead	Dr Cliff Richards
				Integrated Commissioning Partners	None
				Better Care Fund Plan	No
Financial Impact		Intention that this will be within current financial envelope but some is AQP therefore increase demand – increase £		Strategic Objectives supported	CCGICS1, NHSOF3

Milestones		
2014/15		2015/16
Q1	Design new model	Implement new model
Q2	As above	
Q3	Secure new model	
Q4	As above	
Supporting measures		

Project Description		Review the gynae physiotherapy pathway			
Ref	PC141516	Commissioning Area	Planned care	Programme / Project	Planned care general
				Oversight Group	None
Desired Outcome		Clarity of gynae physiotherapy pathway, improved outcomes for people requiring gynae physiotherapy.		Commissioning Lead	Kate Wilding
				Clinical Lead	Dr Fenella Cottier
				Integrated Commissioning Partners	None
				Better Care Fund Plan	No
Financial Impact		Tbc as part of work. Appears no service funded at the moment so may require further financial investment		Strategic Objectives supported	CCGICS1

Milestones		
2014/15		2015/16
Q1	Define current provision	Monitor service
Q2	Define options and agree future state	
Q3	Implement future state	
Q4	As above	
Supporting measures		

Project Description		Increase access to and equity of provision of community gynae services			
Ref	PC141517	Commissioning Area	Planned Care	Programme / Project	Planned care general
				Oversight Group	none
Desired Outcome		Reduction in unnecessary referrals to secondary care		Commissioning Lead	Kate Wilding
				Clinical Lead	Dr Fenella Cottier
				Integrated Commissioning Partners	None
				Better Care Fund Plan	No
Financial Impact		Intention that this will be within existing £ / release £		Strategic Objectives supported	CCGICS1

Milestones		
2014/15		2015/16
Q1	Design new model	Implement
Q2	As above	
Q3	Secure new model	
Q4	As above	
Supporting measures	No of gynae 1st and f/u appointments	

Project Description		Review the provision of urology services			
Ref	PC141518	Commissioning Area	Planned Care	Programme / Project	Planned care general
				Oversight Group	none
Desired Outcome		Reduction in secondary care activity		Commissioning Lead	Emma Alcock
				Clinical Lead	? Dr Fenella Cottier
				Integrated Commissioning Partners	None
				Better Care Fund Plan	No
Financial Impact		Will be within existing resource / or will release £		Strategic Objectives supported	CCGICS1

Milestones		
2014/15		2015/16
Q1	Define current provision and activity	Implement alternatives
Q2	As above	
Q3	Scope and agree alternatives	
Q4	As above	
Supporting measures	No of urology first and follow up appointments in secondary care	

Project Description		Review the provision of the lymphoedema services			
Ref	PC141519	Commissioning Area	Planned care	Programme / Project	Planned care general
				Oversight Group	none
Desired Outcome		Improved access to service		Commissioning Lead	Emma Alcock
				Clinical Lead	? Dr Mel Forrest
				Integrated Commissioning Partners	None
				Better Care Fund Plan	No
Financial Impact		Not clear, may require £		Strategic Objectives supported	CCGICS1

Milestones		
2014/15		2015/16
Q1	Business case	Implement service
Q2	As above	
Q3	Secure service	
Q4	As above	
Supporting measures	No of patients accessing service, others to be determined as part of work	

Project Description		(TBC may be resolved in 2013/14) Review phlebotomy & pathology provision			
Ref	PC141520	Commissioning Area	Planned care	Programme / Project	Planned care general
				Oversight Group	None
Desired Outcome		increased quality of provision, increased equity of provision, increased access to information (if agreed as CQUIN)		Commissioning Lead	Lyndsey Abercromby
				Clinical Lead	Dr Cliff Richards, Dr Mick O'Connor
				Integrated Commissioning Partners	None
				Better Care Fund Plan	No
Financial Impact		Expected to be within current £ envelope, may still require small £ investment if need for domiciliary service established		Strategic Objectives supported	CCGICS1

Milestones		
2014/15		2015/16
Q1	Joint meeting with both main providers	
Q2	Other timescales to be agreed in CQUIN	
Q3		
Q4		
Supporting measures		

Project Description		(TBC may be resolved in 2013/14) Review access to termination of pregnancy services			
Ref	PC141521	Commissioning Area	Planned care	Programme / Project	Planned care general
				Oversight Group	none
Desired Outcome		Improved access to termination of pregnancy services. Clear contractual arrangements. Decision re need for number of providers		Commissioning Lead	Kate Wilding
				Clinical Lead	Dr Fenella Cottier
				Integrated Commissioning Partners	None
				Better Care Fund Plan	No
Financial Impact		Expected to be within current £ envelope		Strategic Objectives supported	CCGICS1, CCGICS5

Milestones		
2014/15		2015/16
Q1	Current contractual arrangement clarified and decision whether will be done on local footprint or wider	
Q2	Business case re need for other provider	
Q3	As above	
Q4	Secure provision (if needed)	
Supporting measures		

A2 Women Children & Families

Project Description		Contribute to on-going work of service reviews for children's community services including 1) To continue to review community services and investigate procurement of Community Paediatric Consultant service (following review of service this year)			
Ref	WCF141502	Commissioning Area	Children & Family	Programme / Project	Community Services
				Oversight Group	None
Desired Outcome		Improve the pathway for diagnosis and treatment of children with ADHD		Commissioning Lead	Sheila McHale
				Clinical Lead	Gill Frame
				Integrated Commissioning Partners	LA
				Better Care Fund Plan	No
Financial Impact		Potential financial savings – possible reduction in contract value. Will be a proportion of £650K		Strategic Objectives supported	CCGICS1, HHAWS2

Milestones		
2014/15		2015/16
Q1	Roll over existing contract – serve notice (due to changes in the service specification)	Potential savings will be made in 2015/16
Q2	Out to procurement	
Q3		
Q4	New service live before April 15/16	
Supporting measures	Increase in number of children transferred to Primary care under shared care protocol. (Baseline nil) Change in Ritalin prescribing from secondary care to Primary care.	

Project Description		Move to local community tariff basis for special schools orthoptic service and expand community provision on a tariff basis.			
Ref	WCF141503	Commissioning Area	Children & Family	Programme / Project	Community Services
				Oversight Group	None
Desired Outcome		Improved access to community based provision within time frames associated with tariff based service (18 weeks)		Commissioning Lead	Sheila McHale
				Clinical Lead	Gill Frame
				Integrated Commissioning Partners	LA
				Better Care Fund Plan	No
Financial Impact		There will a cost attached to expanding community provision £66K special schools		Strategic Objectives supported	CCGICS1, HHAWS2, NHSOF2, NHSOF4, NHSOF5

Milestones		
2014/15		2015/16
Q1	Contract variation	review
Q2	Move to tariff basis (from block)	
Q3		
Q4		
Supporting measures	Need to identify activity – expect to see reduction of waiting list and reduction in number waiting more than 18 weeks	

Project Description		Continue to review with possible procurement community midwifery service			
Ref	WCF141504	Commissioning Area	Children & Family	Programme / Project	Community services
				Oversight Group	None
Desired Outcome		Sustainable service in light of new national tariff, improved outcome for mothers and babies		Commissioning Lead	Sheila McHale
				Clinical Lead	Gill Frame
				Integrated Commissioning Partners	None
				Better Care Fund Plan	Yes
Financial Impact		Likely increase in cost due to tariff impact		Strategic Objectives supported	CCGICS1, NHSOF4, NHSOF5

Milestones		
2014/15		2015/16
Q1	Needs SDC review, wait for outcome of appraisal, Block / tariff	
Q2		
Q3		
Q4		
Supporting measures		

Project Description		Undertake review of Children's Speech & Language services with subsequent procurement during 2014/15			
Ref	WCF141505	Commissioning Area	Children & Family	Programme / Project	Community Services
				Oversight Group	Children's Trust
Desired Outcome		Improved access to community based provision within specified time frames with improved quality based outcome metrics		Commissioning Lead	Sheila McHale
				Clinical Lead	Gill Frame
				Integrated Commissioning Partners	LA
				Better Care Fund Plan	Yes
Financial Impact		Likely to be cost neutral		Strategic Objectives supported	CCGICS1, HHAWS2

Milestones		
2014/15		2015/16
Q1	Roll forward contract and give notice	New service running
Q2	Out to procurement	
Q3		
Q4	Possible new provider identified	
Supporting measures	Improved quality based outcome through Swemweb survey developed, reduction in waiting times, increased numbers going through service.	

Project Description		To support delivery of the Halton's mental Health Strategy in relation to young people including; 1) Continue review of emotional wellbeing and psychological pathway for young people with a view to delivering revised Tier 2 CAMHS specification and procurement during 2014/15			
Ref	WCF141508	Commissioning Area	Children & Family	Programme / Project	CAMHS
				Oversight Group	CAMHS partnership board
Desired Outcome		Improved. Ensure appropriate capacity and earlier transfer up to tier 3 where appropriate (e.g. self-harm).		Commissioning Lead	Sheila McHale / Simon Bell / Gareth Jones
				Clinical Lead	Gill Frame
				Integrated Commissioning Partners	LA
				Better Care Fund Plan	Yes
Financial Impact		Possible financial savings identified from 2015/16		Strategic Objectives supported	CCGICS1, HHAWS2, PHOF1, PHOF2

Milestones		
2014/15		2015/16
Q1	Revised specification end Q1	New service in place
Q2	Consultation	
Q3	Out to procurement	
Q4		
Supporting measures	Need to develop waiting time measures	

Project Description		(TBC may be resolved in 2013/14) Evaluate the Mersey QIPP pilot for children's community nursing service. Including evaluation and on-going funding for end of life care for children			
Ref	WCF141510	Commissioning Area	Children & Family	Programme / Project	Other
				Oversight Group	None
Desired Outcome		This may have to happen this year not next – Whiston hospital at home, pilot completed, service continuing. Could lead to possible inequity (Runcorn / Widnes) as service not currently funded for Warrington. This could be a minimum extra cost of £60k plus end of life care for children currently purchased as a pilot from Clare House Hospice at an extra cost of £25k		Commissioning Lead	Sheila McHale
				Clinical Lead	Gill Frame
				Integrated Commissioning Partners	LA
				Better Care Fund Plan	No
Financial Impact		Possible minimum extra cost of £85k p.a.		Strategic Objectives supported	CCGICS1, HHAWS2

Milestones		
2014/15		2015/16
Q1	Await outcome of SDC, minimum cost of £85k p.a.	
Q2		
Q3		
Q4		
Supporting measures	Maintain current position with regard to early discharge.	

Project Description		Review of the Halton Women's centre			
Ref	WCF141511	Commissioning Area	Children & Family	Programme / Project	Other
				Oversight Group	Children's Trust
Desired Outcome		Improve outcomes for people experiencing domestic abuse		Commissioning Lead	Sheila McHale
				Clinical Lead	Gill Frame
				Integrated Commissioning Partners	LA
				Better Care Fund Plan	Yes
Financial Impact		none		Strategic Objectives supported	CCGICS1, NHSOF4

Milestones		
2014/15		2015/16
Q1	Review service Q1 & Q2	
Q2		
Q3	Work with LA to produce new spec	
Q4		
Supporting measures	Number of women experiencing domestic abuse AND attending service. Swemweb survey developed.	

Project Description		Amend existing asthma care provision for children to build on work done currently to divert emergency admissions and A&E presentations to the new Urgent care centre			
Ref	WCF141512	Commissioning Area	Planned Care	Programme / Project	Respiratory
				Oversight Group	Respiratory Group
Desired Outcome		Reduction in emergency admissions and A&E presentations related to common paediatric conditions in Children.		Commissioning Lead	Kate Wilding / Sheila McHale
				Clinical Lead	Dr Chris Woodforde /Gill Frame
				Integrated Commissioning Partners	LA
				Better Care Fund Plan	No
Financial Impact		Reduce PBR A&E attendance by 5% in year one and 15% by end of year two. Proportionate savings will be made on the current £1.05M spend at Warrington and Whiston. It is anticipated that there will also be a reduction in Urgent Admissions at Whiston of between 3 and 5% due to the reduction in the number of A&E attendances. (between £38,000 and £64,000) at current tariff		Strategic Objectives supported	CCGICS1, NHSOF1, NHSOF2, NHSOF3

Milestones		
2014/15		2015/16
Q1	Data review	
Q2	Take part in Urgent Care project plan preparation work with GP's	
Q3	First diversions / data gather	
Q4	Assess outcome & take remedial action if required	
Supporting measures	Reduction in A&E attendance / admissions at WHH and StHK	

A3 Primary & Community care

Project Description		Strengthen the GPs role at the heart of out of hospital care and supporting people to stay healthy by identifying people at risk of hospital admission including the introduction of a named accountable clinician			
Ref	PCI141501	Commissioning Area	Primary & Community	Programme / Project	Community
				Oversight Group	None
Desired Outcome		Reduction in the number of emergency admissions/readmissions, individual patient care plans, integrated working and self-care		Commissioning Lead	Jo O'Brien
				Clinical Lead	Dr David Lyon
				Integrated Commissioning Partners	LA
				Better Care Fund Plan	Yes
Financial Impact		Tbc, possible reduction in secondary care spend		Strategic Objectives supported	CCGICS1, NHSOF2

Milestones		
2014/15		2015/16
Q1	National guidance issued April/May, strategic group established	
Q2	Actions dependent on requirements of guidance	
Q3		
Q4		
Supporting measures	Reduced emergency admissions, increase patient care plans, increased use of self-care. Further measures to be developed using Swemweb and EQ5D	

Project Description		Review the design of community services to focus on outcome based services			
Ref	PCI141503	Commissioning Area	Primary & Community	Programme / Project	Community
				Oversight Group	None
Desired Outcome		Increased integration, improved outcomes for patients, reduction in inappropriate hospital admissions for conditions normally managed within community		Commissioning Lead	Jo O'Brien
				Clinical Lead	Dr David Lyon
				Integrated Commissioning Partners	LA, PH
				Better Care Fund Plan	Yes
Financial Impact		Expect to be cost neutral		Strategic Objectives supported	CCGICS1, CCGICS3

Milestones		
2014/15		2015/16
Q1	Review current services, service specifications & outcomes in line with CCG priorities and integrated care model	
Q2	As above	
Q3	Develop recommendations and revised specifications following reviews	
Q4	Develop recommendations and revised specifications following reviews	
Supporting measures	Increased integration of services, KPI and outcome measures	

Project Description		To support GP practices and other providers where appropriate to deliver services over and above their core contractual responsibilities (Local Commissioning Schemes – previously known as Enhanced Services)			
Ref	PCI141505	Commissioning Area	Primary & Community	Programme / Project	Primary
				Oversight Group	None
Desired Outcome		Improved patient experience, continuity of care, care closer to home, more integrated care, reduction in inappropriate admissions / A&E attendances		Commissioning Lead	Julie Holmes
				Clinical Lead	Dr Gary O'Hare, Dr Salil Veedu
				Integrated Commissioning Partners	NHSE
				Better Care Fund Plan	No
Financial Impact		Tbc however will require initial investment. Longer term objective is the shift from secondary care into primary/community care as services are developed within the community to reduce activity within secondary care		Strategic Objectives supported	CCGICS1, NHSOF2, NHSOF4,

Milestones		
2014/15		2015/16
Q1	Identify gaps/opportunities in service provision in line with commissioning priorities. Prioritise above and develop a timetable for implementation. Service specifications developed and relevant procurement route to be confirmed, contracts awarded. This work is on-going throughout the year and can commence at any point therefore the process will remain the same.	
Q2	As above	
Q3	As above	
Q4	As above	
Supporting measures	KPI and outcome measures monitored, impact on secondary care activity	

<table>
<tr><td colspan="2">Project Description</td><td colspan="4">A strategy for sustainable general practice services in Halton</td></tr>
<tr><td>Ref</td><td>PCI141506</td><td>Commissioning Area</td><td>Primary & Community</td><td>Programme / Project</td><td>Primary</td></tr>
<tr><td colspan="4" rowspan="5">Desired Outcome</td><td>Oversight Group</td><td>To be agreed</td></tr>
<tr><td colspan="4" rowspan="4">The problem is that general practice services in Halton are not sustainable and there is no agreed strategy to address this. NHS Halton CCG, with NHS England, will support member practices to develop and agree a strategy to deliver sustainable general practice services in Halton. Sustainable general practice services are required to:
• Reduction in variation
• Increase capacity in general practice and the reconfiguration of urgent in hours primary care to reduce unnecessary admissions
• Enable 7/7 working
• Improve long term condition management, particularly for frail and/or elderly people
• Reduce health inequalities
• Increase patient choice and access
• Develop specialist skills, knowledge and service delivery amongst the local workforce providing general practice services
• Provide local service alternatives in straight forward planned care
• Develop a plan for managing the changing age and skill profiles of the local general practice workforce</td><td>Commissioning Lead</td><td>Jo O'Brien</td></tr>
<tr><td>Clinical Lead</td><td>Dr Gary O'Hare, Dr Salil Veedu, Dr Cliff Richards</td></tr>
<tr><td>Integrated Commissioning Partners</td><td>NHSE as the commissioner and principal contractor for general practice services in Halton.
17 general practices in Halton as small/medium businesses and independent contractors within the NHS</td></tr>
<tr><td>Better Care Fund Plan</td><td>No</td></tr>
<tr><td colspan="2">Financial Impact</td><td colspan="2">Tbc, however whilst contractual responsibility sits with NHSE may require considerable CCG staff input which may put pressures on existing core work</td><td>Strategic Objectives supported</td><td>CCGICS3</td></tr>
</table>

Milestones		
2014/15		2015/16
Q1	Agreement on problem statement across key stakeholders	Implementation of final strategy continues
Q2	Development and comparison of alternative strategies	
Q3	Agreement on final strategy.	
Q4	Implementation and evaluation plan agreed and final strategy delivery begins	
Supporting measures	The Key process measure will be the delivery of an agreed strategy for general practice services across Halton. Other process and outcome measures will be developed	

Project Description		Support NHS England in ensuring quality in primary care			
Ref	PCI141508	Commissioning Area	Primary & Community	Programme / Project	Primary
				Oversight Group	None
Desired Outcome		Reduction in variation across membership practices, increased prevalence and screening in line with national averages. Protected time for peer review and learning & development		Commissioning Lead	Jo O'Brien
				Clinical Lead	Dr Gary O'Hare, Dr Salil Veedu
				Integrated Commissioning Partners	NHSE
				Better Care Fund Plan	No
Financial Impact		Cost neutral		Strategic Objectives supported	NHSOF4

Milestones		
2014/15		2015/16
Q1	Identify areas of variance and agree work programme for 14/5. Work with NHS E and neighbouring CCGs to agree common dashboard for Primary Care Quality	
Q2	Launch above with members and continue to monitor through Primary Care Quality & Development Group. Develop programme of practice support though PLT and Peer review.	
Q3	As above	
Q4	As above	
Supporting measures	Reduction in variation in key areas including prevalence, screening and prescribing.	

Project Description		Develop an Integration Health & Social Care IM&T Strategy & work plan to include; 1) exploring ways for clinicians and carers to have access to the same information regardless of setting, 2) explore opportunities for OOH providers to have access to primary care record OOH, 3) use of Telehealth and telemedicine to improve patient care, 4) identify the benefits and possibly introduction of Map of Medicine and 5) extending the uptake and use of Choose & Book to improve pathways to hospital and patient choice			
Ref	PCI141510	Commissioning Area	Primary & Community	Programme / Project	Primary
				Oversight Group	None
Desired Outcome		Joint Strategy developed and work plan implemented, increased interoperability between providers, increased use of summary care records for continuity of care, increased patient choice, care closer to home		Commissioning Lead	Jo O'Brien
				Clinical Lead	Dr David Wilson
				Integrated Commissioning Partners	LA
				Better Care Fund Plan	Yes
Financial Impact		Actual cost tbc, however likely to be significant overall but some funding for informatics provided centrally		Strategic Objectives supported	CCGICS3

Milestones		
2014/15		2015/16
Q1		
Q2		
Q3		
Q4		
Supporting measures		

Project Description		Explore the potential for introduction of a programme of care for Familial hypercholesterolemia			
Ref	PCI141512	Commissioning Area	Primary & Community	Programme / Project	Primary
				Oversight Group	None
Desired Outcome		Reduction in people dying prematurely, enhanced quality of life and experience of care for people with long-term conditions		Commissioning Lead	Julie Holmes
				Clinical Lead	Not applicable
				Integrated Commissioning Partners	PH
				Better Care Fund Plan	No
Financial Impact				Strategic Objectives supported	CCGICS3, NHSOF1, NHSOF2

Milestones		
2014/15		2015/16
Q1	Review the scope of the current service & develop recommendations	
Q2	As above	
Q3	Implement findings from recommendations	
Q4	As above	
Supporting measures	Reduction in strokes, improved measures QOF around Cholesterol	

Project Description		Secure provision of community services from 2015 - new			
Ref	PCI141514	Commissioning Area	Primary & Community	Programme / Project	Community
				Oversight Group	None
Desired Outcome		VfM contract that reflects the needs of the population of Halton supporting more integrated care in the community with a focus on improved outcome measures and a reduction in unnecessary admission to hospital.		Commissioning Lead	Jo O'Brien
				Clinical Lead	Dr David Lyon
				Integrated Commissioning Partners	LA, PH
				Better Care Fund Plan	Yes
Financial Impact		Reduction in current community contract value however will only be informed by the new service specifications		Strategic Objectives supported	CCGICS1, CCGICS3

Milestones		
2014/15		2015/16
Q1	Establish process for procurement and agree services to be considered for procurement	
Q2	As per procurement guide timetable	
Q3	As per procurement guide timetable	
Q4	As per procurement guide timetable	
Supporting measures	Services agreed signed off in quarter 2, procurement timetable adhered to	

A4 Mental Health & Unplanned care

Project Description		Develop local services to reduce suicide attempts			
Ref	MHUC141 501	Commissioning Area	Mental Health & Unplanned Care	Programme / Project	Mental Health
				Oversight Group	5BP Contract Board Mental Health strategic commissioning board
Desired Outcome		Reduce excess mortality in people with mental health problems known to services and from suicide		Commissioning Lead	Jennifer Owen/ Simon Bell
				Clinical Lead	Dr Anne Burke, Dr Elspeth Anwar
				Integrated Commissioning Partners	PH, LA
				Better Care Fund Plan	Yes
Financial Impact		Cost of CPN would be at least £50k. there would be potential savings across the whole health economy but not all of these would be aligned to CCG budgets		Strategic Objectives supported	NHSOF1, NHSOF2, CCGICS1
Milestones					
2014/15				2015/16	
Q1	Suicide prevention strategy development, Pilot around A&E Liaison				
Q2	Implement actions from suicide prevention strategy. Pilot CPN with police across Warrington & Halton				
Q3	As above				
Q4					
Supporting measures	Reduction in suicide attempts				

Project Description		Review the AED liaison psychiatry model across Mid Mersey CCGs			
Ref	MHUC141 502	Commissioning Area	Mental Health & Unplanned Care	Programme / Project	Mental Health
				Oversight Group	5BP contract Board Bridgewater Oohs contract Board-WCCG WHHFT contract board STH&K contract Board Mental Health strategic commissioning board
Desired Outcome		Acute and emergency care for people in mental health crisis is as accessible and high-quality as for physical health emergencies. Ensure equitable liaison psychiatry services to support effective crisis care – Linked to MHUC141501		Commissioning Lead	Jennifer Owen
				Clinical Lead	Dr Anne Burke
				Integrated Commissioning Partners	Other CCGs
				Better Care Fund Plan	No
Financial Impact				Strategic Objectives supported	NHSOF2, NHSOF3, NHSOF4, NHSOF5, HHWS 5, CCGOIS1
Milestones					
2014/15				2015/16	
Q1					
Q2					
Q3					
Q4					
Supporting measures	No variation in 4-hour A&E waits between providers for people in mental health crisis				

Project Description		Develop and launch safe in town initiative across the Borough of Halton			
Ref	MHUC141 503	Commissioning Area	Mental Health & Unplanned Care	Programme / Project	Mental Health
				Oversight Group	Mental Health strategic commissioning board
Desired Outcome		Increase in vulnerable groups feeling safe in their communities		Commissioning Lead	Mark Holt and Lynne Edmondson
				Clinical Lead	Dr David Lyon, Lisa Birtles Smith
				Integrated Commissioning Partners	LA
				Better Care Fund Plan	Yes
Financial Impact				Strategic Objectives supported	NHSOF2, CCGICS1

Milestones		
2014/15		2015/16
Q1		
Q2		
Q3		
Q4		
Supporting measures		

Project Description		Work with other North West CCGs to secure provision of an IAPT service for military veterans			
Ref	MHUC141 504	Commissioning Area	Mental Health & Unplanned Care	Programme / Project	Mental Health
				Oversight Group	5BP contract board IAPT mobilisation group Mental Health strategic commissioning board
Desired Outcome		Improved outcomes for patients		Commissioning Lead	Lynne Edmondson
				Clinical Lead	Dr Anne Burke
				Integrated Commissioning Partners	Other CCGs
				Better Care Fund Plan	No
Financial Impact				Strategic Objectives supported	HHWS5. NHSOF3, NHSOF4, NHSOF5, CCGOIS1

Milestones		
2014/15		2015/16
Q1		
Q2		
Q3		
Q4		
Supporting measures		

Project Description		Review and redesign current eating disorder service			
Ref	MHUC141 506	Commissioning Area	Mental Health & Unplanned Care	Programme / Project	Mental Health
				Oversight Group	CWP contract board 5BP contract board Mental Health strategic commissioning board
Desired Outcome		Improved outcomes for patients		Commissioning Lead	Sheila McHale, Lynne Edmondson, Kate Wilding
				Clinical Lead	Dr Anne Burke
				Integrated Commissioning Partners	Other CCGs
				Better Care Fund Plan	No
Financial Impact				Strategic Objectives supported	HHWS5. NHSOF3, NHSOF4, NHSOF5

Milestones		
2014/15		2015/16
Q1		
Q2		
Q3		
Q4		
Supporting measures		

Project Description		Implement the action plan from the Health Needs Assessment for Learning Disabilities			
Ref	MHUC141 507	Commissioning Area	Mental Health & Unplanned Care	Programme / Project	Learning Disabilities
				Oversight Group	LD Partnership Board
Desired Outcome		Improve outcomes for people with learning disabilities		Commissioning Lead	Lynne Edmondson
				Clinical Lead	Lisa Birtles Smith
				Integrated Commissioning Partners	LA
				Better Care Fund Plan	Yes
Financial Impact				Strategic Objectives supported	NHSOF1, NHSOF2, NHSOF4, CCGICS1, PHOF01, PHOF02.

Milestones		
2014/15		2015/16
Q1		
Q2		
Q3		
Q4		
Supporting measures		

Project Description		Develop alternative employment opportunities for vulnerable groups			
Ref	MHUC141 508	Commissioning Area	Mental Health & Unplanned Care	Programme / Project	Learning Disabilities
				Oversight Group	LD Partnership board
Desired Outcome		Improve emotional wellbeing and support individual personal development		Commissioning Lead	Lynne Edmondson
				Clinical Lead	Lisa Birtles Smith
				Integrated Commissioning Partners	LA
				Better Care Fund Plan	Yes
Financial Impact		£50k provision for working farm		Strategic Objectives supported	NHSOF2, CCGOIS1

Milestones		
2014/15		2015/16
Q1		
Q2		
Q3		
Q4		
Supporting measures		

Project Description		Roll out of learning disabilities health checks to under 16s			
Ref	MHUC141 510	Commissioning Area	Mental Health & Unplanned Care	Programme / Project	
				Oversight Group	
Desired Outcome		Improve outcomes for people with learning disabilities		Commissioning Lead	Lynne Edmondson
				Clinical Lead	Lisa Birtles Smith
				Integrated Commissioning Partners	LA
				Better Care Fund Plan	Yes
Financial Impact		Public Health – no funding implications		Strategic Objectives supported	NHSOF1, NHSOF2, NHSOF4. CCGICS1, PHOF1, PHOF2.

Milestones		
2014/15		2015/16
Q1		
Q2		
Q3		
Q4		
Supporting measures		

Project Description		Delivery of Direct Enhanced Service for Dementia within general practice, to increase awareness and screening for dementia.			
Ref	MHUC141 511	Commissioning Area	Mental Health & Unplanned Care	Programme / Project	Dementia
				Oversight Group	Dementia partnership board
Desired Outcome		67% target for diagnosis by March 2015		Commissioning Lead	Mark Holt
				Clinical Lead	Dr David Lyon
				Integrated Commissioning Partners	LA
				Better Care Fund Plan	Yes
Financial Impact				Strategic Objectives supported	NHSOF2, HHAWS5, CCGOIS1

Milestones		
2014/15		2015/16
Q1		
Q2		
Q3		
Q4		
Supporting measures	C2.13 Estimated diagnosis rate for people with dementia	

Project Description		Support the regional procurement of NHS 111 through identified clinical and managerial leads			
Ref	MHUC141 513	Commissioning Area	Mental Health & Unplanned Care	Programme / Project	Urgent care
				Oversight Group	Urgent care working group
Desired Outcome		A tender for another provider of 111 services will be undertaken across Merseyside, with the outcome to improve access to health advice and reduce need to access GP		Commissioning Lead	Jane Hulme / Lynne Edmondson
				Clinical Lead	Dr Neil Martin
				Integrated Commissioning Partners	Other CCGs
				Better Care Fund Plan	Yes
Financial Impact				Strategic Objectives supported	NHSOF1

Milestones		
2014/15		2015/16
Q1		
Q2		
Q3		
Q4		
Supporting measures		

Project Description		Implement the Urgent Care redesign preferred model			
Ref	MHUC141 514	Commissioning Area	Mental Health & Unplanned Care	Programme / Project	Urgent Care
				Oversight Group	Urgent care working group
Desired Outcome		Reduction in inappropriate A&E attendances and subsequent admissions		Commissioning Lead	Damian Nolan
				Clinical Lead	Dr Neil Martin
				Integrated Commissioning Partners	None
				Better Care Fund Plan	No
Financial Impact		£600k recurrence spend, will result in 5% savings 14/15 and 10% 15/16		Strategic Objectives supported	NHSOF2, NHSOF3, CCGOIS1

Milestones		
2014/15		2015/16
Q1		
Q2		
Q3		
Q4		
Supporting measures		

Project Description		Care Home Liaison Service – To establish a single supplementary specialist service for dementia patients that's able to effectively respond and meet the multiple and complex needs of a care home population through the provision of enhanced support			
Ref	MHUC141 515	Commissioning Area	Mental Health & Unplanned Care	Programme / Project	None Identified
				Oversight Group	Dementia Board
Desired Outcome		The primary objective of the service is to manage the care pathways into and out of care homes, to improve patient care, reduce current levels of illness and prevent unscheduled admissions / readmissions from care homes into secondary care. This service takes active steps to reduce referrals to primary care, ultimately enabling people to remain in their own care home as long as it remains appropriate.		Commissioning Lead	Jenny Owen
				Clinical Lead	David Lyon
				Integrated Commissioning Partners	None
				Better Care Fund Plan	No
Financial Impact		Cost of £150k for 14/15		Strategic Objectives supported	

Milestones		
2014/15		2015/16
Q1		
Q2		
Q3		
Q4		
Supporting measures		

A5.1 Communication

Project Description		Investigate the reasons behind the number of people who do not attend appointments (DNA's). Review practices and develop methods for reduction			
Ref	ADD141501	Commissioning Area	Other	Programme / Project	Communication
				Oversight Group	None
Desired Outcome		Reduction in DNA's across all service areas		Commissioning Lead	Des Chow, Lyndsey Abercromby
				Clinical Lead	Diane Henshaw
				Integrated Commissioning Partners	None
				Better Care Fund Plan	No
Financial Impact		none		Strategic Objectives supported	NHSOF4, CCGICS1

Milestones		
2014/15		2015/16
Q1	Data & evidence gathering including literature review	Actions developed & quick wins started
Q2	Develop & distribute survey	
Q3	Collection and analysis of data	
Q4	Final report	
Supporting measures	From 2015/16 Q2 onwards look to see a reduction in DNA's	

Project Description		Continue to develop mechanisms to ensure we listen to the whole population, including young people and BME communities			
Ref	ADD141502	Commissioning Area	Other	Programme / Project	Communication
				Oversight Group	None
Desired Outcome		Proportionate representation evidenced from public engagement events and consultation exercises. Look especially at the 'protected characteristics' group		Commissioning Lead	Des Chow
				Clinical Lead	N/a
				Integrated Commissioning Partners	LA
				Better Care Fund Plan	Yes
Financial Impact		none		Strategic Objectives supported	CCGICS1, CCGICS2

Milestones		
	2014/15	2015/16
Q1	Identify protected characteristics groups for Halton	
Q2	Ensure all surveys are proportionately targeted to protected characteristics groups.	
Q3		
Q4		
Supporting measures	Evidence of proportionate representation from BME & protected characteristics groups.	

A5.2 Quality

Project Description		Work towards reporting on the quality of services at GP practice level and also at the level of consultant-led teams for a number of specific specialties			
Ref	ADD141503	Commissioning Area	Other	Programme / Project	Quality
				Oversight Group	Quality Committee
Desired Outcome		Production of relevant dashboard & reporting mechanisms Improved quality of services. Reporting as near to real time as possible.		Commissioning Lead	Jan Snoddon
				Clinical Lead	Jan Snoddon
				Integrated Commissioning Partners	None
				Better Care Fund Plan	No
Financial Impact				Strategic Objectives supported	NHSOF4, NHSOF2, CCGOIS1, CCGOIS4

Milestones		
2014/15		2015/16
Q1	Review current provision – define what's needed – need to get as close to real time as possible.	
Q2		
Q3		
Q4	Need to report by domains by end of year.	
Supporting measures		

Project Description		Extend the friends and family test in line with national timescales, including Mental Health and Community based services from April			
Ref	ADD141504	Commissioning Area	Other	Programme / Project	Quality
				Oversight Group	Quality Committee
Desired Outcome		Improved quality of services		Commissioning Lead	Jan Snoddon
				Clinical Lead	Jan Snoddon
				Integrated Commissioning Partners	None
				Better Care Fund Plan	No
Financial Impact		CQUIN with Bridgwater.		Strategic Objectives supported	NHSOF4

Milestones		
2014/15		2015/16
Q1	Pilot 2 GP practices with F&FT, 5BP to collect data in Q1	Full implementation
Q2	First reports generated from 5BP and GP pilots	
Q3	Review success / otherwise of pilot with view to wider roll out	
Q4	Preparation for full implementation with community svs /MH	
Supporting measures		

Project Description		Implement the commissioning outcomes of both the Francis report and the government response			
Ref	ADD141505	Commissioning Area	Other	Programme / Project	Quality
				Oversight Group	Quality Committee
Desired Outcome		Improved quality of services. - Duty of candour - Clinical leadership - Competency		Commissioning Lead	Jan Snoddon
				Clinical Lead	Jan Snoddon
				Integrated Commissioning Partners	None
				Better Care Fund Plan	No
Financial Impact		Cquin with 5BP/BW/ & acute trusts. To show evidence of duty of candour, quality strategy, visibility of clinical leads		Strategic Objectives supported	NHSOF2, NHSOF4, NHSOF5, HICS1,

Milestones		
2014/15		2015/16
Q1	Review of performance against last year and against Cavendish review, 'patients first' government response and Berwick re patient safety collaborative.	
Q2	Presentation and report against updates	
Q3		
Q4		
Supporting measures	Evidence of training programmes, mandatory training. i.e. Infection control, safeguarding	

Project Description		Develop process to monitor and improve quality standards in secondary care including appropriate use of SHMI and HSMR mortality figures			
Ref	ADD141506	Commissioning Area	Other	Programme / Project	Quality
				Oversight Group	Quality committee
Desired Outcome		Evidence of work undertaken by the acute trusts to investigate mortality figures and report findings and areas for improvement are actioned.		Commissioning Lead	Jan Snoddon
				Clinical Lead	Jan Snoddon
				Integrated Commissioning Partners	None
				Better Care Fund Plan	No
Financial Impact				Strategic Objectives supported	NHSOF1, NHSOF5, PHOF1

Milestones		
	2014/15	2015/16
Q1		
Q2		
Q3		
Q4		
Supporting measures		

A5.3 Process & Policy

Project Description		Review the process for applying for grants from the CCG			
Ref	ADD141507	Commissioning Area	Other	Programme / Project	Process & Policy
				Oversight Group	None
Desired Outcome		Clear and transparent process developed, available and implemented		Commissioning Lead	Dave Sweeney
				Clinical Lead	Mike Chester
				Integrated Commissioning Partners	None
				Better Care Fund Plan	No
Financial Impact				Strategic Objectives supported	CCGICS4

Milestones		
2014/15		2015/16
Q1		
Q2		
Q3		
Q4		
Supporting measures		

Project Description		Further develop integrated services between the NHS and Local Authorities for people with complex needs			
Ref	ADD141508	Commissioning Area	Other	Programme / Project	Process & Policy
				Oversight Group	None
Desired Outcome		Develop integration further between the LA and CCG, ensure included in better care fund plan and integrated commissioning framework		Commissioning Lead	Sue Wallace Bonner
				Clinical Lead	Jan Snoddon
				Integrated Commissioning Partners	LA, CCG
				Better Care Fund Plan	Yes
Financial Impact				Strategic Objectives supported	NHSOF2

Milestones		
2014/15		2015/16
Q1		
Q2		
Q3		
Q4		
Supporting measures		

Project Description		Develop plans in relation to the Better Care Fund			
Ref	ADD141509	Commissioning Area	Other	Programme / Project	Process & Policy
				Oversight Group	None
Desired Outcome		Production of plan, which will lead to increased delivery of integrated care		Commissioning Lead	Emma Sutton Thompson / Mike Shaw
				Clinical Lead	Cliff Richards
				Integrated Commissioning Partners	LA/CCG
				Better Care Fund Plan	Yes
Financial Impact				Strategic Objectives supported	CCGICS1, CCGICS2, CCGICS2

Milestones		
2014/15		2015/16
Q1		
Q2		
Q3		
Q4		
Supporting measures		

A5.4 Medicines Optimisation

Project Description		Ensure appropriate prescribing of antibacterials			
Ref	ADD141510	Commissioning Area	Other	Programme / Project	Medicines Optimisation
				Oversight Group	None
Desired Outcome		Reduction in Antibiotic prescribing seen		Commissioning Lead	Lucy Reid
				Clinical Lead	Dr Claire Forde. Dr Jan Breeden
				Integrated Commissioning Partners	None
				Better Care Fund Plan	No
Financial Impact		Small amount of savings possible in meds spend and possible quality payment on reduction in HCAI's		Strategic Objectives supported	CCGICS1, NHSOF3, NHSOF2

Milestones		
2014/15		2015/16
Q1	Quality Prescribing Initiative in place (Q1 to Q3)	
Q2		
Q3	Communication strategy re patients, public and GP's, piece of work needs to be regarding triangulating A&E admissions & attendances for infections & antibiotic prescribing rates)	
Q4		
Supporting measures	Reduction of 10% in prescribing of antibiotics, reduction In antibiotic prescribing for those antibiotics associated with HCAI's (C.diff & MRSA)	

Project Description		Reduce variation in prescribing between Practices			
Ref	ADD141511	Commissioning Area	Other	Programme / Project	Medicines Optimisation
				Oversight Group	None
Desired Outcome		Variation reduced between highest and lowest volume practices		Commissioning Lead	Lucy Reid
				Clinical Lead	Dr Claire Forde. Dr Jan Breeden
				Integrated Commissioning Partners	None
				Better Care Fund Plan	No
Financial Impact		Achieve Quip target.		Strategic Objectives supported	NHSOF3, CCGICS1

Milestones		
2014/15		2015/16
Q1	Initially targeting practices which have the biggest financial impact	
Q2	All practices targeted	
Q3		
Q4		
Supporting measures	Identify key areas of variation by Q1, be able to tell if gap is shrinking. Can use EPACT data from September onwards.	

Project Description		Develop an Integrated approach with Local Authority with community pharmacies			
Ref	ADD141512	Commissioning Area	Other	Programme / Project	Medicines Optimisation
				Oversight Group	None
Desired Outcome		In community pharmacy services in place commissioned jointly by LA and CCG		Commissioning Lead	Lucy Reid
				Clinical Lead	Dr Claire Forde. Dr Jan Breeden
				Integrated Commissioning Partners	LA/CCG
				Better Care Fund Plan	Yes
Financial Impact		Not known yet		Strategic Objectives supported	CCGICS1, NHSOF3

Milestones		
2014/15		2015/16
Q1	Investigating proposals for community pharmacy services	
Q2	To be decided depending on investigations.	
Q3		
Q4		
Supporting measures		

Appendix B: What has influenced our Plans?

B1 National Drivers

B1.1 NHS Mandate[25]

In November 2013 the Department of Health issued the refreshed NHS Mandate.

The objectives in the Mandate focus on the areas identified as being of greatest importance to people, these include

- Preventing ill health
- Managing on-going physical and mental health conditions such as dementia
- Helping people recover from episodes of ill health such as stoke or following injury
- Better care not just better treatment
- Providing safe care – people are treated in a clean and safe environment

The updated mandate reflects the Government's priority to transform the way in which the NHS provides care for older people and those with complex needs – from a system which is reactive, responding when something goes wrong to a proactive service, which is centred around the needs of each individual patient.

This is something which is already being addressed in Halton but has been identified as one of our areas for strategic focus over the next five years.

The Mandate also sets out the ambition for GPs to be responsible for co-ordinating this patient-centred care.

A significant element of NHS Halton CCG's 5 year strategic plan is to review and enhance how GPs and their practices work together and with providers to achieve the best outcomes for patients.

B1.2 The NHS Belongs To The People: A Call To Action[26]

The NHS faces an unprecedented level of future pressure. This is the definitive conclusion of *The NHS Belongs To The People: A Call To Action,* published by NHS England in July 2013.

This report highlighted a number of future pressures that threaten to overwhelm the NHS.

- An ageing population.
- A significant increase in the number of people with long-term conditions – for example, heart disease, diabetes and hypertension.

[25] https://www.gov.uk/government/publications/nhs-mandate-2014-to-2015
[26] http://www.england.nhs.uk/2013/07/11/call-to-action/

- Lifestyle risk factors in the young.
- Greater public expectations.
- Rising costs and constrained financial resources.

The resulting increase in demand combined with rising costs mean that fundamental changes will need to be made to how we deliver and use health care services.

The NHS Belongs To The People: A Call To Action highlights that these changes are about finding ways to do things differently, such as using technology to improve productivity, putting people in charge of their own health and care, integrating health and care services and more.

Some of the changes identified in *The NHS Belongs To The People: A Call To Action* are already underway in Halton. Integrated commissioning has already begun between NHS Halton CCG and Halton Borough Council but we intend to do more, there are opportunities to provide more care outside of hospitals, refocusing on prevention, matching services more closely to individuals' risks, harnessing new technology and making better use of data between organisations.

These opportunities in Halton have been described in more detail in the integrated transformation plan completed in partnership with Halton Borough Council and the two year CCG operational delivery plan.

The strategic directions identified by the CCG 5 year plan are closely aligned to the requirements identified in the NHS Call to Action.

B1.3 NHS Call to Action – Commissioning for Prevention[27]

The NHS Call to Action – Commissioning for prevention document highlighted some of the national statistics highlighting the benefits of prevention, both in terms of financial cost and patient outcomes.
Smoking cessation, suicide prevention and Atrial Fibrillation diagnosis and early treatment have all been shown to have significant short term benefits as well as long term improved outcomes. NHS Halton CCG is committed to improve services in all these areas both now and in the future.
'Commissioning for prevention' also highlighted 5 steps in the planning process

- Analyse Key Health problems
- Prioritise and set common goals
- Identify high-impact programmes
- Plan resources
- Measure and experiment

Proactive prevention has been highlighted as an area of strategic priority for NHS Halton CCG over the next five years.

[27] http://www.england.nhs.uk/wp-content/uploads/2013/11/call-to-action-com-prev.pdf

B1.4 NHS Outcomes Framework[28]

In November 2013 the Department of health published the NHS Outcomes Framework for 2014/15 this is to be read alongside The Mandate from the Government to NHS England.

The domains for 2014/15 remain the same as those for 2013/14 however it was announced that there would be a refresh for 2015/16. The domains are:

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

NHS Halton CCG has aligned this 5 year strategy and delivery plans to the NHS Outcomes Framework, with each project being measured using one or more of the domains.

B1.5 Mid Staffordshire NHS Public Enquiry (Francis Report)[29]

Following an extensive inquiry into failings at Mid-Staffordshire NHS Foundation Trust, Robert Francis QC published his final report on 6th February 2013.

It told a story of appalling suffering of many patients within a culture of secrecy and defensiveness. The inquiry highlighted a whole system failure. A system which should have had checks and balances in place, and working, to ensure that patients were treated with dignity, and suffered no harm.

The 1,782 page report had 290 recommendations with major implications for all levels of the health service across England. It called for a whole service, patient centred focus. The detailed recommendations did not call for a reorganisation of the system, but for a re-emphasis on what is important, to ensure that this does not happen again.

The essential aims identified are to

[28] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/256456/NHS_outcomes.pdf
[29] http://www.midstaffspublicinquiry.com/report

- Foster a common culture shared by all in the service of putting the patient first;
- Develop a set of fundamental standards, easily understood and accepted by patients, the public and healthcare staff, the breach of which should not be tolerated;
- Provide professionally endorsed and evidence-based means of compliance with these fundamental standards which can be understood and adopted by the staff who have to provide the service;
- Ensure openness, transparency and candour throughout the system about matters of concern;
- Ensure that the relentless focus of the healthcare regulator is on policing compliance with these standards;
- Make all those who provide care for patients – individuals and organisations – properly accountable for what they do and to ensure that the public is protected from those not fit to provide such a service;
- Provide for a proper degree of accountability for senior managers and leaders to place all with responsibility for protecting the interests of patients on a level playing field;
- Enhance the recruitment, education, training and support of all the key contributors to the provision of healthcare, but in particular those in nursing and leadership positions, to integrate the essential shared values of the common culture into everything they do;
- Develop and share ever improving means of measuring and understanding the performance of individual professionals, teams, units and provider organisations for the patients, the public, and all other stakeholders in the system.

B1.6 Keogh Report[30]

On 6th February 2013, the Prime Minister announced that he had asked Professor Sir Bruce Keogh, NHS Medical Director for England, to review the quality of care and treatment provided by those NHS trusts and NHS foundation trusts that were persistent outliers on mortality indicators. A total of 14 hospital trusts were investigated as part of this review. The review of all 14 trusts has been completed. At both a local and national level, key findings have been collated and examined and recommendations have been made.

The ambitions below have been identified in the report as being common challenges facing the wider NHS, NHS Halton CCG will be reviewing its position in relation to these ambitions and taking any necessary action to ensure that we meet the highest standards.

Ambition 1

We will have made demonstrable progress towards reducing avoidable deaths in our hospitals, rather than debating what mortality statistics can and can't tell us about the quality of care hospitals are providing.

[30] http://www.nhs.uk/NHSEngland/bruce-keogh-review/Pages/published-reports.aspx

Ambition 2

The boards and leadership of provider and commissioning organisations will be confidently and competently using data and other intelligence for the forensic pursuit of quality improvement. They, along with patients and the public, will have rapid access to accurate, insightful and easy to use data about quality at service line level.

Ambition 3

Patients, carers and members of the public will increasingly feel like they are being treated as vital and equal partners in the design and assessment of their local NHS. They should also be confident that their feedback is being listened to and see how this is impacting on their own care and the care of others.

Ambition 4

Patients and clinicians will have confidence in the quality assessments made by the Care Quality Commission, not least because they will have been active participants in inspections.

Ambition 5

No hospital, however big, small or remote, will be an island unto itself. Professional, academic and managerial isolation will be a thing of the past.

Ambition 6

Nurse staffing levels and skill mix will appropriately reflect the caseload and the severity of illness of the patients they are caring for and be transparently reported by trust boards.

Ambition 7

Junior doctors in specialist training will not just be seen as the clinical leaders of tomorrow, but clinical leaders of today. The NHS will join the best organisations in the world by harnessing the energy and creativity of its 50,000 young doctors.

Ambition 8

All NHS organisations will understand the positive impact that happy and engaged staff have on patient outcomes, including mortality rates, and will be making this a key part of their quality improvement strategy.

B1.7 National Audit Office Report – Maternity services in England[31]

In November 2013 the National Audit Office published its report into maternity services in England.

Overall the report was generally positive about maternity services nationally, but it did highlight that the variation across the country should be addressed.

"NHS maternity services provide good outcomes and positive experiences for most women during a very important time in their lives. Since the Department of Health's 2007 strategy, there have been improvements in maternity services, but the variation in performance across the country, and our findings on how services are being managed, demonstrate there is substantial scope for further improvement. The Department's implementation of its strategy has not matched its ambition."[32]

In terms of the performance relating to Halton residents, this has been highlighted for three trusts where complications or interventions arose.

Liverpool Women's NHS Foundation Trust
Performance significantly worse than the national average for Injury to neonate, better than average for infection rates (neonate), lower emergency caesarean section rate, Higher induction of labour and instrumental delivery
St Helens & Knowsley NHS Foundation Trust
Performance significantly worse for emergency readmission rates (28 days), neonate, and infection rate neonate, higher induction of labour rates and lower instrumental delivery rates
Warrington & Halton NHS Foundation Trust
Performance was statistically better than average for 3rd and 4th degree perineal tears, but significantly worse than average for; Emergency readmission rates 28 days neonate, injury to neonate, emergency admission within 30 days (maternal), infection rates neonate and higher than average rates of induction of labour.

The Maternity, Children and Young People's Strategic Clinical Network will be supporting a review of maternity services across Cheshire and Merseyside. This review will involve providers, commissioners, professional bodies, local authorities (including public health), Healthwatch and people who access maternity services. The review programme is sponsored by NHS Halton CCG on behalf of Merseyside CCGs. It is due to commence in May 2014 and will have the objective of producing a strategy to deliver sustainable, high quality maternity services across Cheshire and Merseyside. The timescales for this review are still to be determined.

[31] https://www.nao.org.uk/report/maternity-services-england/
[32] Amyas Morse, head of the National Audit Office, 8 November 2013

B1.8 Housing Services[33]

A report by the National Housing Federation and endorsed by the NHS Alliance identified where GP Practices could serve their populations closer to home and more cost effectively through developing constructive collaborations with their local housing partners.
Supported housing services help older and vulnerable residents live healthier, more independent lives. Services can include simple adaptations like handrails and ramps, hospital discharge projects, or combined support and accommodation packages for people with mental health problems, adults with learning disabilities or people living with dementia.

B1.9 New approaches to commissioning

Prime Contractor
NHS Halton CCG will be investigating implementing 'Prime Contractor' arrangements for a whole pathway of care or model of care where tiers of care are closely networked, enabling alignment of incentives and accountability for quality improvement and capacity management.

B2 Local Drivers

B2.1 Finance

Taking anticipated growth into account the cumulative effect of the 'do nothing position' would be a shortfall of £39m over the next five years. Savings are required to be found in each of the next five years.

The Dr Foster Hospital Guide 2013[34] highlights NHS Halton CCG as one of just six CCGs in the country which were identified as an area of 'smart spending' between 2011 and 2013.
These are areas where money has been identified as being used more effectively with regard to avoidable emergency admissions and less effective procedures.
NHS Halton CCG showed a reduction of 6% in the number of avoidable emergency admissions, whilst at the same time there has been a reduction of 25% in the number of less effective procedures being carried out.

B2.1.1 Independent economic assessment

Independent Assurance of Financial and Operational plan QIPP savings

[33] http://www.housing.org.uk/media/press-releases/gps-unsure-how-to-commission-vital-support-services
[34] http://myhospitalguide.drfosterintelligence.co.uk/#/download-centre

Between October 2013 and June 2014 the commissioning intentions and associated financial impact have been developed and incorporated into the financial plan and the 5 and 2 year plans.

The financial savings allocated to some of the commissioning intentions have been calculated using the information available such as anticipated levels of change in activity and the expected unit costs attached to this activity.

In order to provider further, independent, assurance as to the feasibility of these commissioning intentions to achieve the necessary level of savings an independent health economics organisation ,i5 Health Ltd, was commissioned.

In addition, Capita, were commissioned to provide a retrospective, current and future view of health and social care activity, spend and patient flows across the Mid Mersey Area, covering NHS Halton, Knowsley, St Helens and Warrington CCG's. This additional investigation has also provided assurance that the current focus of commissioning is the correct one and that significant savings are possible in Acute care without destabilising the Acute care providers.

Methodology

Both i5 and Capita have used different methods to calculate the potential levels of benefit available in the health economy, however both paint a similar picture.

I5 reviewed actual Halton Acute patient data over a seven month period from April to October 2013, using the actual numbers of patients attending A&E, what time they attended, how long they were admitted for (if they were admitted) what treatment / diagnostics they received (if any) the types and acuity of the conditions they presented with and the costs associated with the attendance and/or admittance i5 have calculated the actual cost of activity which could have been treated elsewhere

Capita have used a more statistical approach in that whilst they looked at the same data they have also looked at the variations between General Practices and what the potential savings would be if some (but not all) of this variation could be removed. After taking into account variations in age and deprivation related heath there remain variations in activity such as A&E Attendance and Non-elective activity which are potential areas that savings could be made. Capita have calculated two levels of savings, one based on the reduction of the variation between practices to the best quartile of practices, the second level of savings is based on the schemes identified in the BCF and operational plans and in Capita's judgement would be the maximum amount of saving available.

Both i5 and Capita have assumed some growth in electives and Capita goes into some detail around the significant shift in elective activity towards daycase.

Neither i5 nor Capita have factored in the cost of the schemes needed in the community or elsewhere to achieve the savings in the Acute sector

Headline figures

Savings Identified, (figures in £,000's)						
Financial Plan (2 year)*	Financial Plan (5 year)*	Operational plan (2 year)	I5 Health***	BCF****	Capita likely savings (5 year)*****	Capita Max savings (5 Year)******
3,708	7,951	3,930	3,638	377	1,665	3,393

* The Financial plan figures reported here are the cumulative recurrent QIPP savings and do not include running cost, tariff and price efficiency savings)

*** The sum total of i5 Health's savings is actually £5,978,000 (adjusted for a more realistic A&E attendance cost), however this include schemes in which the savings overlap, when an adjustment is made for this the total amount of savings available in acute care is £4,522,000, This includes some schemes which have not been identified in the operational plan such as 'Roving GP support with Ambulance crews' When these schemes are excluded the total amount of savings for schemes which match in i5 and the operational plan is £3,638,000

**** The savings identified in the BCF are the top level reported in the template, this does not show the breakdown of all savings, as some schemes whilst saving money in the acute sector will cost money elsewhere.

*****The Capita likely savings are based on reductions on acute activity to the best performing 25% of Practices in regards to A&E attendance, Outpatient appointments (first and follow up), Avoidable emergency admissions and early supported discharge.

******The Capita Max savings scenario includes savings identified in the BCF and operational plan, since these plans over cover a two year period the bulk of the £3,393,000 savings identified as 5 year, will in fact be achieved in the first two years, assuming that the Urgent care centre and reduction in variations in general practice activity can be achieved

Conclusion

Overall both the i5 and Capita assessments give assurance that the commissioning intentions are focussed in the right areas (Acute care, Older people),and that the level of savings identified in the financial and operational plan are broadly achievable, although at the top end of what is possible.

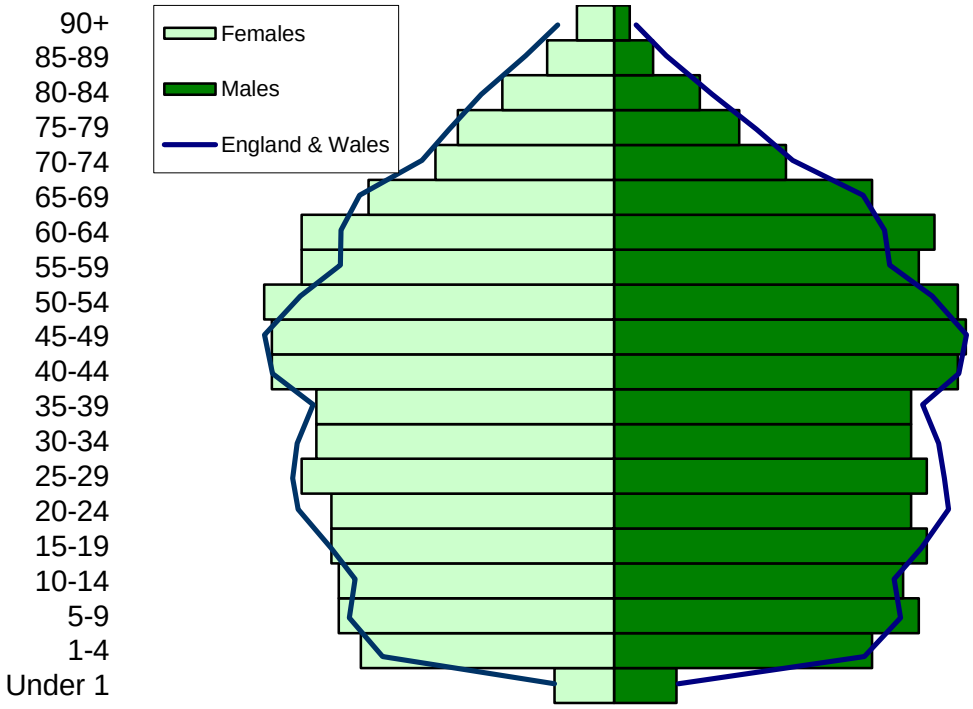
B2.2 Joint Strategic Needs Assessment[35]

The Joint Strategic Needs Assessment (JSNA) provides valuable data on the health and wellbeing of the population of Halton. The data within this document has been used to inform NHS Halton CCG when developing its vision for the next five years and its future commissioning intentions. The full document is available online, however selected data have been reproduced here.

B2.2.1 Demographics

As highlighted in the NHS Call to Action and the NHS mandate an ageing population presents a future pressure to the NHS. Halton is not immune to these pressures, the chart below shows the population profile for Halton for 2012

2012 population profile for Halton.



- **In the short term (2011 - 2014)** Halton's population is projected to grow by 1% from 125,700 to 126,800
- **In the medium term (2011 - 2017)** Halton's population is projected to grow by 2% from 125,700 to 128,000

[35] http://www3.halton.gov.uk/councilanddemocracy/statisticsandcensusinformation/318888/

- **In the long term (2011 - 2021)** Halton's population is projected to grow by 3% from 125,700 to 129,300. This is still lower than the North West region which is projected to grow by 4% and nationally, which is projected to grow by 9%
- **Younger people (0 - 15 year olds)** - population projected to grow by 10% (2011 - 2021)
- **Working age (16 - 64 year olds)** - population projected to decline by 5% (2011 - 2021)
- **Older people (65+)** - population projected to grow by 33% from 18,600 in 2011 to 24,700 in 2021

Following national and regional trends, Halton's population continues to age with older people making up an increasing proportion of the population. The growth in the numbers of older people will increase the demands for both formal and informal support. Small decreases in the working age population mean there are fewer people to provide and pay for this additional support.

Source: Halton JSNA

B2.2.2 Dementia

As highlighted in the NHS mandate, Dementia is one of the areas identified as an area of greatest importance to people.
Halton GP practices currently perform very well in relation to the early identification of people with dementia with an estimated diagnosis rate of 59.5%, this is the 2nd highest in the north west, and 12th highest CCG area nationally (out of 211)

The table below shows how the number of people predicted to have dementia is expected to increase to 2020

People aged 65 and over predicted to have dementia, by age, projected to 2020[36]					
	2012	2014	2016	2018	2020
People aged 65-69	81	92	99	92	90
People aged 70-74	126	137	142	173	189
People aged 75-79	218	223	228	235	252
People aged 80-84	312	312	335	345	359
People aged 85-89	283	283	300	339	361
People aged 90	209	209	209	237	268
Total population aged 65 and over predicted to have dementia	1,229	1,256	1,314	1,421	1,518

[36] Source: POPPI *Table produced on 05/12/13 16:44 from www.poppi.org.uk version 8.0 Figures may not sum due to rounding. Crown copyright 2012*

There is predicted to be a 23.5% increase in the number of people with dementia over the next 7 years, this is an additional 289 older people.

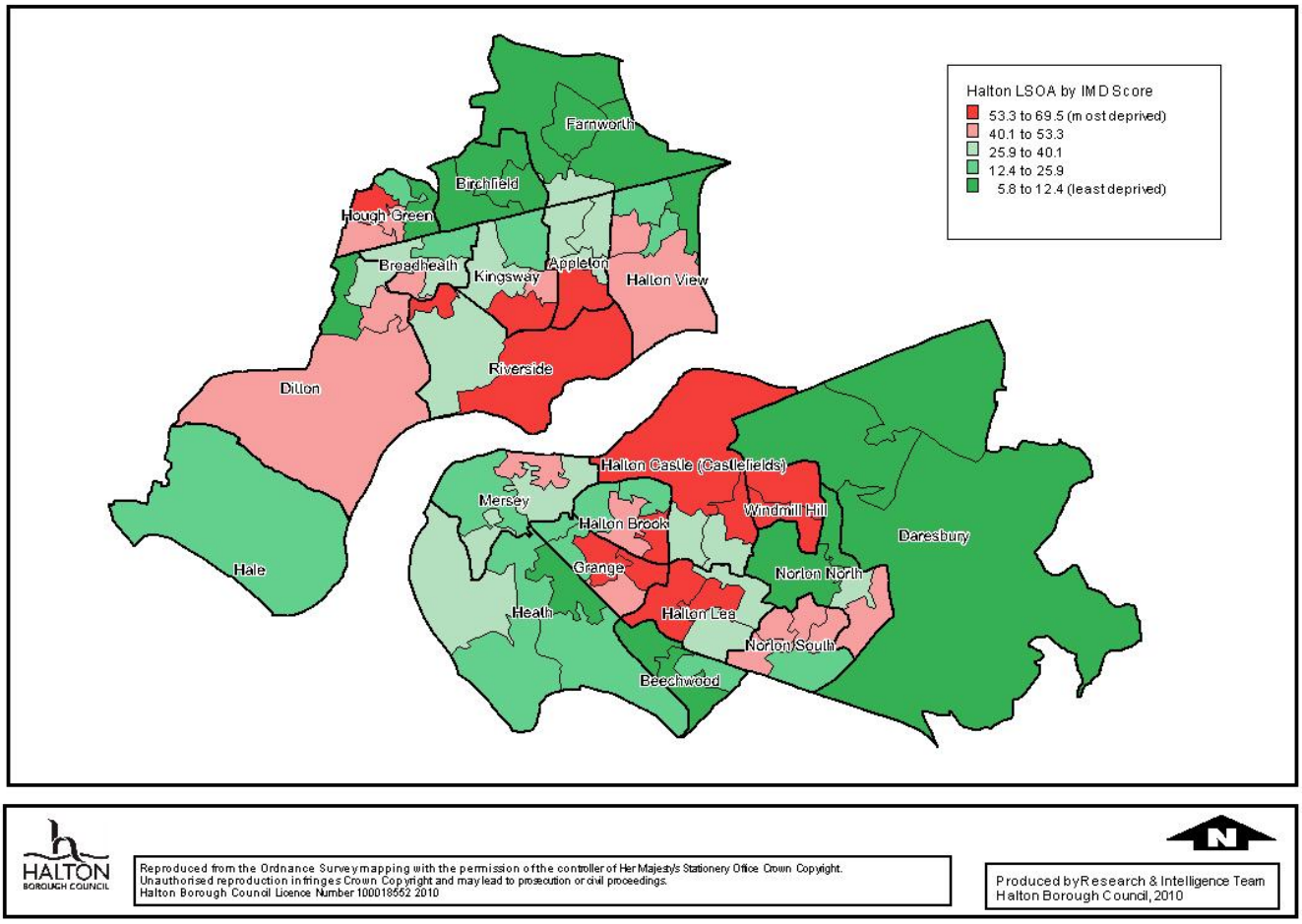
B2.2.3 Deprivation Profile

The JSNA identifies that Halton is a relatively deprived community, deprivation can have a significant impact of the health of communities and one of the areas highlighted as a strategic objective for the CCG over the next five years is to reduce the health impact of these inequalities.

B2.2.4 Index of Multiple Deprivation (IMD) 2010

- Halton is ranked as the 27th most deprived local authority in England (out of 326 local authorities). This is the 3rd worst out of the six local authorities which make up the Liverpool City Region, behind Liverpool and Knowsley.
- The ward with the highest average IMD score in 2010 and therefore the most deprived ward in Halton is Windmill Hill. The least deprived ward in Halton is Birchfield.
- The overall IMD is made up of seven domain measures. Daresbury ward does well across all of these whilst Windmill Hill has some of the highest scores.
- Deprivation scores at small area geography (known as Lower Super Output Areas) shows that the area with the highest deprivation is located in Kingsway ward.
- There are 21 LSOAs in Halton that fall in the top 10% most deprived nationally. Of these, 10 fall in the top 3% most deprived nationally and 2 fall in the top 1%.

Map 1: Overall IMD 2010 score at LSOA level in Halton[37]



Source: Halton JSNA

37 http://www3.halton.gov.uk/lgnl/policyandresources/policyplanningtransportation/researchandintelligence/pdfs/IMD2010report.pdf

B2.3 Health Profile[38]

The health of people in Halton is generally worse than the England average. Deprivation is higher than average and about 7,000 children live in poverty. Life expectancy for both men and women is lower than the England average.

Life expectancy is 11.1 years lower for men and 10.8 years lower for women in the most deprived areas of Halton than in the least deprived areas.

Over the last 10 years, all cause mortality rates have fallen. The early death rate from heart disease and stroke has fallen but is worse than the England average. The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.[39]

●	Significantly worse than England average
●	Not significantly different from England average
●	Significantly better than England average

[38] http://www3.halton.gov.uk/lgnl/policyandresources/318448/318454/HealthProfile2012Halton00ET.pdf

[39] *1 % people in this area living in 20% most deprived areas in England, 2010 2 % children (under 16) in families receiving means-tested benefits & low income, 2010 3 Crude rate per 1,000 households, 2011/12 4 % at Key Stage 4, 2011/12 5 Recorded violence against the person crimes, crude rate per 1,000 population, 2011/12 6 Crude rate per 1,000 population aged16-64, 2012 7 % mothers smoking in pregnancy where status is known, 2011/12 8 % mothers initiating breast feeding where status is known, 2011/12 9 % school children in Year 6 (age 10-11), 2011/12 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population, 2007/08 to 2009/10 (pooled) 11 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2009-2011 12 % adults aged 18 and over, 2011/12 13 % aged 16+ in the resident population, 2008-2009 14 % adults, modelled estimate using Health Survey for England 2006-2008 15 % adults achieving at least 150 mins physical activity per week, 20 12 16 % adults, modelled estimate using Health Survey for England 2006 -2008 17 Directly age standardised rate per 100,000 population, aged under 75, 2008-2010 18 Directly age sex standardised rate per 100,000 population, 201 1/12 19 Directly age sex standardised rate per 100,000 population, 2010/11 20 Estimated users of opiate and/or crack cocaine aged 15-64, crude rate per 1,000 population, 2010/11 21 % people on GP registers with a recorded diagnosis of diabetes 2011/12 22 Crude rate per 100,000 population, 2009-2011 23 Crude rate per 100,000 population, 2012 (chlamydia screening coverage may influence rate) 24 Directly age and sex standardised rate for emergency admissions, per 100,000 population aged 65 and over, 2011/12 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.08-31.07.11 26 At birth, 2009-2011 27 At birth, 2009-2011 28 Rate per 1,000 live births, 2009-2011 29 Directly age standardised rate per 100,000 population aged 35 and over, 2009-2011 30 Directly age standardised rate per 100,000 population aged under 75, 2009-2011 31 Directly age standardised rate per 100,000 population aged under 75, 2009-2011 32 Rate per 100,000 population, 2009-2011*

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	**1** Deprivation	61431	48.9	20.3	83.7		0.0
	2 Proportion of children in poverty	6770	27.3	21.1	45.9		6.2
	3 Statutory homelessness	64	1.3	2.3	9.7		0.0
	4 GCSE achieved (5A*-C inc. Eng & Maths)	808	59.0	59.0	31.9		81.0
	5 Violent crime	1737	14.6	13.6	32.7		4.2
	6 Long term unemployment	1106	13.4	9.5	31.3		1.2
Children's and young people's health	**7** Smoking in pregnancy ‡	335	21.2	13.3	30.0		2.9
	8 Starting breast feeding ‡	812	51.3	74.8	41.8		96.0
	9 Obese Children (Year 6) ‡	242	19.4	19.2	28.5		10.3
	10 Alcohol-specific hospital stays (under 18)	42	153.9	61.8	154.9		12.5
	11 Teenage pregnancy (under 18) ‡	126	51.8	34.0	58.5		11.7
Adults' health and lifestyle	**12** Adults smoking	n/a	23.1	20.0	29.4		8.2
	13 Increasing and higher risk drinking	n/a	22.5	22.3	25.1		15.7
	14 Healthy eating adults	n/a	22.7	28.7	19.3		47.8
	15 Physically active adults	n/a	49.8	56.0	43.8		68.5
	16 Obese adults ‡	n/a	25.9	24.2	30.7		13.9
Disease and poor health	**17** Incidence of malignant melanoma	22	18.4	14.5	28.8		3.2
	18 Hospital stays for self-harm	500	416.4	207.9	542.4		51.2
	19 Hospital stays for alcohol related harm ‡	3739	2834	1895	3276		910
	20 Drug misuse	818	9.8	8.6	26.3		0.8
	21 People diagnosed with diabetes	7108	7.0	5.8	8.4		3.4
	22 New cases of tuberculosis	1	1.1	15.4	137.0		0.0
	23 Acute sexually transmitted infections	988	786	804	3210		162
	24 Hip fracture in 65s and over	141	600	457	621		327
Life expectancy and causes of death	**25** Excess winter deaths ‡	31	8.7	19.1	35.3		-0.4
	26 Life expectancy – male	n/a	76.5	78.9	73.8		83.0
	27 Life expectancy – female	n/a	80.7	82.9	79.3		86.4
	28 Infant deaths	7	4.6	4.3	8.0		1.1
	29 Smoking related deaths	232	277	201	356		122
	30 Early deaths: heart disease and stroke	114	82.4	60.9	113.3		29.2
	31 Early deaths: cancer	197	142.7	108.1	153.2		77.7
	32 Road injuries and deaths	41	32.6	41.9	125.1		13.1

Health Profile summary for Halton 2013

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- No significance can be calculated

Domain	Indicator	Halton compared to England: 2013 profile	Halton improved or worsened since 2012 profile.	Comments on data
Our communities	**1** Deprivation			Across England this figure has become worse.
	2 Children in poverty			Across England this figure has become worse.
	3 Statutory homelessness			2012/13 published data shows number and rate have gone up to 86 people (1.7 per 1,000), from 64 and 1.3 per 1,000 in 2011/12.
	4 GCSE achieved (5A*-C Inc. Eng & Maths)			No updated data available.
	5 Violent crime			No updated data available.
	6 Long term unemployment			England average also worsened.
Children & young people's health	**7** Smoking in pregnancy			-2012/13 published data shows this has reduced from 21.2% in 2011/12 to 18.9%.now at North West average.
	8 Starting breast feeding			-2012/13 published data shows this has increased from 51.3% in 2011/12 to 52.3%.
	9 Obese children (Year 6)			Significant reduction in excess weight.
	10 Alcohol-specific hospital			*Provisional* local data for 2010/11-2012/13 shows rate has

	stays (under 18)			decreased to 72.3 (compared to 153.9 for 2007/08-2009/10 quoted on 2013 profile).
	11 Teenage pregnancy (under 18)			Significant reduction to North West average of 24 per annum, a local value of 1.5
Adults' health & lifestyle	**12** Adults smoking			Reduction but this is limited due to the uptake of E cigarettes.
	13 Increasing & higher risk drinking			Reduction in health profile but actual increase in A&E emergency admissions.
	14 Healthy eating adults		/	Based on modelled estimates (no update in 2013 profile).
	15 Physically active adults		/	Indicator criteria changed so cannot compare. No updated data available since 2013 profile.
	16 Obese adults		/	Based on modelled estimates (no update in 2013 profile).
Disease and poor health	**17** Incidence of malignant melanoma (skin cancer)		/	No updated data available. Increasing incidence of malignant melanoma means that more people are being identified with melanoma which if it is recognized and treated early, it is almost always curable, but if it is not, the cancer can advance and spread to other parts of the body, where it becomes hard to treat and can be fatal.
	18 Hospital stays for self-harm			- England average worsened. - 2012/13 *provisional* local data shows rate has decreased to 359 (from 416 in 2011/12).
	19 Hospital stays for alcohol related harm			-England average also worsened. -2011/12 published data & provisional 2012/13 data shows no change from 2010/11 for Halton.
	20 Drug misuse			Based on modelled estimates 2010/11. No updated data available.
	21 People diagnosed with diabetes			-England average also worsened.
	22 New cases of tuberculosis			Only 1-2 cases per year. No updated data available.
	23 Acute sexually transmitted		/	Indicator not included on previous profiles. No updated data

	infections			available.
	24 Hip fracture in over-65s			2012/13 p*rovisional* local data shows rate has decreased to 501 (from 600 in 2011/12).
Life expectancy and causes of death	**25** Excess winter deaths			No updated data available.
	26 Life expectancy – male			2010-12 *provisional* local data shows male life expectancy has increased to 77.3 from 76.5 in 2009-11.
	27 Life expectancy – female			2010-12 *provisional* local data shows female life expectancy was 80.6; this is no change from 2009-11.
	28 Infant deaths			2010-12 *provisional* local data shows rate has decrease to 4.1 from 4.6 in 2009-11.
	29 Smoking related deaths			No updated data available
	30 Early deaths: heart disease & stroke			2010-12 *provisional* local data shows the <75 circulatory mortality rate was 82.9; this is no change from 82.4 in 2009-11.
	31 Early deaths: cancer			-Average number of deaths remained same since 2011 profile data; rate decreased (due to population increase). -2010-12 *provisional* local data shows rate has decreased to 137.3; this is slight reduction from 142.7 in 2009-11.
	32 Road injuries and deaths			2010-12 published shows average number of road deaths was 40 per year; this has not changed since 2009-11.

B2.4 Halton Health & Wellbeing Strategy 2012-15

Informed by the Joint Strategic Needs Assessment (JSNA) and in consultation with local residents, strategic partners and other stakeholders, the strategy identified five key priorities to help us to achieve our vision. The five priorities for action are as follows:

- Prevention and early detection of cancer
- Improved child development
- Reduction in the number of falls in adults
- Reduction in the harm from alcohol
- Prevention and early detection of mental health conditions

The Joint Health and Wellbeing Strategy sets the framework for the commissioning of health and wellbeing services in Halton with a particular emphasis on prevention and early intervention. This has been identified as an area of strategic focus for NHS Halton CCG.

B2.5 Halton Borough Council, Communities Directorate, Directorate Plan 2014-17

The Halton Borough Council Communities Directorate Plan identifies its strategic priorities and challenges to 2017. There are several areas where NHS Halton CCG and the communities directorate will be working together to improve the health and wellbeing of the population.
These include;
Health & wellbeing – Loneliness, Falls, Urgent care
Integration – ITF, Care Homes Project, Therapy Services
Dementia
Acute & Related services
Joint Health & social care Learning Disability Self Assessment Framework.
Safeguarding, Dignity & Domestic abuse

B2.6 Better Care Fund – 2014/16

NHS Halton CCG and Halton Borough Council are already working together and moving toward full integration of health and social care for the benefit of the people of Halton to improve outcomes for both patients and people receiving health and social care services.

The Better Care Fund (BCF) plan sets out the shared vision between Halton Borough Council and NHS Halton CCG for health and social care services over the next two years.

The BCF is described as a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and Local Authorities.

In addition to the endorsement of Halton Borough Council's Executive Board and NHS Halton CCG's Governing Body, our approach to integration has the full endorsement of the Health and Wellbeing board.

The Vision identified in the BCF plan and an integral part of NHS Halton CCG's 5 year strategic plan is: To improve the health and wellbeing of Halton people so they live longer, healthier and happier lives.

Within 5 years the commissioning and delivery of all aspects of health, social care and well-being will be transformed within the borough of Halton. Building on our innovative solutions and experiences the children, young people, adults, older people and communities of Halton will experience a fully integrated system that tailors its responses to their needs as individuals, members of families, carers and participants in their communities.

The key components of the plan are:

1) Integrated commissioning

NHS Halton CCG is co-located alongside Halton Borough Council Social Care and Public Health and we have already seen the positive impact this has had on breaking down organisational, professional and cultural barriers. Halton's approach to urgent care, via the establishment of the urgent care partnership board, demonstrates the shared commitment to improving outcomes for service users/patients and their carers whilst making the most efficient use of public resources.

2) Working to reduce health inequalities (taking a life course approach)

Health inequalities in Halton are reducing and there have been significant improvements in rate of CVD, Smoking prevalence, Child obesity and COPD. However, challenges remain if we are to close the gap between Halton and the national average. Integrated senior management teams, commissioning meetings and planning meetings with staff from a range of backgrounds ensures a joined up approach to improving health inequalities.
Halton's Health and wellbeing service brings together the Health Improvement Team, the wellbeing GP Practices Team and the Adult Social care early intervention and Prevention team. This is a new approach that combines and aligns expertise from Public Health, Primary Care and Adult Social Care.

3) Supporting Independence

There are a range of integrated services which focus on promoting recovery from illness, preventing unnecessary hospital admissions or premature admissions to residential care, supporting timely discharge from hospital and maximising opportunities for independent living.

4) Care closer to home

There are a number of services which have been redesigned to support care closer to home, including; The reconfiguration of Both Adult Social care and Community nursing teams to align the teams around the local GP communities; The Community Multi-disciplinary Teams project; Integrated care home support teams and the Integrated Safeguarding unit.

B2.7 Public Consultation

NHS Halton CCG has already established a strong reputation as an organisation that engages with and listens to local people. In a series of public events we developed our draft commissioning intentions with patients, the public, providers, voluntary groups and employees in order to shape our plans

NHS Halton CCG takes very seriously its duty to involve patients and the public in its decision making and will continue to engage people going forward. We also recognise that there is considerable scope to increase our collaboration with patients, the public and the voluntary sector, and will continue to expand engagement activities.

B2.8 Provider and Clinical Consultation

Following production of draft list of commissioning intentions a series of events took place with participation from providers, clinicians and the Health & Wellbeing board to develop the vision, priorities for the health economy over the next five years and what services need to be commissioned over the next five years to achieve the desired outcomes.

B2.9 Halton Borough Council Public Health Commissioning Intentions 2014/15[40]

NHS Halton CCG has effective working relationships with Public Health. NHS Halton CCG plans have been developed alongside public Health commissioning intentions, the links between the plans is evident in the commissioning intentions in the NHS Halton CCG plan where public health have been identified as a partner, and likewise in the Public Health commissioning intentions where the CCG has been identified as a partner around areas of school age health, health checks, health improvement service and healthy eating services. CBT, Smoking cessation, alcohol and drug strategy.

[40] Halton Borough Council Public Health Commissioning Operational Work Plan 2014-15 Version 2 22nd January 2014

B3 Principles of effective commissioning

In addition the national and local drivers referenced above, this 5 year strategy is guided and shaped by the following principles of effective commissioning.

Right patient	In order for patients to receive optimum care, they need to be assessed and referred appropriately.
Right provider	Ensuring patients are referred to the most appropriate provider will support achievement of 18 weeks as well as the most effective use of resources.
Right treatment	The national service specification compliance process, together with the implementation of national clinical policies, will ensure that only the most effective treatments are commissioned from compliant providers, supported by outcome based evidence.
Right place	Patients should receive their treatment in the optimum care setting. This means that patients should receive care within designated centres that meet clinical standards, and that delayed admission and discharge into and out of specialised care should be considered a priority for action.
Right time	This recognises the importance of early referral and prompt treatment, with a particular emphasis on compliance with national waiting times and delayed discharges.
Right price	The development of local and national tariffs that represent best value for money whilst ensuring appropriate levels of reimbursement is fundamentally important.

Appendix C – High Impact Interventions

Using the 'Anytown Health System' NHS Tool NHS Halton CCG identified where schemes developed as commissioning intentions for the next two years were also identified as schemes with a high impact. This provided assurance that the schemes developed were foccussed in the correct areas and also provided a prioritisation tool should this be needed.

The high impact interventions (HIIs)

1 Early diagnosis
Early detection and diagnosis to improve survival rates and lower overall treatment costs
PC141505 – Review pathway around cancer presentations. This will look at the evidence across all pathways, and will include examining the evidence to introduce a targeted screening programme to increase early detection rates of lung cancer.
PC141508 – Review access to lifestyles services for patients with cancer, for example breast cancer weight loss and exercise programme
PC141512 – Review the cardiology direct access service

2 Reducing variability within primary care by optimising medicines use and referring
Reducing unwanted variation in primary care referring and prescribing
ADD141511 – Reduce variation in prescribing between practices
PCI141506 – A strategy for sustainable general practice services in Halton.

3 Self-management: Patient-carer communities
Self-management programme for those suffering with a long-term condition
PC141501 – Develop a respiratory strategy for Halton to include the possibility of using technology to manage sleep apnoea in the community, and considering whether weight management is part of the pathway.
PC141514 – Review the scope of the community diabetes provision
PCI141501 – Strengthen the GP's role at the heart of out of hospital care and supporting people to stay healthy
PCI141505 – To support GP practices and other providers where appropriate to deliver services over and above their core contractual responsibilities.

4 Telehealth/Telecare
Health apps, Telehealth and Telecare equipment which help people to manage their own long term conditions in conjunction with their clinicians, introduced to empower people whilst at the same time ensure that their own actions remain embedded in the care they receive from the NHS
PC141501 - Develop a respiratory strategy for Halton to include the possibility of using technology to manage sleep apnoea in the community,
PCI141510 – Develop an integrated Health and Social Care IM&T strategy to include the use of Telehealth and telemedicine to improve patient care.

5 Case management and coordinated care
Multi-disciplinary case management for the frail elderly and those suffering with a long-term condition
PCI141501 - Strengthen the GP's role at the heart of out of hospital care and supporting people to stay healthy by identifying people at risk of hospital admission including the introduction of a named accountable clinician
PCI141503 – Review the design of community services to focus on outcome based services
PCI141505 - To support GP practices and other providers where appropriate to deliver services over and above their core contractual responsibilities.

6 Mental Health – Rapid Assessment Interface and Discharge (RAID)
Psychiatric liaison services that provide mental health care to people being treated for physical health conditions
MHUC141502 – Review the AED liaison psychiatry model across Mid Mersey CCG's

7 Dementia pathway
Fully integrated network model to improve health outcomes and achieve efficiencies in dementia care
MHUC141515 – Care Home Liaison Service – To establish a single supplementary specialist service for dementia patients.

8 Palliative care
Community based, consultant-led palliative care service
WCF141510 – Evaluate the Mersey QIPP pilot for children's community nursing service. Including evaluation and on-going funding for end of life care for children.

Appendix D –Statistical Terminology

Quintile – The performance of a group of CCGs can be grouped together into 'qunitiles' these are 1/5ths, where the best 1/5th of performers are grouped together, followed by the next best 1/5th and so on. Performance is often judged on where a CCG sits within these quintiles.

Quartile – As per quintile but CCG's are grouped into 1/4 qtrs. This may be done where there are not enough CCG's to put into quintiles.

Confidence Interval – This is used where a performance indicator is based on a sample of population. This is most commonly found in surveys. The Confidence Interval is the range of values (often referred to as the upper and lower confidence interval) where the 'true' value is most likely to be if the whole population were surveyed.

Median – The 'average' value can be calculated in one of three ways, the 'Mean', 'Median' or 'Mode'. The most commonly used average is the 'Mean' and where a graph or table refers to the average it is usually the 'mean'

Mean – all values added together and divided by the number of values, for example, 5+10+25 = 40 the mean is 40/3 = 13.33

Median – this is the middle value of a set of data if the data were arranged in order, this is often used where one or two outling data values could potentially skew the data, for example

5+10+11+12+13+14+500 The median value would be 12

Mode – This is the most common number that appears in a data set, for example,

5+6+6+6+8+9+9+50 The Mode would be 6

INDEX