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Health and Adult Social Care Scrutiny Committee

Agenda

Date:	**Wednesday, 20th May, 2009**
Time:	**10.00 am**
Venue:	**Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ**

The agenda is divided into 2 parts. Part 1 is taken in the presence of the public and press. Part 2 items will be considered in the absence of the public and press for the reasons indicated on the agenda and at the foot of each report.

PART 1 – MATTERS TO BE CONSIDERED WITH THE PUBLIC AND PRESS PRESENT

1. **Apologies for Absence**

2. **Declaration of Interests/Party Whip**

   To provide an opportunity for Members and Officers to declare any personal and/or prejudicial interests or members to declare the existence of a party whip in relation to any item on the agenda.

Please contact Denise French on 01270 529643
E-Mail: denise.french@cheshireeast.gov.uk with any apologies or requests for further information or to give notice of a question to be asked by a member of the public

3. **Public Speaking Time/Open Session**

In accordance with Procedure Rules Nos.11 and 35 a total period of 10 minutes is allocated for members of the public to address the Committee on any matter relevant to the work of the Committee.

Individual members of the public may speak for up to 5 minutes but the Chairman will decide how the period of time allocated for public speaking will be apportioned where there are a number of speakers.

Note: In order for officers to undertake any background research it would be helpful if questions were submitted at least one working day before the meeting.

4. **Minutes of Previous meeting** (Pages 1 - 4)

To approve the minutes of the meeting held on 23 March 2009.

5. **Joint Strategic Needs Assessment** (Pages 5 - 30)

To consider a Report on progress made in developing the Joint Strategic Needs Assessment for Cheshire East; the headline results and findings of the consultation; and proposed governance arrangements to develop the process further

6. **Adult Social Care Redesign - Implementation** (Pages 31 - 62)

To consider a Report of the Strategic Director People on the proposed implementation of the Adult Social Care Redesign programme.

7. **Calendar of Meetings** (Pages 63 - 64)

To consider a report of the Borough Solicitor on the Calendar of Meetings.

8. **Swine Flu Epidemic**

The Committee will be aware that an outbreak of swine flu began in Mexico and there have been a number of cases in other countries including the United Kingdom.

There is close partnership working taking place between a number of agencies including local authorities, the health service, the police and regional and national government to prepare for any further cases in England.

Fiona Field, Director of Governance and Strategic Planning at Central and Eastern Cheshire Primary Care Trust will verbally update the Committee on the latest position in relation to Swine Flu.

Agenda Item 4

CHESHIRE EAST COUNCIL

Minutes of a meeting of the **Health and Adult Social Care Scrutiny Committee**
held on Monday, 23rd March, 2009 at Council Chamber, Municipal Buildings, Earle Street, Crewe CW1 2BJ

PRESENT

Councillor A Richardson (Chairman)
Councillor G Baxendale (Vice-Chairman)

Councillors Mrs S Bentley, R Fletcher, Mrs D Flude, Miss S Furlong, Ms O Hunter, Mrs S Jones, A Kolker, A Martin, A Moran, Mrs L Smetham, A Thwaite and J Wray

Apologies

Councillors (none)

27 **APOLOGIES FOR ABSENCE**

None

28 **DECLARATIONS OF INTEREST**

RESOLVED: That the following Declarations of Interest be noted:

(a) Councillor A Richardson – personal interest on the grounds that he was a Member of Cheshire County Council and Crewe and Nantwich Borough Council;
(b) Councillor G Baxendale – personal interest on the grounds that he was a Member of Congleton Borough Council and Congleton Town Council;
(c) Councillor R Fletcher – personal interest on the grounds that he was a Member of Cheshire County Council and Congleton Borough Council;
(d) Councillor S Jones – personal interest on the grounds that she was a Member of Alsager Town Council;
(e) Councillor A Martin – personal interest on the grounds that he was a Member of Nantwich Town Council;
(f) Councillor A Moran – personal interest on the grounds that he was a Member of Cheshire County Council and Nantwich Town Council; and
(g) Councillor A Thwaite – personal interest on the grounds that he was a Member of Congleton Borough Council.

29 **PUBLIC SPEAKING TIME/OPEN SESSION**

There were no Members of the Public present who wished to address the Committee.

30 **MINUTES OF PREVIOUS MEETING**

RESOLVED: That the minutes of the meeting of the Committee held on 23 February be approved as a correct record.

31 CURRENT ISSUES

The Governance Lead Officer briefed the Committee on various current issues:

- The Committee's role in scrutinising the Local Area Agreement in particular in relation to Adult Safeguarding and the Children's Trust/Children's Safeguarding;
- The role for Local Authorities to scrutinise Crime and Disorder Partnerships;
- The recent Guidance on Councillor Call for Action which would be reported more fully to Governance and Constitution Committee on 16 April;
- The issue relating to Public Speaking Time/Open Session would also be discussed at Governance and Constitution Committee on 16 April.

RESOLVED: That the update on current issues be noted.

32 CHESHIRE COUNTY COUNCIL REFLECTIONS/LEGACY

The Committee considered a report of the Governance Lead Officer on legacy issues from Cheshire County Council in relation to the scrutiny of health and adult social care.

The Committee's attention was drawn to a number of specific matters:

- Implications of the realignment of the two Cheshire Primary Care Trusts' (PCT) boundaries, which was shortly to be the subject of a consultation period led by Western Cheshire PCT;
- Social Care Redesign – this was due to be reported back to the Committee shortly;
- Patient Transport Services;
- North West Ambulance Service (NWAS) – at the County Council's final Health and Adult Social Care Scrutiny Select Committee meeting NWAS had attended to do a presentation to Members and agreed to attend future Scrutiny meetings on a regular six monthly basis;
- Relationships with Local Involvement Networks (LINks).

RESOLVED: That

(a) the list of legacy items contained within the report be noted;

(b) a presentation by a representative(s) of the Local Involvement Network (LINk) be done to an early meeting of the Committee;

(c) regular induction events continue based on issues identified by the Committee and officers; and

(d) the Committee conduct an Audit of the Recommendations contained within the 6 Scrutiny Reviews carried out in the area of Health Scrutiny by the County Council – Diabetes, Obesity, Tobacco Control, Suicide Prevention Services, Access to Dental Services and Transport at the Countess of Chester Hospital Site.

33 ANNUAL WORK PROGRAMME

The Committee considered a report of the Governance Lead Officer listing various items previously identified by the Committee for inclusion in the Work Programme. The Committee had previously agreed to hold Mid Point meetings as one way of developing its Work Programme. The Committee noted that a first meeting of the Joint Scrutiny Committee with Wirral MB Council and Cheshire West and Chester Council was to be held in May and feedback would be presented to the next available meeting.

RESOLVED: That the report be noted.

34 FUTURE TRAINING/INDUCTION NEEDS

There were no additional Training/Induction Needs to those already identified above.

The meeting commenced at 1.00 pm and concluded at 1.45 pm

Councillor A Richardson (Chairman)

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JOINT STRATEGIC NEEDS ASSESSMENT FOR CHESHIRE EAST

1. PURPOSE

This report has been prepared to inform the Cheshire East Health and Adult Social Care Scrutiny Committee of:

- the progress made in developing the Joint Strategic Needs Assessment for Cheshire East;
- the headline results and findings of the consultation; and
- the proposed governance arrangements to develop the process further.

2. BACKGROUND

The Local Government and Public Involvement in Health Act (2007) places a duty on upper-tier local authorities (or unitary Councils) and Primary Care Trusts to undertake Joint Strategic Needs Assessment (JSNA).

Joint Strategic Needs Assessment is a process that identifies the current and future health and wellbeing needs of a local population, informing the priorities and targets set by Local Area Agreements and leading to agreed commissioning priorities that will improve outcomes and reduce health inequalities.

In December 2007, the Department of Health published guidance on Joint Strategic Needs Assessments. It is expected that the lead on producing a Joint Strategic Needs Assessment would be taken by the Director of Public Health, the Director of Adult Social Services and the Director of Children's Services, working in collaboration with Directors of Commissioning. The guidance makes it plain that the Joint Strategic Needs Assessment is not to be just about health and social care; it is the business of the whole system.

The Joint Strategic Needs Assessment process is underpinned by:

- partnership working (see above)
- community engagement: actively engaging with communities, patients, service users, carers, and providers including the third and private sectors to develop a full understanding of needs, with a particular focus on the views of vulnerable groups;
- evidence of effectiveness: identifying relevant best practice, innovation and research to inform how needs will best be met.

The Health Care Commission Core Standards and the World Class Commissioning competencies emphasise the role of Joint Strategic Needs Assessment in driving the long term commissioning strategies of Primary Care Trusts and their collaborative work with community partners, and includes an emphasis on public and patient engagement. The forthcoming Comprehensive Area Assessment will also focus on the Joint Strategic Needs Assessment and Cheshire East Council and its partners will be required to provide evidence that:

- they understand the needs and aspirations of the diverse communities in Cheshire East by ensuring that the Joint Strategic Needs Assessment inputs

to the sustainable communities strategy and Local Area Agreement and focuses on the needs of the vulnerable and areas of inequality.
- they deliver outcomes and improvement by ensuring that the Joint Strategic Needs Assessment informs commissioning decisions which in turn lead to improved health and wellbeing and reducing inequalities for all.
- the future prospects for the area are being considered, including how the Joint Strategic Needs Assessment will be updated and how true partnership and community engagement can be achieved.

In Cheshire, two Joint Strategic Needs Assessments have been produced reflecting the different needs of the Cheshire West and Chester and Cheshire East areas and these have been developed using a common process and approach. The Joint Strategic Needs Assessments are dynamic needs assessments which are hosted on websites to enable them to be continually updated and refined as new information and intelligence is developed locally, nationally and internationally.

3. A FIRST LOOK REPORT: KEY FINDINGS

In November 2008, a report entitled "Cheshire East Joint Strategic Needs Assessment: A First Look" was published which set out some of the initial findings of the Joint Strategic Needs Assessment, and what Central and Eastern Primary Care Trust and Cheshire County Council think are the main issues affecting people's health and wellbeing within Cheshire East.

At this initial stage, the Primary Care Trust and Local Authority drew up a list of early priorities:
- Children and young people aged 0 to 18 years;
- Older people aged 65 years and over;
- Long-term health conditions - these are conditions such as diabetes, high blood pressure, dementia and strokes which all affect people's daily living;
- Inequalities - the causes of different health outcomes for people in Cheshire East including access to services; and
- Lifestyle choices that impact on the health and quality of life of an individual.

Since the publication of the 'First Look Report' many of the nationally prescribed Joint Strategic Needs Assessment 'chapters' have been completed (Appendix 2). The full version of the Joint Strategic Needs Assessment is available at http://www.cecpct.nhs.uk/templates/Page.aspx?id=520.

A sample of the 'findings' are documented in Appendix 1. The Joint Strategic Needs Assessment describes a population of 360,800 people living in the Cheshire East area. Key findings illustrate a significant increase in the number of older and very old people in the population. Cancer and Cardiovascular disease remain the main causes of death. Alcohol is the largest emerging lifestyle threat to health with increasing numbers of hospital admissions consequent upon the binge and hazardous drinking of over a quarter of the population. Smoking remains a significant cause of preventable illness and premature death. It is the primary reason for the gap in healthy life expectancy between rich and poor with over a fifth of pregnant women being still recorded as smokers at the time of delivery (2007/08). Less than 60% of mothers try to breast feed. There is good uptake of many

immunisations, but low numbers of children having the MMR vaccine which has resulted in a recent outbreak of measles in the community.

4. RESULTS FROM JOINT STRATEGIC NEEDS ASSESSMENT ENGAGEMENT

The First Look Report (available at http://www.cecpct.nhs.uk/upload/JSNA/Cheshire%20East%20JSNA%20-%20A%20First%20Look.pdf) was distributed widely throughout Cheshire and the Primary Care Trust Director of Public Health and team have been highlighting the Joint Strategic Needs Assessment at meetings with partners to raise awareness of its importance. Local people and partner organisations have been asked what they think of health and well-being in Cheshire East and whether they agree with the reports' early findings. The consultation period ran from 17th November 2008 to 20th February 2009. This was an opportunity for them to tell the Primary Care Trust and Local Authority whether they agreed with the priority areas chosen and to help them shape the final priorities. Questionnaires were distributed with the reports and an online survey was also accessible on the Primary Care Trust website. The questionnaire focussed on the early priority areas for Cheshire East and gave respondents the opportunity to provide further comments about their views of the First Look Reports' findings. Equality and diversity information was also collected to provide the Primary Care Trust and Local Authority with an indication of who was completing the questionnaire and whether they were representing a particular organisation or whether they were members of the general population.

In total, ten questionnaires were completed; although this number is disappointing, the Primary Care Trust and Council are grateful to those individuals who returned a questionnaire as the comments that have been received are constructive and they can be used to further develop the Joint Strategic Needs Assessment.

Out of the ten questionnaires completed, when asked if they agreed that the areas identified in the First Look Report were the right priorities for Cheshire East, 50% of respondents agreed. Stakeholders were asked if they agreed that the First Look Report addressed the health and well-being needs of older people, children and young people, and people with long term conditions. 40% of respondents agreed that the report focussed on the needs of older people; however 40% also disagreed. With regards to the needs of children and young people and those with long term conditions, 40% and 60% respectively agreed. When asked whether the First Look Report addressed the inequalities in health and well-being across Cheshire East, 50% of responders agreed, however three people (30%) disagreed. The final question that stakeholders were asked related to the allocation of resources and whether they should be directed to areas where they will make most difference; 90% agreed with this.

Responders chose to provide further comments with their questionnaire and the common themes from these related to:

- ***partnership working:*** the Joint Strategic Needs Assessment has been welcomed by partners and is viewed as a good driver to address need across Cheshire East, however there is the recognition that further joined up working

is required; communication and engagement with local communities and the Third Sector was particularly mentioned.
- ***the inclusion of further topics:*** examples of areas that had not been included in the report were highlighted.
- ***joint commissioning areas a priority:*** areas that fall into the joint commissioning portfolio were given a specific mention and these included mental health, long term conditions and disabilities, and the health and social care needs of older people.

Of the respondents who completed the equality and diversity monitoring section of the questionnaire, 56% were male and 44% were female. The majority of responders were aged between 45 and 64 years old (56%) and were employed full time (44%). When describing their sexual orientation, 89% indicated that they were heterosexual. 88% of people did not consider themselves to have a disability and the majority (60%) indicated that they were Christians. 100% of responders were of white origin with the majority (89%) indicating that they were of English nationality.

5. FUTURE GOVERNANCE ARRANGEMENTS

In Cheshire East, the Primary Care Trust Director of Public Health will continue to provide strong leadership for the Joint Strategic Needs Assessment; however it will be important to ensure that the accountability for the Joint Strategic Needs Assessment also sits within the new Local Authority. The Primary Care Trust and Local Authority will be responsible for providing adequate resources for the continual refreshment of data and information so that the assessment is kept up to date and comprehensive.

It is proposed that a Joint Strategic Needs Assessment Steering Group is established for Cheshire East to direct the future development of the Joint Strategic Needs Assessment and Steering Group representatives should include:

- Primary Care Trust Director of Public Health
- Primary Care Trust Director of Commissioning
- Cheshire East Council Strategic Director – People
- Nominee from Cheshire East Congress (Third Sector)
- Nominee from the Crime and Disorder Reduction Partnership (CDRP)
- Nominee from Environment and Sustainability Local Strategic Partnership Thematic Group
- Nominee from Learning, Skills and Economic Development Local Strategic Partnership Thematic Group

The Steering Group should report progress to the Local Strategic Partnership and Primary Care Trust Board on a six monthly basis.

6. FUTURE USAGE OF THE JOINT STRATEGIC NEEDS ASSESSMENT

Producing a Joint Strategic Needs Assessment is only the start of a process; the assessment will have a variety of uses:

- Its data, over time, will enable the Local Strategic Partnership to monitor progress on achieving the outcomes which lie at the heart of the National Indicator set.
- It will inform the development of specific commissioning plans. All commissioning strategies should be required to demonstrate how and where they have drawn upon the assessment's analysis of needs.
- It will be a means of engaging with communities about local needs.
- It will be drawn upon by the variety of stakeholders who wish to keep up to date with the developing situation in their communities.

7. RECOMMENDATIONS / ACTIONS

The Committee is asked to:

- Note what has been done to complete a 'First Look' and the Joint Strategic Needs Assessment for Cheshire East;
- Consider the feedback received through the consultation exercise on the Joint Strategic Needs Assessment set out in Appendix 3.

APPENDIX 1:
A SAMPLE OF THE EMERGING KEY FACTS

1. POPULATION

- Cheshire East has a population of around 360,800 residents.
- It has an older population than that of England. The local proportion of women is higher than the England proportion in all age bands from 35 and over. The local male proportion does not overtake the national until 40.
- There is variation across the patch – with many of the older persons living in the north and east.
- The population of Cheshire East will increase by 21,700 people between 2006 and 2016.
- There will be large sustained increases in the number of older people. By 2016, the number of people aged 85 or over will increase by 42%, an additional 3,400 people in a potentially vulnerable group.
- The overall number of under 15s is predicted to increase by 2.4%, this masks a considerable increase in the under 5s (7.4%, 1,400 children) over a 10 year period. This is important in ensuring the provision of adequate maternity services and education provision in the future.
- In 2007, there were 3,860 live births in Cheshire East, which represents an average of 1.90 live-born children per woman.
- 8.5% more babies were born in the four year period from 2004 to 2007 than in the previous four year period from 2000 to 2003. This cohort of children will produce a rise in need for younger age education and social care services.
- Around 93.9% of the population of Cheshire East is White British, compared to 84.2% in England as a whole.
- The three largest ethnic groups other than White British in the area are: Other White 2.0%, White Irish 0.8%, and Indian 0.6%.

2. LIFESTYLE

Smoking remains a significant cause of preventable morbidity and premature death; it is the primary reason for the gap in healthy life expectancy between rich and poor.

- Smoking prevalence varies greatly across Cheshire East. Smoking prevalence is higher in urban areas, such as Crewe (26.2%), Macclesfield (22.2%), and Middlewich (21.3%) and may be associated with deprivation. The prevalence of smoking is much lower in rural areas, for example, Macclesfield Rural (12.7%).
- In 2005, 29% of routine and manual workers smoked, making them a priority group for action.
- National evidence suggests that most of the estimated 57,700 smokers in Cheshire East are likely to want to give up and that smoking cessation programmes are successful.
- In the Central and Eastern Cheshire Primary Care Trust, 19.6% of women were recorded as smokers at the time of delivery in 2007/08. In the first quarter of 2008/09, this figure had increased to 21.1%.

- Smoking during pregnancy: Smoking at the time of delivery has remained constant since 2005/06 and, unless improvement is seen, the PCT will struggle to meet the 15% target by 2010.

Alcohol is the largest and emerging lifestyle threat to health and well being in the area.

- There were 6,680 hospital admissions due to alcohol related harm during 2006/2007.
- The directly age and sex standardised rate of admissions for alcohol related harm for Central and Eastern Cheshire Primary Care Trust increased by 61% between 2002/2003 and 2006/2007 and the standardised rate for the Central and Eastern Cheshire Primary Care Trust was above that for England.
- There are large geographical variations in admissions due to alcohol related harm across Cheshire East, with alcohol related harm being a particular issue in Crewe.
- Binge and hazardous drinking patterns are serious Public Health issues in Cheshire East.

Physical activity

- Adult participation in physical activity (as measured through sport and active recreation) in Cheshire East is generally similar to the national average.
- Activity rates are lowest in Crewe & Nantwich and highest in Macclesfield. Activity rates in Macclesfield are ranked 1st in the North West and 2nd overall in England.
- Children in Cheshire East exceed the national average of 86% in participation in at least two hours of high quality Physical Education and school sport in a typical week.

Breast feeding

- In Central and Eastern Cheshire Primary Care Trust, 58.7% of women initiated breastfeeding in 2007/08.
- Central and Eastern Cheshire Primary Care Trust is not meeting its target in terms of mothers initiating breastfeeding. The target for 2008/09 has changed in order to monitor the percentage of infants where breastfeeding has continued to 6-8 weeks.
- The World Class Commissioning Target for the end of the project in 2013/2014 is 91% (initiation) but this target is to be reviewed each year taking into account the baseline (2008/09), the progress of the project, the progress of comparable Primary Care Trusts (Office for National Statistics group - prosperous small towns c) and subsequent years achievements. It is planned that the target for 2009/10 is a 3% increase on 2008/09.

Road Traffic accidents

- There has been a reduction in the number of people killed and seriously injured on the roads from the 1994/98 baseline and Cheshire East is

consistently meeting the government target of a 40% reduction from baseline in people killed and injured and a 50% reduction from baseline in the number of children killed and injured. More analyses are required to identify other potential preventative measures. Public Health and NHS trusts will work with the Crime and Disorder Reduction Partnerships and the Road Safety Partnerships to identify the public health aspects of collisions and to clarify and data related issues.

Sexual Health - AIDS HIV

- There has been a slight increase in new cases of HIV across Cheshire East. The majority of new cases are in men who have been exposed through sex with other men (MSM).. As there is no cure for HIV, the importance of prevention cannot be overstressed.

3. ADULT SOCIAL CARE

- Across Cheshire East in 2006/07, 14,488 people (an average of 278 a week) contacted the Local Authority in relation to Adult Social Care.
- 35% of contacts led to a further assessment. The remaining 65% of contacts had needs that were attended to at or near the point of contact.
- There are large geographical variations in the numbers of contacts leading to a further assessment at Lower Super Output Area.
- The number of people over 75 in need of Social Care for mobility and self care is set to rise by 64% by 2025.
- The Local Authority is reforming services in line with Self Directed Support.
- Across Cheshire East in 2006/07, 4091 people were assessed by the Local Authority for their Adult Social Care needs.
- 71% of contacts went on to receive services, 15% did not have services offered and the remainder had another sequel to the assessment.
- There are large geographical variations in the numbers of assessments at lower super output area. High numbers of assessments rarely match areas of multiple deprivations. This is also the case when comparing both those with a medium and high priority at assessment and with financial assessments for those with no or some income, the exception being parts of Crewe, Congleton and Macclesfield.

APPENDIX 2:
JOINT STRATEGIC NEEDS ASSESSMENT CORE DATASET

Demography	
Sub-domain	**Indicator**
Population numbers	Estimated and projected population by age-band and gender
Births	Current births
Ethnicity	Estimated population by ethnic group
Disability	Estimated number of disabled people, overall and/or by impairment group
Religion	Estimated population by religious group
Migrant population	Estimated population by migrant status
Local area	Number of households
	Breakdown of area into constituent communities/neighbourhoods
	Deprivation band
	ONS classification
	Social marketing categories
	Urban / rural classification

Social and Environmental Context	
Sub-domain	**Indicator**
Poverty	Proportion of children in poverty (NI 116)
Living arrangements	Housing tenure
	Overcrowding
	Adults with learning disabilities in settled accommodation (NI 145 and Vital Sign VSC05)
	Adults in contact with secondary mental health services in settled accommodation (NI 149 and Vital Sign VSC06)
	Living alone
	Central heating
	Access to car or van etc
Economic	Overall employment rate (NI 151)
	Working age people on out-of-work benefits (NI 152)
	Working age people claiming out-of-work benefits in the worst performing neighbourhoods (NI 153)
	Adults with learning disabilities in employment (NI 146 and Vital Sign VSC07)
	Adults in contact with secondary mental health services in employment (NI 150 and Vital Sign VSC08)
	Unemployment rate
	Claimant count
	Average incomes
Environment	Access to services
Voice	Satisfaction of people over 65 with home and neighbourhood (NI 138)

Lifestyles and Risk Factors	
Sub-sub-domain	**Indicator**
Smoking	Modelled and/or recorded smoking prevalence
	Quit rates (NI 123 and Vital Sign VSB05)
Eating habits	Modelled and/or recorded eating behaviour
	Prevalence of breastfeeding at 6-8 weeks from birth (NI 53 and Vital Sign VSB11)
Alcohol	Alcohol-harm related hospital admission rates (NI 39 and Vital Sign VSC26)
	Modelled and/or recorded drinking behaviour
Physical activity	Participation in sport and active recreation

Lifestyles and Risk Factors	
Sub-sub-domain	**Indicator**
Teenage pregnancy	Under 18 conceptions (NI 112 and Vital Sign VSB08)
	Under 16 conceptions
Hypertension	Modelled and/or recorded hypertension
Obesity	Modelled and/or recorded obesity (adult)
	Obesity among primary school age children in Reception Year (NI 55 and Vital Sign VSB09)
	Obesity among primary school age children in Year 6 (NI 56 & Vital Sign VSB09)

Burden of ill-health and disease	
Sub-sub-domain	**Indicator**
All causes	All-Age All-Cause Mortality (NI 120 and Vital Sign VSB01)
	Infant mortality
	Life expectancy
	Main causes of death
	Hospital admissions – top 10 causes
	Self-reported measure of overall health and wellbeing (NI 119)
	Healthy life expectancy at age 65 (NI 137 and Vital Sign VSC25)
Causes considered amenable to healthcare	Mortality rate from causes considered amenable to healthcare (Vital Sign VSC30)
Due to smoking	Deaths attributable to smoking
Diabetes	Modelled v. recorded prevalence
	Estimated excess deaths among people with diabetes
General	Mortality rate from all circulatory diseases under 75 (NI 121 and Vital Sign VSB02)
Coronary heart disease	Mortality
	Modelled v. recorded prevalence
	Hospital admission rate for MI (proxy for incidence)
	Admissions for cardiac revascularisation
Stroke	Mortality
	Hospital admission rate for stroke (proxy for incidence)
Cancer	Mortality rate from all cancers under age 75 (NI 122 and Vital Sign VSB03)
	Cancer registrations
COPD	COPD mortality
	COPD modelled v. recorded prevalence
TB	TB notifications
STIs & HIV	KC60 GUM STI data, particularly gonorrhoea
	New diagnoses of HIV/Aids
	Late diagnoses of HIV/Aids
	Uptake of Chlamydia screening in under-25s (NI 113 and Vital Sign VSB13)
Dental Health	% dmft in 5-year olds
Mental Health	Prevalence of dementia
	Suicide and injury of undetermined intent mortality rate (Vital Sign VSB04)
	Mental illness needs indices and prevalence rates
Falls	Hospital admissions for fractured proximal femur (proxy for incidence)
Road accidents	People killed or seriously injured on roads
	Children killed or seriously injured on roads (NI 48)
Injuries	Hospital admissions caused by unintentional and deliberate injuries to children and young people (NI 70 and Vital Sign VSC29)
Arthritis	Admissions for hip and knee replacement

Health and Social Care Services	
Sub-domain	**Indicator**
Social care	*Physical disability, frailty and sensory impairment* 1. Number of clients 2. Number receiving services in community
	Learning disability 1. Number of clients 2. Number receiving services in community
	Mental health 1. Number of clients 2. Number receiving services in community
	Substance misuse 1. Number of clients 2. Number receiving services in community
	Vulnerable people 1. Number of clients 2. Number receiving services in community
	Timeliness of social care assessment (NI 132 and Vital Sign VSC12) and packages (NI 133 and Vital Sign VSC13)
	People supported to live independently through social services (NI 136 and Vital Sign VSC03)
	Carers receiving needs assessment or review and a specific carer's service, or advice and information (NI 135)
	Adults and older people receiving direct payments and/or individual budgets per 100,000 population aged 18 and over (Vital Sign VSC17, NI 130)
Health services	Early access for women to maternity services (NI 126, Vital Sign VSB06)
	Number of people accessing NHS dentistry (Vital Sign VSB18)
	Uptake rates for flu jab
	Proportion of children who complete immunisation by recommended ages (Vital Sign VSB10)
	Proportion of women aged 47-49 and 71-73 offered screening for breast cancer (Vital Sign VSA09)
	Offer of an appointment at a GUM service within 48 hours
	Long acting reversible contraception methods
	Access to NHS funded abortions before 10 weeks gestation
	Proportion of people with depression and/or anxiety disorders who are offered psychological therapies (Vital Sign VSC02)
	Proportion of people with long-term conditions supported to be independent and in control of their condition (NI 124, Vital Sign VSC11)
Voice	The extent to which older people receive the support they need to live independently at home (NI 139)
	User reported measure of respect and dignity in their treatment (NI 128 and Vital Sign VSC32)
	Self-reported experience of social care users (NI 127)
	National Patients Survey Programme findings for local institutions
	Parental experience of services for disabled children (NI 54, Vital Sign VSC33)
	Patient experience of access to primary care (Vital Sign VSA06)
	User reported measure of respect and dignity in their treatment (NI 128 and Vital Sign VSC32)

APPENDIX 3:
DETAILED ANALYSIS OF RESPONSES RECEIVED

Question 1:
To what extent do you agree that the areas outlined in the First Look Report are the right priorities for Cheshire East?

Answer Options	Response Count	Percentage
Strongly agree	0	0.0
Agree	5	50.0
Neither agree nor disagree	1	10.0
Disagree	3	30.0
Strongly disagree	0	0.0
Answered question	9	90.0
Skipped question	1	10.0
Total	10	100.0

Question 2:
To what extent do you agree that the First Look Report addresses the health and well-being needs of children and young people?

Answer Options	Response Count	Percentage
Strongly agree	0	0.0
Agree	4	40.0
Neither agree nor disagree	3	30.0
Disagree	1	10.0
Strongly disagree	2	20.0
Answered question	10	100.0
Skipped question	0	0.0
Total	10	100.0

Question 3:
To what extent do you agree that the First Look Report addresses the health and well-being needs of older people?

Answer Options	Response Count	Percentage
Strongly agree	0	0.0
Agree	4	40.0
Neither agree nor disagree	1	10.0
Disagree	4	40.0
Strongly agree	1	10.0
Answered question	10	100.0
Skipped question	0	0.0
Total	10	100.0

Question 4:
To what extent do you agree that the First Look Report addresses the health and well-being needs of people with long-term conditions?

Answer Options	Response Count	Percentage
Strongly agree	0	0.0
Agree	6	60.0
Neither agree nor disagree	1	10.0
Disagree	3	30.0
Strongly disagree	0	0.0
Answered question	10	100.0
Skipped question	0	0.0
Total	10	100.0

Question 5:
To what extent do you agree that the First Look Report addresses the inequalities in health and well-being across Cheshire East?

Answer Options	Response Count	Percentage
Strongly agree	0	0.0
Agree	5	50.0
Neither agree nor disagree	2	20.0
Disagree	3	30.0
Strongly disagree	0	0.0
Answered question	10	100.0
Skipped question	0	0.0
Total	10	100.0

Question 6:
To what extent do you agree that we need to direct our resources to where they will make the most difference?

Answer Options	Response Count	Percentage
Strongly agree	4	40.0
Agree	5	50.0
Neither agree nor disagree	1	10.0
Disagree	0	0.0
Strongly disagree	0	0.0
Answered question	10	100.0
Skipped question	0	0.0
Total	10	100.0

Question 7:
Further comments

	Response Count	Percentage
Comments made	8	80.0
Comments not made	2	20.0
Total	10	100.0

Respondent 1	• Welcome the general direction of the JSNA and its focus on health inequalities and the need to be basing services and activities on up-to-date local health data. • However, surprised to find that although physical activity and nutrition are highlighted as specific areas, obesity is not. Obesity is

	and appears to be increasingly a major public health issue and one which requires immediate and coordinated action and so should it not have great prominence within the JSNA? • Similarly there is no particular section or reference to Older People. Again there are many public health issues related in particular to older people, Falls Prevention is an obvious example, and again this is an areas where joint action between the NHS and local authorities, is not only essential, but has the potential to have a substantial impact. ***Crewe and Nantwich Borough Council***
Respondent 2	• Cheshire Fire & Rescue Service welcomes the Cheshire East Joint Strategic Needs Assessment, which has recently been prepared between the Council and PCTs and released for public consultation. • Many of the factors affecting the health and well-being of our communities identified in the report reflect similar areas of focus from a fire and rescue service perspective. An ageing population, high levels of smoking and alcohol consumption and increased mental health problems all increase the risk of fire to our communities. • The fire and rescue service brand is well recognised nationally and locally, enabling us to connect with many of the hard to reach vulnerable groups in Cheshire East to deliver fire and non-fire related messages. As one of these vulnerable groups (the 85+ age group) currently includes 8,200 residents within Cheshire East and is expected to increase by as much as 41.5% by 2016, we aim to assist our partners in reaching these residents through effective partnership working projects including Contact Assessments. • Cheshire Fire & Rescue Service invests significantly in engaging young people through delivery of Princes Trust; Kooldown; Fire Cadets and Respect programmes. This investment reduces the volume of deliberate fires, impacts substantially upon levels of anti-social behaviour and helps to increase the amount of physical activity undertaken by youngsters. The great success of these programmes is attributed to the fact that these engagement techniques are delivered in the main to disadvantaged youngsters, which provides them with increased self-esteem, improved social skills, and increased education and training opportunities. • We therefore welcome every opportunity to build upon the partnership work that is already underway, in order to deliver improvement at a faster rate for both our partners and us through the new Local Strategic Partnership framework. ***Cheshire Fire and Rescue Service***
Respondent 3	• The hospital emergency admissions data /codes don't appear to include admissions for accidental injury. This omission is a lost opportunity for the JSNA to put falls prevention (older adults) and preventing accidental injury to children (0-14) into the list of future priorities for Cheshire East.

	• In terms of falls and older adults this has always been an important priority both at national and local level in terms of reducing hospital admissions and improving well being for older adults. Not aware that this priority has changed. • In terms of preventing accidental injury to children, the 2007 joint report from the Health Care Commission and the Audit Commission, entitled "Better Safe than Sorry" identified the need to improve data collection, leadership and action planning at local level to address the problem of child accidents (in the home and on the road, particularly around addressing health inequalities. • On addressing health inequalities and directing resources to where they will make a difference there is a danger that some areas across the whole Cheshire East footprint will attract more resources than others. Action planning for health improvement and reducing inequalities needs to be informed by needs assessment at a local level, involving and working with communities to ensure best use of resources to avoid the danger of missing small health inequality hot spots and widening health inequality gaps. • The health improvement agenda is massively complex and from experience, other competing priorities and limited resources and budgets across partners means proactive health improvement work is often stretched across too many priorities at once, example alcohol v. obesity. There needs to be a clear programme and action planning, clearly defining partners' inputs with a strong focus on a few key priorities at any one time across all partners / communities / third sector if we are to make better progress. Also important for monitoring and evaluation of future working to be built into the process. • Some good partnership work and projects have been delivered to improve health and well being, often through external funding. It is important that the experience and outcomes gained from this work and projects, should not be lost, but help to inform future working and mainstream delivery. ***Macclesfield Borough Council - Health Improvement Service***
Respondent 4	• I have read the report "A First Look" and the information and the statistics are impressive and will be a good basis. However the report does not state the six priorities, why they have been chosen or how they will be achieved. I had to look in the bulletin to confirm the chosen priorities. • The health professionals who already work in the East side of Cheshire have been working together in partnership for some time and are already fully aware of the areas that need to be dealt with. • The report mentions the work carried out by the Primary care trust, for example the Stop smoking service; the National height and weight programme; Breast screening rates etc. However the report does not highlight any work that is currently being done by the health professionals that work for each of the local authorities that will become Cheshire East. For example the work promoting

	exercise and open spaces; work promoting healthy eating and the prevention of food poisoning; the work to reduce obesity; health and safety at work enforcement etc. • If this report is to reflect the "needs" of Cheshire East Council, and if subsequently the priorities are to be identified, then the existing work being carried out will need to be mapped. All four councils that are joining to become Cheshire East have been doing work to promote health to date, but they may not have concentrated on the same targets. ***Congleton Borough Council***
Respondent 5	• There is insufficient evidence to reach most conclusions. You seek to find out more information without saying 'how' and if you don't have resources what happens? No progress? • The needs of children are described in an inadequate manner; you describe activity, diet, obesity, but the permissive approach in schools is inadequate. Major government-led directives through the Department for Children is required – no mention of working through channels to the top. • There is some evidence of cooperation and professional linking between different agencies. The extent of joint working on a range of issues is unknown to us, but evidence seems scant; within meetings such as LSPs, it is no doubt good but a fieldwork level it is unknown. • The extent of physical ill health among people with severe mental health problems is well known, but it appears that the indices of ill health are largely static; this is not only important for this group, but it helps to stew some other adverse indices as well. • Much time is spent on devising strategies, sometimes the cost benefits ratio is hard to see. There have been, for instance, four Suicide Prevention Strategies over the years. Upon each reorganisation, a new one has been produced at great cost. There has never been, so far as I am aware, any money to implement findings; while the production of strategies was necessary for traffic light targets to be achieved, for us on the outside it creates a level of despair. • For all health needs describes in the JSNA, there are possible developments but they may require complementary approaches. These could include market stall type events, "unattached" development workers of all kinds to visit pubs or GP surgeries. An appropriate street worker approach applies as much to the affluent areas as the deprived. The scope for different approaches and shedding the traditional image of the professional could be valuable. ***Crewe and Nantwich Open Minds*** ***(Mental Health Sector Planning Group)***

Respondent 6	• I am particularly encouraged to see that there is some focus being given to the health of those with long term conditions. The work of the Neuromuscular Centre (NMC) is completely focussed on the provision of effective specialised treatment and support for adults across Cheshire (and beyond) who have neuromuscular long term conditions. 100% of our service users report treatment at NMC enables them to stay out of hospital by, for example, vastly reducing incidence of falls and chest infections. • I sense from the report that the focus on long term conditions will mean recognition that people with long term conditions need and benefit from carefully planned care over many years – perhaps this could be more explicitly said? • I would particularly like to see explicit mention of a commitment to enabling self managed care (expert patient) approaches. This is, in my experience, a particularly effective way of sharing the challenge of flexibly planning long term care. • I would expect mention of the need for accessible exercise, but you miss the link that this is important for those with long term conditions. • One of our key objectives at NMC is to enable people to gain and/or continue in paid employment. Focus on increasing employment opportunities for those with disabilities and maximising income for those with long term conditions (and their carers) are priorities. 85% of our service users report NMC as the prime enabler for them being in paid employment. You do mention numbers of people on incapacity benefit but do not really develop the theme into a firm stated priority for action. I feel you should. • Another key objective for us is focussing on improved quality of life. This doesn't seem to get a mention albeit there is focus on correlation between long term conditions and living in the poorest parts of the area. I would argue that poorer quality of life is a particular issue for those with long term conditions and shows little regard to where they live. • As a voluntary sector provider of treatment services for patient with a range of neuromuscular long term conditions, I would welcome a stronger recognition of the vital role of voluntary sector providers for these groups. I would also welcome renewed explicit commitment to working in partnership with the voluntary sector. ***NeuroMuscular Centre***
Respondent 7	• The introduction does state that services for people with long term conditions and disabilities must also be addressed but no reference is made in the remainder of the paper to long term neurological conditions and the number of people affected. ***Mid Cheshire Hospitals NHS Foundation Trust***

Respondent 8	• It is not clear whether this report is written for the general public or professionals. If the former, the following comments are relevant: o Too much jargon and unexplained terminology, e.g. world class commissioning, LAA, LSOA, MSOA – this is spelt out once but what does middle super output area mean – WPD, elective, metabolic syndrome. o Questions 2 to 5 (of the questionnaire) ask whether the report 'addresses' certain issues. Does that mean 'cover', 'deals with'? In either case, it does not set out real actions. o There are a lot of statistics but little / no action other than to obtain more. And what is a stacked bar chart and what is it supposed to tell me? • Much good material but a lot that is not clear. Let's hope the 'second look' improves on this one. • Will the responses be (a) taken on board and (b) published?

Equality and Diversity Monitoring

Question 1:
Gender

Answer Options	Response Count	Percentage	Percentage (answered questions only)
Male	5	50.0	55.6
Female	4	40.0	44.4
Answered question	9	90.0	100.0
Skipped question	1	10.0	-
Total	10	100.0	-

Question 2:
Age

Answer Options	Response Count	Percentage	Percentage (answered questions only)
Under 18	0	0.0	0.0
18 - 24	0	0.0	0.0
25 - 34	0	0.0	0.0
35 - 44	1	10.0	11.1
45 - 54	4	40.0	44.4
55 - 64	1	10.0	11.1
65 - 74	2	20.0	22.2
75+	1	10.0	11.1
Answered question	9	90.0	100.0
Skipped question	1	10.0	-
Total	10	100.0	-

Question 3:
What are the first three characters of your postcode?

	Response Count	Percentage
Answered question	7	70.0
Skipped question	3	30.0
Total	10	100.0

- SK1
- ST7
- CW1
- CW3
- CW4
- CW7
- CW10

Question 4:
Which of these activities best describes your situation?

Answer Options	Response Count	Percentage	Percentage (answered questions only)
Full time work	4	40.0	44.4
Part time work	1	10.0	11.1
Self employed	0	0.0	0.0
Full time education	0	0.0	0.0
Unemployed	0	0.0	0.0
Retired	3	30.0	33.3
Other (please state)	1	10.0	11.1
Answered question	9	90.0	100.0
Skipped question	1	10.0	-
Total	10	100.0	-

Question 5:
How would you describe your sexual orientation?

Answer Options	Response Count	Percentage	Percentage (answered questions only)
Gay	0	0.0	0.0
Lesbian	0	0.0	0.0
Bisexual	0	0.0	0.0
Heterosexual	8	80.0	88.9
Prefer not to say	1	10.0	11.1
Answered question	9	90.0	100.0
Skipped question	1	10.0	-
Total	10	100.0	-

Question 6:
Do you consider yourself to have a disability?

Answer Options	Response Count	Percentage	Percentage (answered questions only)
Yes	1	10.0	12.5
No	7	70.0	87.5
Answered question	8	80.0	100.0
Skipped question	2	20.0	-
Total	10	100.0	-

Question 7:
If you have answered 'YES' to having a disability, how would you describe your impairment?

Answer Options	Response Count	Percentage
Physical Impairment	1	100.0
Sensory Impairment	0	0.0
Mental Health Condition	0	0.0
Learning disability/ difficulty	0	0.0
Long-standing illness	0	0.0
Other (please state)	0	0.0
Total	1	100.0

Question 8:
Please indicate your religion or belief

Answer Options	Response Count	Percentage	Percentage (answered questions only)
Atheism	2	20.0	22.2
Buddhism	0	0.0	0.0
Christianity	6	60.0	66.7
Hinduism	0	0.0	0.0
Islam	0	0.0	0.0
Judaism	0	0.0	0.0
Sikhism	0	0.0	0.0
Prefer not to say	1	10.0	11.1
Other (please state)	0	0.0	0.0
Answered question	9	90.0	100.0
Skipped question	1	10.0	-
Total	10	100.0	-

Question 9:
Please indicate your racial origin/nationality

Answer Options	Response Count	Percentage	Percentage (answered questions only)
Asian: Bangladeshi	0	0.0	0.0
Asian: Chinese	0	0.0	0.0
Asian: Indian	0	0.0	0.0
Asian: Pakistani	0	0.0	0.0
Asian: Other	0	0.0	0.0
Black: Caribbean	0	0.0	0.0
Black: African	0	0.0	0.0
Black: Other	0	0.0	0.0
Mixed: White and Asian	0	0.0	0.0
Mixed: White and Black African	0	0.0	0.0
Mixed: White and Black Caribbean	0	0.0	0.0
Mixed: Other	0	0.0	0.0
White: English	8	80.0	88.9
White: Welsh	0	0.0	0.0
White: Scottish	1	10.0	11.1
White: Irish	0	0.0	0.0
White: Other	0	0.0	0.0
Other: Gypsy	0	0.0	0.0
Other: Traveller	0	0.0	0.0
Other: Any other nationality	0	0.0	0.0
Answered question	9	90.0	100.0
Skipped question	1	10.0	-
Total	10	100.0	-

Question 10:
Are you completing this questionnaire as a representative from an organisation?

Answer Options	Response Count	Percentage
Yes	8	80.0
No	2	20.0
Answered question	10	100.0
Skipped question	0	0.0
Total	10	100.0

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Agenda Item 6

CHESHIRE EAST COUNCIL

HEALTH AND ADULT SOCIAL CARE SCRUTINY COMMITTEE

Date of meeting: 20 May 2009
Report of: Strategic Director – People Directorate
Title: Adult Social Care Redesign - Implementation

1.0 Purpose of Report

1.1 The attached draft report provides an update to the Cabinet on the redesign and implementation of Adult Social Care services and identifies key decisions for taking this forward. It is a comprehensive report that contains significant operational and financial implications for a service which is undergoing transformation and which constitutes a large proportion of the Cheshire East budget at £72m in 2009-10.

1.2 Transformation of Adults Social Care is being driven nationally and these changes represent the most radical review of services for over 20 years. Redesign is now in an advanced state within Cheshire East and will deliver the broad objectives of localised services; handing over control and choice to individuals; reducing bureaucracy; improving preventive and information services and changing the shape and nature of provision.

2.0 Decision Required

Cabinet have been presented with a number of decisions regarding the next stages of the redesign of services for Adults Social Care, as shown in the attached report. Scrutiny Committee are asked to provide any advice or comments in order to assist with these decisions.

3.0 Reasons for Recommendations

3.1 Members have previously approved the direction of travel for Adults Social Care and have incorporated this within the 2009-10 budget proposals. The attached report allows Scrutiny and Cabinet members to take account of the results of the public consultation exercise and to note the detailed implications of the principles of Adult Social care redesign. Permission will be requested from Cabinet to ‘go live’ with the new model in July 2009 applying earmarked temporary monies to support the necessary changes as outlined in the report.

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CHESHIRE EAST COUNCIL

CABINET – DRAFT REPORT

Date of meeting:	16 June 2009
Report of:	Strategic Director – People Directorate
Title:	Adult Social Care Redesign - Implementation

1.0 Purpose of Report

1.0 This paper provides an update on the redesign and implementation of Adult Social Care services and identifies key decisions for taking this forward. It is a comprehensive report that contains significant operational and financial implications for a service which is undergoing transformation and which constitutes a large proportion of the Cheshire East budget at £72m in 2009-10.

1.1 Transformation is being driven nationally and these changes represent the most radical review of services for over 20 years. Redesign is now in an advanced state within Cheshire East and will deliver the broad objectives of localised services; handing over control and choice to individuals; reducing bureaucracy; improving preventive and information services and changing the shape and nature of provision.

2.0 Decisions Required

The Cabinet is recommended to decide to:

2.1 Adopt the new model of Social Care services for Adults, which fully embraces and expresses the personalisation of services.

2.2 Note the responses to the public consultation exercise and support the action taken to incorporate these views within the new model, as appropriate.

2.3 Agree that the implementation of the new model should involve the development and establishment of locality teams across East Cheshire by March 2010, in line with the Council's commitment to localism and Local Area Partnerships.

2.4 Approve the phased implementation by locality teams, starting in Wilmslow, of an upfront Resource Allocation System (RAS) for *all new users* and for users requiring an *unscheduled* review (as defined within the report).

2.5 Agree that a review of implementation of RAS should be undertaken dutring 2009-10 and that subject to the outcomes of that review its application should be extended to all existing users by the end of 20010-11.

2.6 Note the intention to develop a schedule of prices for provider services, based on the current policy of full cost recovery and authorises the Adults and Finance Portfolio Holders to approve the pricing schedule prior to the start of implementation.

2.7 Note the intention to instigate a review the Council's Finance and Contract Procedure Rules to ensure compliance with a personalised approach to commissioning adult social care services

2.8 Agree that reablement services should be offered free of charge to users assessed with Critical or Substantial needs under Fairer Access to Care Services (FACS) criteria on a cost neutral basis.

2.9 Approve the earmarking of Social Care Reform Grant and other carried forward Social Care specific resources up to a maximum of £6.9m, to deliver the changes required as outlined in this report, insofar as these costs cannot be contained within the Directorate outturn position for the duration of the implementation.

2.10 Agree that robust financial and performance management systems should be put in place and that the risks inherent in implementation should be carefully managed on a whole Council basis.

2.11 Require regular reports to be made to members during the implementation of the new model over the medium term**.**

3.0 Background and Options

Context

3.1 In October 2008, Shadow Cheshire East Cabinet accepted Cheshire County Council's recommendations for the delivery of a new model of social care. This model is based on nationally-driven principles of personalisation for Adult Services, as well as the adoption of prevention approaches, lean systems and more customer focused processes. From November 2008 until February 2009, the County Council carried out a comprehensive public consultation exercise about this model and published an evaluation of the results in March 2009 for the two new Councils to receive and address.

3.2 In February 2009, the Shadow Cheshire East Council set its Adult Services budget at £70m, incorporating a reduction of £4.1m (6%). The disaggregated budget contains an underlying overspend against adults under the age of 65, and an underspend against adults over 65. There are emerging growth pressures across the board.

3.3 Central Government has provided Local Authorities with Social Care Reform Grant for three years from 2008-09 in recognition of the magnitude of changes required to move away from traditional models of care and in order to drive through those changes. The Department of Health has made it clear that social care services (in the widest sense) must transform as outlined in Local Authority Circulars 2008 (1) and 2009 (1). Cheshire East has been allocated £1.2m Social Care Reform Grant in 2009-10, which will have to be repaid if not spent as intended. In addition, there is a sum of £3.8m unspent Social Care specific grant monies carried forward from the County Council's Community Services budget and £1.9m one-off budget allocated to transform social care from previous budget settlements. This makes a total of £6.9m as referred to above in decision 2.9. The use of these

resources will provide essential pump priming and transitional support in order to deliver the new model of social care within the challenging budget set and against the backdrop of growth. **Target savings are unachievable without this phased funding, and will put services at risk.**

3.4 The Council will need to consider all the above factors, and how to manage the associated risks, in making decisions about the pace and nature of changes to Adult Social Care Services in the medium term, and what resources it will make available in the longer term. If implemented responsibly, however, the new model provides more responsive services to users, more sustainable services for a wider group in the longer term, counters growth that is being experienced nationally and makes optimal use of resources available to the Council.

The New Model

3.5 Previous reports have outlined in detail the main features and principles underpinning the new model and the programme of work on Adult Social Care Redesign which sits behind its design. In summary, Councils are expected to shift from traditional methods of assessment and provision and enable more choice and control for users to:

(a) understand what they are entitled to, and

(b) have more choice about how best to achieve outcomes against assessed need.

These factors, if applied properly, constitute a massive change to the current delivery of services, to the nature of the services provided and to the financial and operational management of those services.

3.6 Aspects of the new model have been implemented and combined with the transfer to Cheshire East, following the approval by the Shadow Cabinet in October 2008. The new management structure and functional split between Provision, Strategic Commissioning and Individual Commissioning therefore constitute a major shift from the traditional approach to care services and provide the necessary framework to deliver the rest of the model. The structure chart is shown at **Appendix 1.**

3.7 The next stage requires the following actions:

Locality Teams

3.8 In order to improve overall responsiveness and better local working, it is proposed that six locality teams are formed to undertake provision of information and signposting, preventive services, assessment, reablement[1], support planning, provision/commissioning of brokerage and provision of advocacy. A major piece of work has been undertaken to review the processes and systems to be undertaken by these teams, and evidence suggests that a significant amount of unproductive activity can be removed from current systems. The

[1] Reablement is about giving people over the age of 18 years the opportunity and confidence to relearn/regain some of the skills they may have lost, as a consequence of poor health, disability/impairment or going into hospital or residential care, and to gain new skills that help them to maintain their independence

resources required by each team have been estimated on the basis of projected demand in each area. Each team will be 'mapped' onto the seven Local Area Partnership (LAP) boundaries agreed within Cheshire East (one LAP will contain two Patch teams), so that in time their performance can be managed and measured on that basis with other key partners within each locality as well as making an active contribution to how the Council develops LAP working. It is estimated that six operational teams will operate out of four office bases. All teams will encompass flexible and mobile working systems, and be provided with the necessary technical kit for which capital provision exists.

3.9 A detailed implementation plan has been drawn up following extensive consultation with staff, managers, partners and users, and it is proposed that the new model is implemented patch-by- patch starting in Wilmslow in July 2009. All locality teams will be operational by February 2010. A new staffing structure is planned to be in place by October 2009. This aspect of the model will deliver permanent efficiencies, in terms of lean systems and fewer staff involved in process and administration. It will provide enhanced services in terms of prevention and reablement, which in turn will generate better outcomes for individuals. This approach should reduce growth pressures on the social care budget. It will require temporary funding in terms of change management resource and potential redundancy costs.

Provider Services

3.10 Giving users more choice and control will inevitably impact on the current provider market. It is intended to develop more commercial and business-like practice within current in-house providers, and better value and choice for users. In addition, bringing all our providers into a single structure instead of splitting across Adult and Older Client Groups allows leaner staffing structures to be implemented, whilst protecting the level of service. Internal providers will be challenged to cover all costs (including overheads) with income from users and commissioners, to ensure that (a) users want their services and (b) they are financially viable.

3.11 Savings are planned, this year through significant restructuring and reductions in posts as well as rationalising provision where there is a business case for efficiency, as agreed during the budget setting process. In future years, further savings will be achieved through a reshaping of services where only services that meet required outcomes within budget will survive. In the longer term, different, more commercial operating models for providers are currently being explored – in conjunction with Health colleagues – and will be brought back to Members for consideration in due course. Temporary funding is required for change management input, potential redundancy costs and to fund any impact of 'double running' services while some are decommissioned where no longer chosen, required or viable.

3.12 The Strategic Commissioning part of the service will be charged with monitoring and managing the impact on, and effectiveness of, these services, and ensuring that an appropriate level of service is available to meet the Authority's duty of care both from suitable internal and external sources. This includes a specific role to help to manage the market and provide services in a more integrated and efficient manner.

Transport

3.13 The provision of transport will also need to be reviewed in the light of personalisation of services and cost pressures. Most of the transport currently provided within Adult Services is not an assessed care need, and as such does not have to be provided directly by the Authority. However, it has been provided for many years to many people and there is now significant 'dependency' on this form of transport that will take time to tackle. The review will take place over coming months, with recommendations to be brought to Cabinet to coincide with the next budget-setting cycle. It is possible that public consultation will be required for significant changes to current provision. In the meantime, all new users will only be offered transport where it constitutes an assessed need.

Resource Allocation System (RAS)

3.14 Personalisation of Adult Services requires that all users are given a 'Personal Budget' based on an upfront and transparent Resource Allocation System. This means that individuals are told of the level of resources they are entitled to at an early stage in their contact with the service. This work is being driven nationally, and more work has been done in Cheshire than in most authorities, to determine an efficient and safe way of allocating funds for this purpose. More detail about the development of a national RAS framework, the local research carried out by Cheshire County Council and the different approaches to making allocations is attached at **Appendix 2.** Authorities have, since 1998, been legally obliged to offer cash payments to individuals to meet needs in the form of a Direct Payment, but take up nationally has been slow for a variety of reasons. The Government's intention is that the take up of Direct Payments (DPs) and application of Personal Budgets are dramatically increased, that the processes underpinning user choices are transformed and that the method by which DPs are calculated is more transparent and objective e.g. through a RAS. Local Area Agreement (LAA) targets exist and are published annually to monitor Councils' progress towards this goal. Cheshire East is currently exceeding these targets due to the work undertaken in redesigning social care so far, but will not meet the next target level (NI 130) without major changes in culture, procurement rules and structure.

3.15 This directive can be achieved through the application of a formula-based RAS where needs are assessed and allocated 'points' – these are then converted into a numeric allocation through a set formula. Users can opt to take this allocation as a cash payment (Direct Payment). If users opt NOT to take a cash payment, they can continue

to receive services direct from the Council to the level determined in the RAS. This is referred to as a 'virtual budget'. At the present time it is not legally possible for users to purchase services from internal providers using a direct payment. Currently the only way services can be provided to users by internal providers therefore is through a virtual budget.

3.16 It is proposed that the Council adopts an up front Resource Allocation System for all new users and users requiring unscheduled reviews on a phased basis during 2009-10**.** The intention is to then migrate all remaining existing users at review stage by the end of Year 2 (20010/11), subject to an evaluation of this approach and further research during Year 1. This evaluation will be undertaken to ensure that such a method is providing the right outcomes for users and a stable financial situation for the Council and will be reported back to members if significant issues emerge. A summary of the definition of users and the proposed phasing is shown at **Appendix 3.**

3.17 To give an indication of scale, if a formula is applied, full roll out to all users would total **£30m** in a year on current budget. RAS would be applied as part of the roll out of locality teams, patch-by-patch. In the first year a contingency of 20% **(£7.6m)** will be held in the Strategic Commissioning service. This will be used where it is identified that the allocation of funding under RAS does not allow the user to meet their assessed needs and therefore does not fulfil the Council's duty of care – these cases should be exceptional and in future years the level of contingency should be adjusted as the accuracy of allocations improves with experience.

3.18 The amount of funding allocated through the RAS, and contingency levels, and the mechanism by which this is done should be reviewed by the Council on an annual basis as part of the budget-setting exercise. **It must be emphasised that the RAS cannot be used by Councils to make efficiencies and savings per se, as the duty of care to meet assessed need will not change through these developments.**

Procurement issues

3.19 The move towards Personalisation creates a tension between the Council's procurement rules and an individual's scope to direct the commissioning of their support needs. Whilst it will be possible to introduce some elements of individual choice into the present procurement arrangements it will be necessary to review the Council's Finance and Contract Procedure rules if individual choice and control is to be built in to future procurement strategies. This tension applies where individuals choose a virtual budget (as opposed to a Direct Payment) and leave their resource allocation with the Council to commission services to meet the needs of their Support Plan. The Government target N1 130 requires that 'the person (or their representative) can use the funding in ways and at times of their choosing' and the Council's ability to fully meet this criteria (and therefore its desired LAA rating) will be impeded until the current rules are adjusted to reflect this exception.

3.20 Proposals will be presented to Members as they are developed during the first year of implementation. In the meantime, under current procurement rules we will aim to maximise individual choice and control within the current constitutional framework.

Charging Policy and Price Setting

3.21 Service users assessed with critical and substantial needs and who are therefore eligible for services through Fairer Access to Care Services (FACS) criteria, need then to be financially assessed to determine the level of contribution those individuals make to the cost of their assessed needs. The Council's charging policy, which is written in accordance with the Department of Health Fairer Charging Guidance, is not changing under these current proposals. However, there is a need to review some aspects of the current approach to setting the price of services under the inherited County Council policy. As underlined in the public consultation exercise, under the new model it is proposed that Provider Services, and other non residential care services commissioned by the Council, charge at full cost and that existing subsidies are removed in the interests of consistency, transparency and fairness. A schedule of prices is being developed in line with the principles shown at **Appendix 4.** Authority is requested for the Adults and Finance Portfolio Holder to sign off the schedule of prices prior to the start of implementation. Prices will be reviewed on an annual basis to allow for market changes and changes in cost base.

3.22 This change in approach is less of an issue in Year 1, where mainly new users to services will be affected. However, the combination of a new method of calculating allocations (RAS) and internal provider prices reflecting full cost may affect some users already using current services. As stated above, this was one of the main features of the public consultation exercise – there will be 'winners and losers' in this process, and this will have to be managed during the transitional period through the provision of transitional relief funding.

Reablement and Prevention

3.23 Through its budget setting process, the Council agreed to fund reablement and preventative services as part of the implementation of the new model. These services will supplement the existing provision, and will be located across different parts of the service and jointly with Health. It is proposed specifically that those individuals with assessed Critical or Substantial needs will be offered a maximum of six weeks reablement services free of charge, on the basis that this will improve their quality of life and reduce the call on social care budget allocated through the RAS. Overall, the impact on the budget will be neutral.

3.24 The precise application of reablement and preventive services is being developed through specific pilot studies, and will be tested in the roll out of new ways of working in locality teams during the year, for review before the next budget-setting process. Provision of these services that increase independence is being driven nationally.

Joint Working with Health

3.25 Integrated and seamless services delivered jointly with Health are key to leaner, more efficient services. People Directorate of the Council and Central and Eastern Cheshire PCT are now working closely together, and are developing joint change programmes so that services can be designed in the most effective manner. A specific project focusing on the top 100 high intensity users of both Council and Health services is being jointly progressed, and will inform the future design of services. This is being initiated with the involvement of GP practices and community matrons as part of the roll out of the locality team in Wilmslow. In addition, we are exploring alternative delivery models for providers jointly with Health as mentioned above.

Consultation

3.26 A major public consultation exercise was undertaken by Cheshire County Council from November 2008 to February 2009, and results published in March 2009. All the relevant documentation and information from the consultation is publicly available on the Council's website, and a summary of responses is shown at **Appendix 5.** More than 18,000 documents outlining the new model were distributed across the County and over 600 responses were received. The process and evaluation of responses was reported to the County Council's Adult and Health Scrutiny Committee.

3.27 This consultation has provided invaluable feedback for Councils to consider and address as they deliver the new model of social care. Although much of the overall direction is set by Government, there is local discretion which can allow us to respond to public views.

3.28 From the responses received, there was overall support for more choice and control, for clear and transparent charging mechanisms, for alternatives to current services and for more flexibility. Conversely, there were concerns about dealing directly with cash and arranging more tailored types of care unless the necessary support and advice was in place. Such support will be essential when rolling out personal budgets and encouraging people to develop personalised packages of care.

3.29 Specific proposals within the new model reflecting feedback from this exercise are as follows:

3.29.1 There will be a phased implementation of a RAS based Personal budget and locality working starting with new users and those requiring unscheduled review;

3.29.2 There will be further redesign of brokerage and support services to ensure those who need support to get maximum benefit from the new system are equipped to do so;

3.29.3 There will be an transparent schedule of prices where users will be more aware of the choices available to them;

3.29.4 There will be an undertaking by the Council that, where users do not want to handle or administer direct payments, the Adults Service will work on behalf of users to exercise as much choice and control as possible under current rules in utilising virtual budgets;

3.29.5 Pilot the offer of a free reablement service where it can be shown to reduce cost pressure on the Social Care budget;

3.29.6 Explore and address perceptions that changes will affect people unfairly through a comprehensive Equality Impact Assessment (see below).

3.30 Consultation with all stakeholders will need to continue throughout this period of change to monitor and evaluate effectiveness.

Equality Impact Assessment (EIA)

3.31 All Councils have a duty to assess the impact of significant policy changes on diverse user groups. An impact assessment has been prepared in respect of Adult Social Care Redesign and a meeting, facilitated by CHUREC, was held in April 2009 to ascertain and address any issues which may present a potential disadvantage. A report of the meeting will be received by the Council for its consideration in implementation. On the whole, however, personalisation by its very nature should result in services which are more tailored to individual needs and which are inclusive; it is hoped, therefore, that more diversity is achieved. Results of the EIA will be publicly available on the internet and will be taken account of in the implementation of changes as far as possible.

4.0 Financial Implications 2009/10 and beyond

4.1 The Adult Services budget is under severe pressure both locally and nationally due in part to demographic changes and public expectations. Traditional methods of providing social care services are now deemed be unsustainable in the longer term, and do not represent the best use of resources for the best outcomes. There will have to be serious consideration, however, of the amount of reductions that can continue to be made in the future if the Council is to meet its statutory responsibilities and meet national targets.

4.2 The new model of social care is the key mechanism to deliver more responsive services within a reducing cost envelope. Within its 2009-10 budget the Council set a gross budget reduction of £4.1m. The proposals within this report are designed to deliver £3.4m of that target with other specific measures to deliver the remainder eg. Extra Care Housing.

4.3 It had been anticipated that such changes would need significant pump priming of available grants / transitional funding, over and above the National Social Care Reform Grant allocations, in order to be delivered effectively and safely. Access and Capacity Grant was therefore set aside for this purpose during the design work done previously to bring this implementation to fruition. This has been carried forward within the

Cheshire East budget with an understanding that this would be available to fund the transformation. It is proposed therefore that the Council confirm the earmarking of up to £6.9m available Social Care specific grants / temporary funds for this purpose. Broadly speaking this is needed to resource change management skills, potential redundancy costs, double running of services whilst they are decommissioned and phasing support pending the full year realisation of benefits. A summary of the potential commitments and calls on this fund is summarised at Appendix 6. It is proposed that expenditure against this grant is authorised through the Head of Transformation and Finance Manager (People Directorate) ensuring that it is being used for the purposes of transition and transformation over the next 1 – 2 years, ie. the implementation period.

4.4 Robust financial and performance management systems will need to be operated by both service and corporate colleagues in partnership in order to ensure these changes are delivered within budget, that the RAS is being applied appropriately and that preventive and reablement services are generating benefits. This will be a challenge, given the demands of ensuring corporate systems are up and running effectively within a new Council. However, the cost of not pursuing these changes would be excessive and at the same time fail to meet Government directives and public expectations for better, more individualised services. Use of temporary resources to support the change and progress towards the outcomes and financial targets will be closely monitored and reported to members through the Council's outturn reporting process, allowing for review and recourse where necessary.

5.0 Legal Implications

5.1 There are several legal implications which arise as a result of personalisation but no new legislation has been introduced to support the process. All changes therefore have to take place within the existing community care legislation framework. Officers have worked alongside senior officers from Legal Services throughout the development of these proposals and will continue to consult with them on a frequent basis as the proposals are implemented.

6.0 Risk Assessment

6.1 The Adult Social Care Redesign programme has been managed from its inception using the Prince 2 methodology – a disciplined structure of project management which focuses attention on milestones, accountabilities and interdependencies. Risk and Issue Logs have been maintained throughout the process and will continue throughout implementation. Inevitably – as with any transformation – there are several risks in terms of cultural issues, financial management, legal challenge, short term performance management, disruption to existing services, market instability and user anxiety, which have been identified in this report. However, these can be addressed if the nature and pace of change is dealt with responsibly and if the Council responds in a dynamic, coherent and corporate manner.

7.0 Reasons for Recommendation

7.1 Members have previously approved the direction of travel for Adults Social Care and have incorporated this within the 2009-10 budget proposals. This report allows members to take account of the results of the public consultation exercise and to note the detailed implications of the principles of Adult Social care redesign. Permission is requested to 'go live' with the new model in July 2009 applying earmarked temporary monies to support the necessary changes as outlined in this report.

Appendices

Appendix 1 Structure Chart	
Appendix 2 Background Information	
Appendix 3 Phasing of Resource Allocation System Introduction	
Appendix 4 Internal Provider Prices	
Appendix 5 Summary of Responses to the Consultation	
Appendix 6 Temporary Costs and Funding	

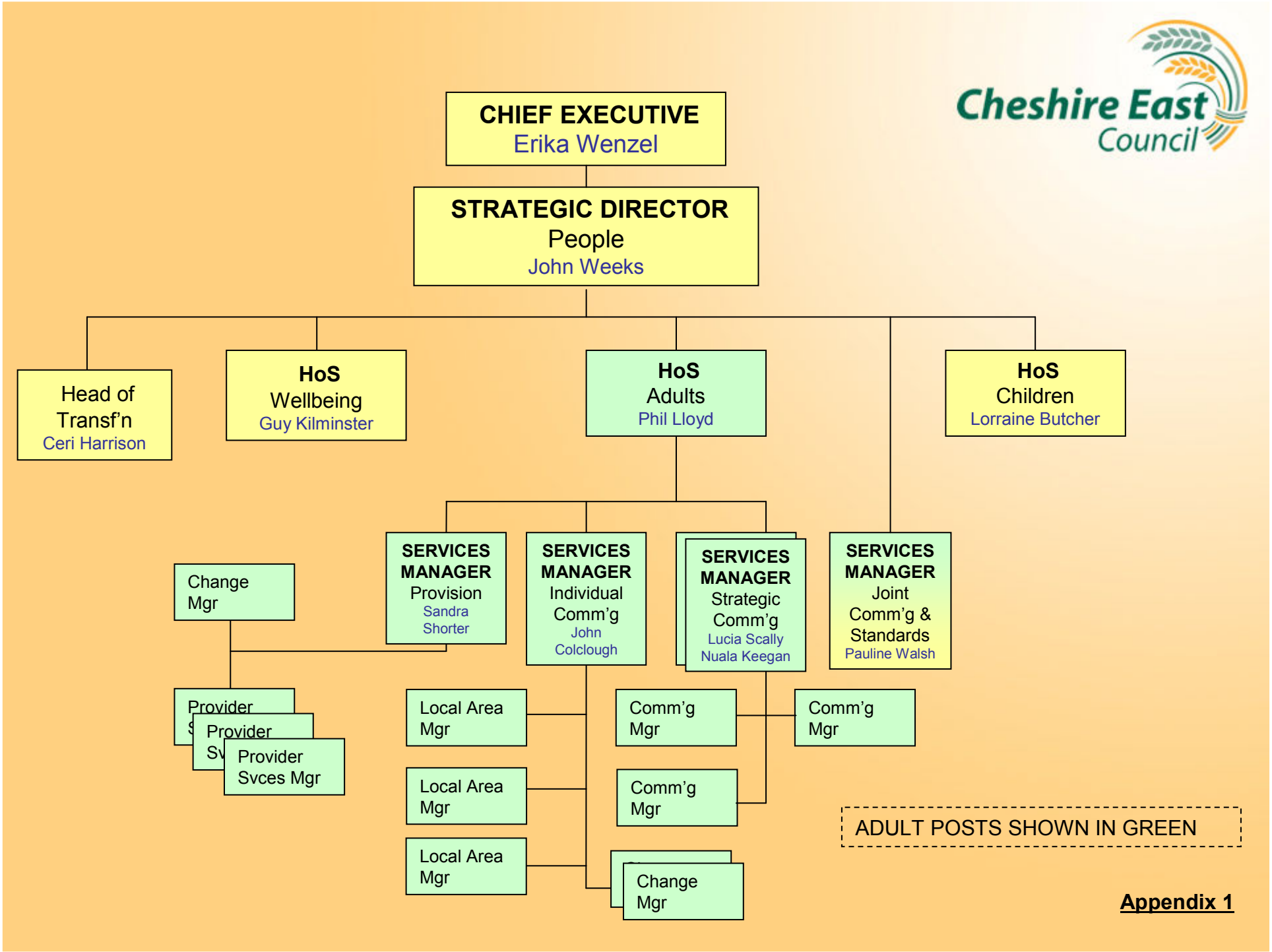
For further information:

Portfolio Holder: Councillor Domleo
Officer: Ceri Harrison / Phil Lloyd
Tel No: 01244 972170
Email: Ceri.Harrison@Cheshireeast.gov.uk

Background Documents:

Documents are available for inspection at:

Local Authority Circular
Consultation and Evaluation Document
Glossary of Terms


CHIEF EXECUTIVE
Erika Wenzel
STRATEGIC DIRECTOR
People
John Weeks
Head of Transf'n
Ceri Harrison
HoS
Wellbeing
Guy Kilminster
HoS
Adults
Phil Lloyd
HoS
Children
Lorraine Butcher
Change Mgr
SERVICES MANAGER
Provision
Sandra Shorter
SERVICES MANAGER
Individual Comm'g
John Colclough
SERVICES MANAGER
Strategic Comm'g
Lucia Scally
Nuala Keegan
SERVICES MANAGER
Joint Comm'g & Standards
Pauline Walsh
Provider
Provider
Provider Svces Mgr
Local Area Mgr
Local Area Mgr
Local Area Mgr
Comm'g Mgr
Comm'g Mgr
Comm'g Mgr
Change Mgr
ADULT POSTS SHOWN IN GREEN

Appendix 1

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Appendix 2

Cabinet - 16 June 2009
Adults Social Care Redesign

Resource Allocation System (RAS) – Background Information

Approach to testing RAS in Cheshire County Council

The approach to testing and modelling the RAS in Cheshire was as follows and in two distinct stages:

Stage one being around a reasonably representative sample of services-user cases, allowing for later refinement of questions, and giving a basis for the initial points for £s allocations and an algorithm for taking account of unpaid carer support (ie, support from family and friends).

Stage two was more thoroughly rigorous and comprehensive, using a statistically significant sample to represent the target population, aiming at 95% confidence level and 9% confidence interval. This was intended to test the use of the questionnaire with well-briefed care managers based on clients on the current caseload, identify the cost of each of these individual's care package, carry out a reasonableness test – ie, could the RAS allocation work for individuals – and then to carry out further modelling and undertake variance analysis. It is important to reaffirm at a population level the averaging out of variances. High level packages of £1000 were taken out of the RAS and provision will be made through a support planning approach/Best Value approach. A contingency also needed to be agreed to ensure the functioning of the financial framework.

Development of the National RAS

The National RAS is being developed to assist Councils by providing an "off-the-shelf" framework that can be utilized locally based on local requirements. It contains three main components:

- A financial framework to develop a RAS;
- An (agreed) self-assessment/RAS questionnaire with suggested scores;
- A systems map

The Department of Health has commissioned 12 Local Authorities who have developed their own RAS and also in co-production with Citizen Leaders to undertake this work. Cheshire County Council (now Cheshire East) was one of these authorities. The aim was for the work developed by these Councils to be evaluated by the group in Autumn 2009, with an ongoing commitment to share progress regionally.

There are key commonalities between the local RAS and the National RAS Framework, which it is important to highlight at the outset before describing any differences.

These commonalities are:

- The basis that the RAS is about a transparent and equitable way of providing resource to meet eligible need.

- The RAS is only ever an indicative amount, with LAs overriding duty to meet assessed eligible needs remaining.

- The RAS is affordable and sustainable.

- That the financial frameworks (or process/approach) used to determine how the RAS should be calculated locally, were the same.

- Likewise the system maps - showing the stage at which the RAS should be deployed – were the same.

- There are high levels of synergy around the domains of need on which the RAS questionnaires are based.

The key differences between the local RAS and the National RAS are in relation to the financial framework, where in the National RAS there will be different allocation tables for different service-user groups and the Budget envelope covers all budget areas, eg Residential Care. Also, in Cheshire we have been in a position to carry out a more thorough and comprehensive approach to the testing and modelling as described above.

Finally, work is still underway by the National RAS group in relation to taking account unpaid carer support (from family and friends) and therefore the resource available to individuals, whereas the Cheshire RAS has addressed this.

Appendix 3

Phasing of the Resource Allocation System Introduction

The introduction of the use of the RAS will take place alongside the introduction of the new patch teams, area by area, as detailed below.

For new users and existing users requiring unscheduled reviews*	
Starting July 2009	Wilmslow Knutsford
Starting Oct/Nov 2009	Macclesfield Poynton
Starting Dec 2009	Congleton
Starting Jan/Feb 2010	Crewe Nantwich
For existing users at time of scheduled annual review	
Starting Mar 2010 Completion by Mar 2011	All areas

** An existing case should be considered as requiring Unscheduled Review when:*
there has been a significant change in the person's needs (ie, a new area of need in FACS terms has been presented) which is likely to persist beyond a 6 week period. Estimated numbers are approximately 3,500 per annum

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APPENDIX 4

INTERNAL PROVIDER PRICES

BACKGROUND

The new model of social care, with personal budgets in the hands of individuals, requires internal providers to set 'prices' for their services for the first time.

> ***Important note****: these* ***prices*** *are the amounts needed from a service user's personal budget to purchase internal provider services, and are distinct from* ***charges****, which are amounts charged to an individual from their own money, based on their assessed ability to pay.*

Providers will generate income sufficient to cover their full costs through a combination of services to ***individual commissioners*** (prices charged to service users, funded from personal budgets allocated through the RAS) and ***strategically-commissioned services*** (funded outside the RAS).

The prices referred to in this Appendix relate only to ***individually-commissioned services***.

PHASE 1 APPROACH

For July 2009, the following principles will apply and will underpin the calculation of internal provider prices:

1. **Standard Average Prices**

   Initially, prices will be calculated on a *standardised, average basis* i.e. each service provision type will set a single price for a single, time-based unit of service, regardless of locality (e.g. one hourly rate for home care, one daily rate for day services, one night rate for respite services etc).

2. **Cost Base**

   Wherever possible, costs will be based on the average costs for 2008/09 from the financial ledger. The main exceptions to this will be:

   - where costs of a service are known to have changed; in this case, the most accurate current costs will be used;
   - where the service delivery model has changed, such that it no longer reflects the structure recorded on the financial ledger; in such instances, costs from other centre codes will be apportioned on the most appropriate basis.

3. **Activity Base**

   Wherever possible, existing activity records for 2008/09 will be used, based upon the most recent 'average' activity period, except where future activity can be reasonably expected to deviate from historic patterns to a material degree. The methodology for calculation of activity will be standardised across similar services, and will be made available for information.

4. **Full Cost Recovery**

   Providers will set prices at the same level as costs, including a contribution towards some overheads (see point 3 below). Providers will not set prices that generate a profit, as they are not yet constituted with the ability to trade

5. **Overheads**

   Prices will include recovery of the following overheads:

   - indirect management structure costs
   - corporate support costs (inc. finance, legal, HR, property management, Health & Safety and IT)
   - transport costs

   They will not include the following:

   - democratic core costs
   - transformation programme management costs

6. **Other Funding Streams**

   Services funded either wholly or partly by other funding streams (e.g. health monies, Supporting People income etc) will set prices net of that income i.e. Cheshire East Council will not seek to 'double recover' the costs of that element of the service. Where this funding is location-specific, the effect of that income will be spread across the whole of the relevant service, in keeping with the principle of standardised, average prices (see Point 1 above).

7. **Strategically Commissioned Services**

   Costs associated with the provision of strategically commissioned services, including reablement and the 'service of last resort', will be removed from the calculation of these prices.

8. **Contingency**

   An element of contingency has been withheld from the RAS allocation to fund transitional relief and supplementary allocations, as required. Internal provider prices are unaffected.

The list of actual prices will follow, and will be shown in Table 1 below.

Internal providers will be supplied with information technology to enable them to monitor and manage the impact of their prices on their full cost recovery position. Prices will be set at the beginning of the implementation in July 2009, and they will not be reviewed more frequently than on an ***annual basis***.

In addition, internal providers will develop standard ***terms and conditions*** for the application of these prices that identify for the service user the way in which these prices will apply.

PHASE 2 AND BEYOND

As the RAS allocation is rolled out on a patch-by-patch basis, detailed work will continue on options for setting local prices (i.e. specific to a given provider unit) and activity- or need- (rather than time) based prices e.g. separate prices for swimming at a day service, as compared with horse riding or snooker, additional prices for additional support needs etc.

Table 1

Service	Establishment(s)	Unit	Price

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Appendix 5

Summary of responses to the consultation on the future direction of Adult Social Care in Cheshire

Health & Adult Social Care Scrutiny Committee: 11 March 2009

1. CONSULTATION PROCESS

The public consultation period took place between 17 November 2008 and 16 February 2009.

In order to reach certain groups this consultation process went beyond the traditional, written consultation exercises. As well as public meetings held in East and West Cheshire there were also six roadshow events where a bus staffed by officers representing Cheshire was situated in busy public areas.

2. MEETINGS AND EVENTS

These took place throughout January and February 2009.

Six public consultation meetings were held in Christleton, Macclesfield, Crewe, Winsford, Ellesmere Port and Congleton at which a total of 327 people attended.

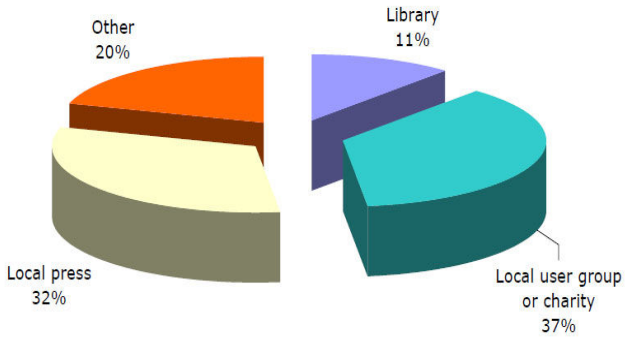
Roadshow events took place in Nantwich, Chester, Ellesmere Port, Macclesfield, Northwich, Congleton and Alsager.

3. DOCUMENT, QUESTIONNAIRE AND RESPONSES

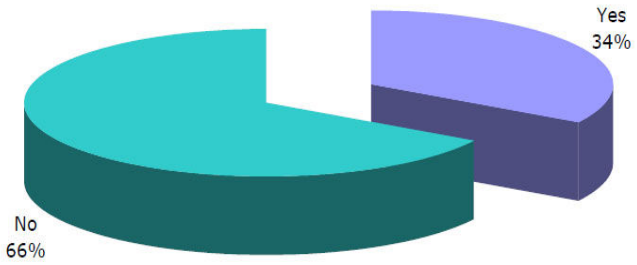
A 16-page consultation document, *Let's Make it Personal in Cheshire,* with a tear out questionnaire and a 12-page shorter version/easy read document was produced. Eighteen thousand copies of the consultation document (including easy read versions) were distributed to members of the Cheshire Older People's Network, charities, libraries, GP surgeries, health promotion networks and members of the consultation team spoke about the consultation in a number of forums; the document was also available on the web. Over 600 responses were received.

The questions asked are shown below along with summarised responses:

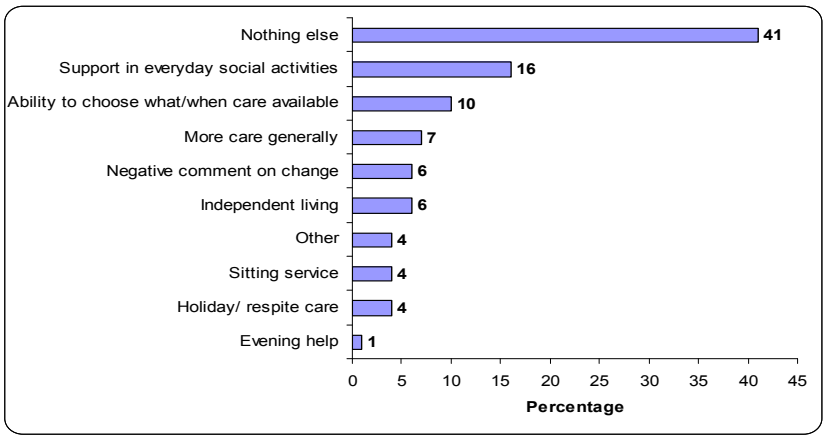
Question 1 - How did you find out about this consultation?



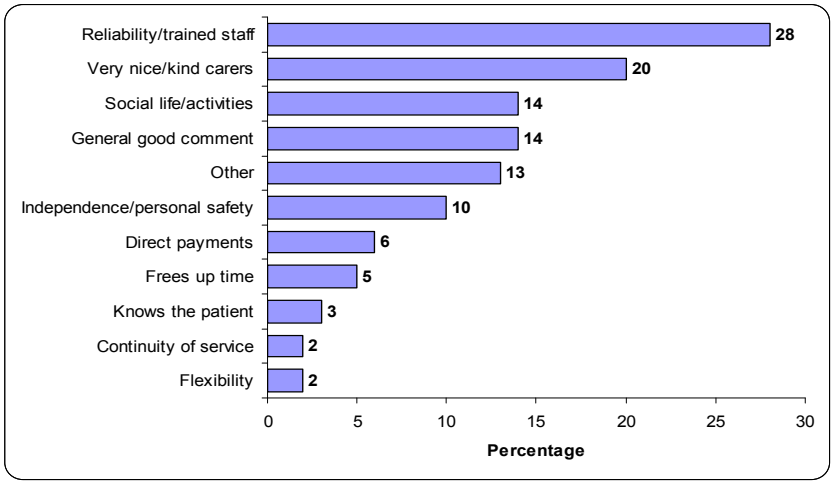
Question 2 - Are you an existing service user or carer?



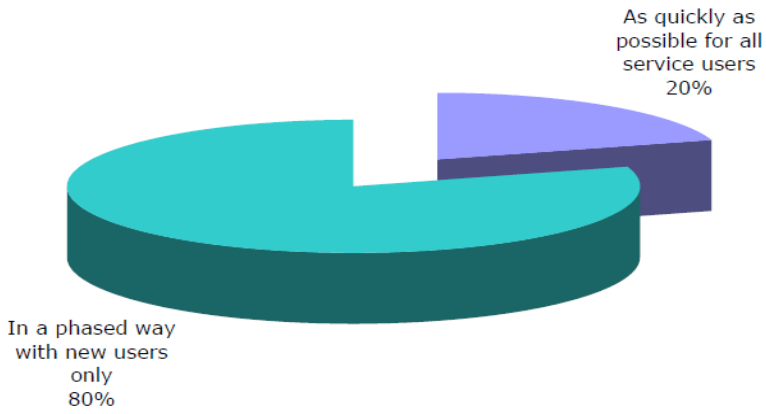
Question 3 - Given that the new proposals will offer more choice on how to meet your needs, is there support which you currently don't get that you would like to spend your Personal Budget on?



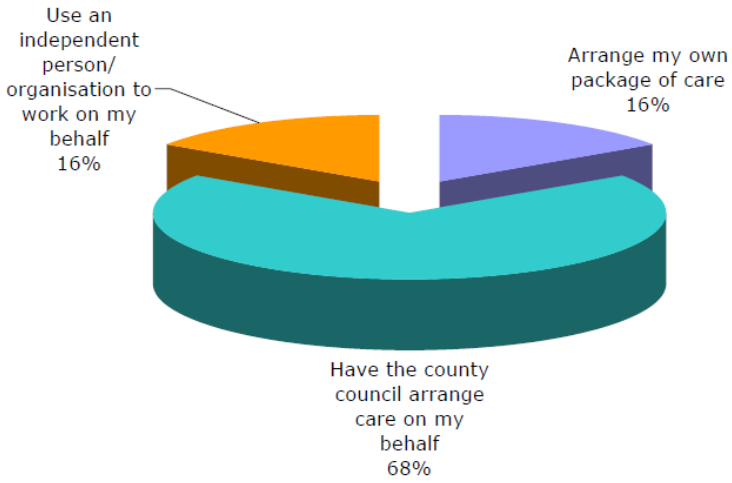
Question 4 - What do you particularly value about the care services we provide at the moment?



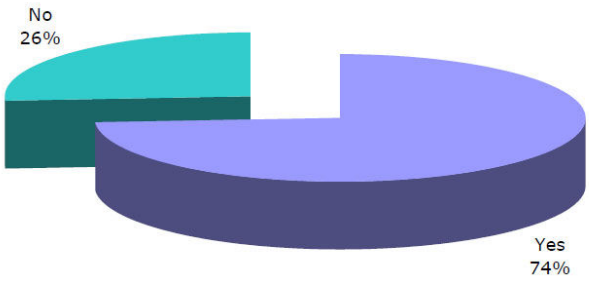
Question 5 - I would prefer to see the proposed new system introduced



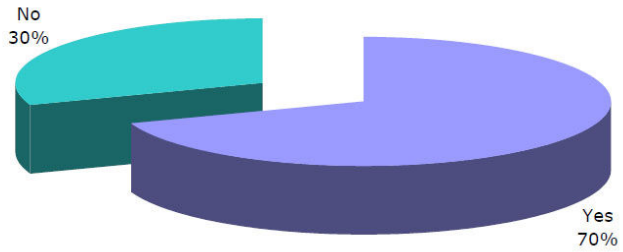
Question 6 - Given the choice I would prefer to



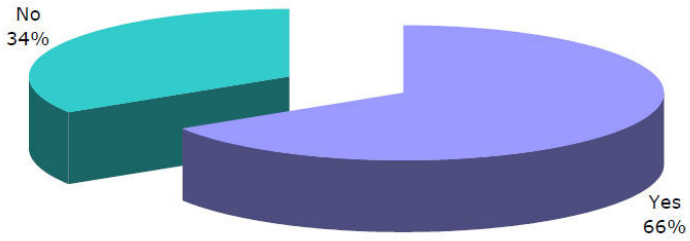
Question 7 - I would welcome a clearer set of prices from the County Council, which will allow me to compare the costs for care services and make the appropriate decisions to suit my circumstances, even if this means that the costs of some elements of a care package may change.



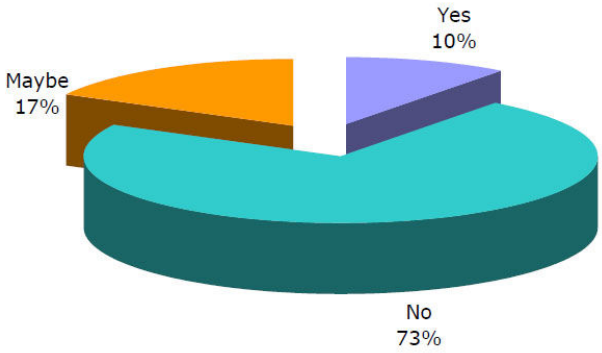
Question 8 - Would you use an offer of 'reablement' services if these were free of charge (up to six weeks)?



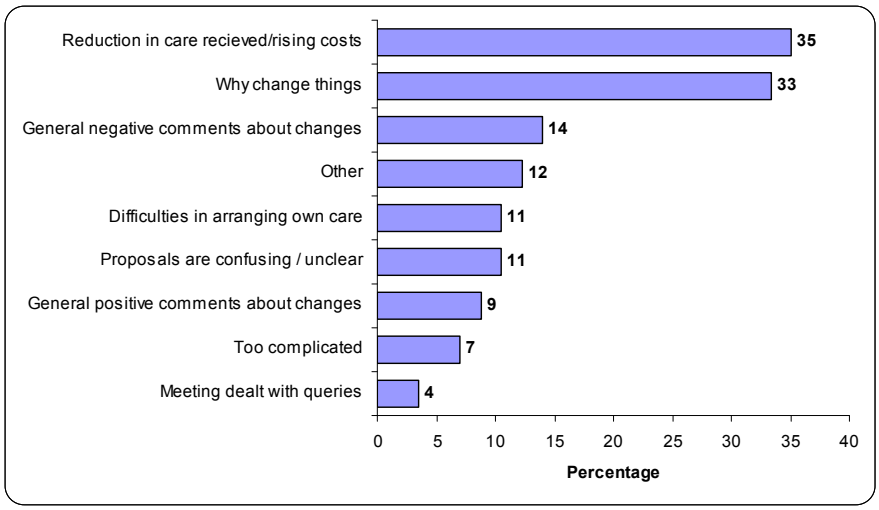
Question 9 - With a Personal Budget your contribution (and the Council's) would not vary month on month. If your needs or services fluctuated by small amounts it is assumed these would even out over time. Would this increased certainty help you to manage your budget?



Question 10 - Do you feel that these changes will affect you unfairly on the basis of your race, gender, disability, sexuality or culture?



Question 11 - Please tell us about any other comments or concerns that you might have regarding these proposals



KEY ISSUES RAISED

Generally, people's concerns can be summarised as follows:

- Pace of Change.
- Support service users will receive in managing their budget.
- Will it mean cuts in service?
- Quality of Services.
- Safeguards.

NEXT STEPS

- Health and Adult Social Care Scrutiny Committee to comment and advise.
- Summary of responses to be widely published.
- New councils to receive summary of responses and take account of this consultation exercise in developing new models for Adult Social Care.

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APPENDIX 6

TEMPORARY COSTS AND FUNDING

	East £000s	
Grant Carry Forward (subject to outturn)		
Access and Capacity	-2,723	
Social Care Redesign (SCR)	-502	
Training	-566	
	-3,791	
New Grant Allocations		
SCR Implementation Grant	**-1,205**	
Temporary Budgets Available		
Transforming Cheshire Change Budget	-399	
SCR Implementation Budget	-624	
SCR Growth Budget	-936	
	-1,959	
Funding	**-6,955**	
Potential calls on temporary funding:-		
Temporary Costs		
Transitioning – SCR Implementation		
Phased Savings	1,063	Relates to phased reduction in provider costs & reduction of care package costs through reablement
Addtl savings to fund 0.5% inflation decision	231	Budget setting requirement
Double Running Costs	1,250	Where individuals choose other providers but our services are still running under capacity
Change Team	600	Costs of backfill/external consultants, etc
Early Adopters	250	Cost of launching new ways of working whilst decommissioning old team structure
Redundancy – broad estimate	1,500	Worst case scenario
	4,894	
Addtl Cost of Inherited Payroll		
Employees	300	Cost of disag staff structure over 2009-10 budget
Agency Workers	220	
	520	
Permanent Gaps Requiring Temp Funding		
Other funding requests		
Access restructure	175	Cost of splitting Access and maintaining whilst launching new ways of working
Dementia Strategy – to consider	-	Set-up costs of Dementia Strategy will need to be funded from current grant provision
Direct Payments admin	120	
PARIS financials support	100	Cost to bolster current implementation
PARIS development team – to consider	-	
SAP team	145	
Other	72	
	612	
Flexible Mobile Working Saving	**146**	Imposed via budget setting to pay back capital investment – budget already contains £250k target
Costs	**6,172**	
Remaining Balance	**-783**	

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CHESHIRE EAST COUNCIL

HEALTH AND ADULT SOCIAL CARE SCRUTINY COMMITTEE

Date of meeting: Wednesday 20 May 2009
Report of: Borough Solicitor
Title: Calendar of Meetings

1.0 Purpose of Report

1.1 To review the programme of meetings for the year.

2.0 Decision Required

2.1 That the Committee revise its current programme of meetings, to meet in future normally on an 8 week cycle as described below, so as to enable arrangements to be made for mid point meetings as previously determined, and to accommodate other Health and Adult Social Care scrutiny requirements.

3.0 Financial Implications 2009/10 and beyond

3.1 None.

4.0 Background and Options

Background

4.1 With the exception of August, the Committee is currently due to meet every month this year through to April 2010 inclusive. All of the other Scrutiny Committees are operating on a six meetings per year cycle. In addition, the Committee on 16 December 2008 decided to hold "mid point" meetings of the Chairman, Vice Chairman and Group Spokespersons, in order to review and plan the Health and Adult Social Care business and to assess and take preliminary views on NHS proposals for Substantial Developments and Variations of services. It was intended that as well as Cheshire East Officers, representatives of the PCT and the Hospital Trusts as appropriate should attend the mid point meetings to help with business planning and develop effective working relationships.

4.2 Whilst it is recognised that the volume of business required to be dealt with by the Committee will be demanding, Members may feel on reflection that a regular Committee meeting every 4 weeks may not be sustainable. There is a need to retain space to address short notice scrutiny issues and conduct scrutiny through specific reviews and Joint Panels as well as through the full Committee. The dates of meetings for the Mental Health Partnership Trust Joint Scrutiny

Committee with Wirral and Cheshire West and Chester Councils have yet to be fixed for the year and will have to be accommodated. It would also be very difficult to provide for the mid point meetings within such a demanding cycle. There will undoubtedly be a lot of Member Development and familiarisation activity required over the forthcoming year at least to help Members "get to grips" with the very wide external agenda in the NHS in particular.

4.3 Accordingly the Committee may wish to consider moving to an 8 week pattern of meetings, similar to the other Scrutiny Committees. If this was acceptable, the current dates for the meetings after this would be retained in July, September, November, January and March. The remaining dates could be kept in the diary and used for the mid point meetings and Member Development activities. Of course, if exceptionally there was formal business which could not await the next meeting, the Committee could still be convened on the previously arranged dates to deal with it. The calendar of meetings for the following year (2010 - 11) could then be agreed in the light of this year's experience.

5.0 Risk Assessment

5.1 There are no identifiable risks.

For further information:

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Background Documents:

Documents are available for inspection at: None