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Health and Adult Social Care Scrutiny Committee

Agenda

Date:	**Thursday, 9th September, 2010**
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.

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

Please contact	Denise French on 01270 686464
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

A total period of 15 minutes is allocated for members of the public to make a statement(s) on any matter that falls within the remit 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 members of the public notified the Scrutiny officer listed at the foot of the agenda, at least one working day before the meeting with brief details of the matter to be covered.

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

To approve the minutes of the meeting held on 12 August 2010.

5. **Dr Foster report "How Safe is your Hospital?"**

Paul Dodds, Medical Director of Mid Cheshire Hospitals NHS Foundation Trust, and Dr Bill Forsyth, Medical Director of Central and Eastern Cheshire Primary Care Trust, will brief the Committee on issues contained in the Dr Foster report “How Safe is your Hospital?”.

6. **Temporary closure of Tatton Ward, Knutsford Community Hospital by East Cheshire Hospital Trust** (Pages 5 - 8)

To consider a report on the temporary closure of the Tatton Ward.

7. **Proposed changes to Mental Health Services in Central and Eastern Cheshire** (Pages 9 - 20)

To consider a report on proposed changes to mental health services.

8. **Annual Public Health Report** (Pages 21 - 54)

Dr Heather Grimbaldeston, Director of Public Health, will present on the Annual Public Health Report and a copy of her presentation is attached.

The Annual Public Health Report will be circulated to all Members of the Council on 3 September, please bring your copy with you to the meeting.

9. **Joint Strategic Needs Assessment** (Pages 55 - 62)

To consider a report on the Joint Strategic Needs Assessment.

10. **Review of Health Inequalities in Cheshire East** (Pages 63 - 76)

To consider a report of the Associate Director of Public Health, Central and Eastern Cheshire Primary Care Trust, on health inequalities.

11. **NHS White Paper - Equity and Excellence, Liberating the NHS** (Pages 77 - 84)

Fiona Field, Director of Governance and Strategic Planning, Central and Eastern Cheshire Primary Care Trust, will brief on the main issues contained within the NHS White Paper published in July 2010. A briefing note outlining the main points is attached.

Agenda Item 4

CHESHIRE EAST COUNCIL

Minutes of a meeting of the **Health and Adult Social Care Scrutiny Committee**
held on Thursday, 12th August, 2010 at Council Chamber, Municipal Buildings, Earle Street, Crewe CW1 2BJ

PRESENT

Councillor B Silvester (Chairman)
Councillor C Beard (Vice-Chairman)

Councillors D Flude, S Furlong, S Jones, W Livesley, A Martin, A Moran, A Thwaite and C Tomlinson

Apologies

Councillors C Andrew, G Baxendale and S Bentley

53 **SUBSTITUTE**

Councillor R Parker

54 **IN ATTENDANCE**

Councillor R Domleo, Portfolio Holder for Adult Services
Councillor O Hunter, Cabinet Support Member for Adult and Health Services
Councillors T Beard, R Cartlidge and R Westwood

55 **OFFICERS**

P Lloyd, Head of Adult Services
J Greenwood, People Directorate
M Flynn, Legal and Democratic Services

56 **DECLARATION OF INTERESTS/PARTY WHIP**

Councillor D Flude – Personal Interest as a member of the Alzheimers' Society and Cheshire Independent Advocacy

Councillors R Domleo and O Hunter – Personal and Prejudicial Interest in respect of item 57 – Call In of Key Decision 48 – Future Provision for Older People with Dementia – in accordance with paragraphs 11 and 12 of the Member Code of Conduct.

57 **PUBLIC SPEAKING TIME/OPEN SESSION**

Mrs Denise Roberts spoke regarding her concerns at the proposed closure of Cypress House, Handforth which was to be the subject of consideration by the Committee later in the meeting at item 57.

58 MINUTES OF PREVIOUS MEETING

RESOLVED - That the minutes of the meeting held on 1 July 2010 be approved as a correct record and signed by the Chairman.

59 CALL IN OF KEY DECISION 48 - FUTURE PROVISION FOR OLDER PEOPLE WITH DEMENTIA

In accordance with the Scrutiny Procedure Rules, a valid notice had been submitted which required this Committee to consider and, if appropriate, offer advice on the decision taken by Cabinet on 19 July 2010 concerning the implementation of the Living with Dementia Strategy and the closure of Cypress House, Handforth. The Chairman advised Members of the procedure to be followed, and the options available to the Committee, as set out in the report included in the agenda.

On behalf of the Members who had signed the call in notice, Councillor D Flude outlined the basis for the call in, namely that the business case to develop further sites in Macclesfield and Congleton jointly with the Central and Eastern Cheshire Primary Care Trust (PCT) might not be achievable, due to financial constraints and the proposed abolition of PCT's in 2013. It was also felt that insufficient opportunity had been given to the Committee in its overview role to examine the development of the Dementia Policy, from which the decision to close Cypress House had arisen.

Councillor R Domleo, as the Portfolio Holder for Adult Services, outlined to the Committee the reasons for the decision taken by the Cabinet with regard to the Living with Dementia Strategy, and the specific proposal to close Cypress House. The report considered by the Cabinet, which set out the issues and options, together with the full decision of Cabinet had been circulated to the Committee to provide the necessary detailed information. Cabinet took the view that, although social care redesign had made the delivery of services more efficient, more remained to be done to remove spare capacity from the system. The under utilisation of beds in Cypress House made it necessary to consider the future provision there, particularly as sufficient alternative and suitable facilities were available in the locality. The closure of Cypress House could be agreed without any diminution of service to users and carers.

The Portfolio Holder indicated that the proposed changes could, if necessary, be delivered prior to 2013 without the active engagement of health partners, although it was understood that the PCT was already beginning to discuss with GP Practice Consortia the future direction and delivery of key projects including the changes relating to the Dementia Strategy. It would be regrettable if structural changes in the NHS were to have a detrimental effect on the need to provide a more relevant and effective pattern of provision for dementia sufferers. The call in, whilst raising these issues, did not in the Cabinet Member's view say how the

financial constraints and structural changes would impact on the decision to close Cypress House.

Members of the Committee asked a number of questions, which covered the following issues:

- Whether the consultations on the closure of Cypress House dealt with the financial constraints faced by the authority and the impact on the neighbourhood, as well as the implications for service users and carers

- Whether customers who required intermediate care following discharge from hospital could still access this provision prior to their return home, and whether they would have to travel further to obtain a bed

- Whether the alternative provision including the Handforth Centre could offer the same levels of support, services and user experience including the opportunities for social interaction as at Cypress House, given its Care Quality Commission rating as excellent

- How the resources available and utilisation levels at Cypress House compared with other establishments

- The extent to which the decision to close Cypress House had been finance led, rather than by the needs of service users

- Whether the proceeds of sale from the surplus property would be reinvested into Adult Social Care services

In response, the Portfolio Holder confirmed that the average vacancy rate across the five Community Support Service residential establishments was 56 beds at any one time, and that this could not be sustained. Even with the closure of Cypress House 31 surplus beds would remain in the system, so customers requiring a bed would be able to access the service. The consultation had been about which of the premises should be closed, and recognised that alternative facilities in the north of the Borough were located within reasonable distance from Cypress House. There was evidence that even at present, service users chose to travel to their preferred facility, which may not be the nearest one.

Councillor Domleo was impressed with the quality and enthusiasm of the staff at Handforth House and noted that many would be redeployed from Cypress House, thereby bringing their relevant skills and experience with them. The Council's policy was that surplus property became a corporate resource, any income from which was not necessarily used for the benefit of the service concerned.

Members reiterated the view that it would have been preferable for the Committee to have been able to exercise its overview role more fully in advising on the development of the Dementia Policy, in addition to consideration of the detailed proposals which resulted from the application of that Policy.

There being no more questions for the Cabinet Member, in view of their Personal and Prejudicial Interest in the matter, at this point both Councillors Domleo and Hunter withdrew from the meeting.

In accordance with the call in procedure, the Committee considered whether or not advice should be provided to the Cabinet on its decision. Members raised issues concerning the priority to be afforded to the needs of service users, given that the incidence of Dementia was increasing in the Cheshire East area, taking into account the surplus capacity and financial considerations. Members were advised that the cost of keeping Cypress House open amounted to £16000 per week, which could be redirected to provide additional investment in other care services. At the last meeting of the Committee, a Task Group had been appointed to carry out a review of Support for Older People with Dementia, to which the proposal for Cypress House could be referred in the context of the Dementia Policy. Members also took into account the resource implications and the costs involved in delaying the proposed closure.

RESOLVED

That no advice be offered to the Cabinet on this matter.

The meeting commenced at 2.00 pm and concluded at 3.07 pm

Councillor B Silvester (Chairman)

East Cheshire NHS
NHS Trust

Report of	Director of Performance and Quality
Paper prepared by	Kath Senior – Director of Performance and Quality Ann Marriott / Debbie Burgess – Medical Business Unit
Subject/Title	Temporary Closure of Tatton Ward
Background papers (if relevant)	N/A
Purpose of Paper	To inform the Overview and Scrutiny Committee of the rationale for the temporary closure of 18 beds at Knutsford Community Hospital and the associated management plan
Action/Decision required	Agreement on approach and shared understanding of actions to mitigate clinical risk
Identify NHSLA and CQC Standards to which this report relates:	**CQC Standards** **Suitability of staffing** Outcome 13 - Sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity. **Quality and management** O16 Assessing and monitoring of the quality of service provision to identify and manage risks relating to the health, welfare and safety of service users **NHS LA** Standard 1 - effective governance & risk management
Link to: ➢ **Trust's Strategic Direction** ➢ **Corporate Objectives**	**Patients** To continuously improve quality, safety and the patient experience.
Resource impact	
Abbreviations	CQC – Care Quality Commission ECT – East Cheshire NHS Trust PBC – Practice Based Commissioning EMB – Executive Management Board

Temporary Closure of Tatton Ward

1. Purpose of Report

1.1. To inform the Overview and Scrutiny Committee of the temporary closure of 18 beds on the Tatton Ward, Knutsford Community Hospital, with effect from Monday 6 September.
1.2. To explain the rationale for closing the beds and describe the range of options considered prior to closure.
1.3. To describe the process for managing the impact of bed closure
1.4. To provide assurance on the process for reviewing bed and staffing status

2. Context

East Cheshire NHS Trust provides Intermediate Care Based Bed services for the local health community across 3 sites:

- Tatton Ward at Knutsford Community Hospital has 18 intermediate care beds
- Aston Ward at Congleton War Memorial Hospital has 28 intermediate care beds
- Ward 11 at the Macclesfield site has a further 10 intermediate care beds.

In recent months, there have been persistent problems in recruiting middle grade doctors and this has seriously depleted the medical staffing rota. This has been compounded by a consultant staff vacancy. Efforts to secure locum staffing have been unsuccessful. Whilst the elderly care consultant and other medical staff have strived to provide an extended medical staff presence at both Knutsford and Congleton sites, this is not sustainable, even in the short term. An alternative way of providing inpatient care is urgently required that enables safe and sustainable staffing levels in the short term. This will allow a review of current staffing levels, recruitment, skill mix, utilisation and case mix, to be undertaken in collaboration with local GPs, commissioners, social services and other agencies.

The Macclesfield site has had 15 beds closed on an acute medical ward for the last 3 months and this has enabled essential maintenance work to be undertaken. The level of demand for acute beds is currently such that there is no requirement to re-open these 15 acute beds.

3. Options

1) Close Aston Ward at Congleton War Memorial Hospital

   The Aston Ward has 28 Intermediate Care beds and this level of reduction would place a significant amount of pressure on remaining beds in the health community.

2) Close an acute ward on the main hospital site and redeploy staff to Knutsford

   There are already 15 beds closed on the Macclesfield site and the medical staff rotas are still unable to provide a safe level of medical staffing across the 3 sites. This option does not ease the pressure on medical staffing rotas.

3) Close beds at Tatton Ward, Knutsford

   The Tatton Ward has 18 beds which could be re-provided on the Macclesfield site by converting the acute beds which are currently closed.

   In the short term, this is the preferred option.

4. Approach

4.1. The Tatton Ward will be closed to admissions for 4 months and medical staff will be deployed across the 2 remaining sites. This allows time to review staff rotas, skill mix, bed occupancy and utilisation. It is estimated that this will take 3-4 months. In addition, nursing and clinical support staff from Tatton Ward will be re-deployed to appropriate ward areas at Macclesfield and Congleton, dependent on skills and experience. An acute rehabilitation team will be established to mitigate potential impact of a change of use of beds on ward 10. This will ensure patients receive appropriate nursing care, therapy and clinical treatment, and maintain the focus on effective and timely patient discharge. Length of stay will be closely monitored.

These arrangements will be reviewed weekly by the senior management team. If the issues can be resolved within 4 months the beds will be re-opened.

5. Risks

5.1. The timing of the closure
If there is a peak in admissions during the early winter period there may be a shortfall in bed capacity and this may delay patient admission and discharge processes. The trust has appropriate polices and procedures in place to support the management of escalating bed pressures and will continue to work closely with partners in primary and social care to prevent delays in admission and discharge processes.

5.2. Inability to recruit medical staffing in the medium term
If continued recruitment fails then this will impact on the timing of the decision to re-open the beds. The trust regularly reviews skill mix and staffing levels in all acute areas and will continue to advertise middle grade vacancies. A new consultant will commence in post in November.

6. Communication

6.1. Clear, consistent and appropriate communication with key stakeholders is essential.

The following groups have been briefed:

- Staff on Tatton and Aston
- East Cheshire Trust staff
- Cheshire East Council
- Cheshire East Community Health, specifically the intermediate care service
- Patients at Aston, including relatives and carers
- Member of Parliament for Knutsford
- League of Friends for Tatton
- General Practitioners and PBC leads
- General public and media

7. Summary

7.1. In summary, this is a temporary transfer of service provision to mitigate clinical risk associated with a shortfall on medical staff rotas. The care provided to all patients must be clinically safe and sustainable and it has been agreed that the temporary closure of Tatton Ward is the preferred option in the short term.

This situation will be reviewed by the Executive Management Board (EMB) on a regular basis and in consultation with key stakeholders.

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Central and Eastern Cheshire NHS Primary Care Trust

cwp

Cheshire and Wirral Partnership NHS NHS Foundation Trust

Briefing Paper for Overview and Scrutiny Committees

September 2010

Proposed Changes to Mental Health Services in central and eastern Cheshire

Contents:

Proposed Changes to Mental Health Services in central and eastern Cheshire

The attached paper has been written to advise Overview and Scrutiny Committees within the area served by Central and Eastern Cheshire PCT (the PCT) of proposed changes to mental health services provided by Cheshire and Wirral Partnership NHS Foundation Trust (CWP) within the central and eastern Cheshire area.

This paper will be presented by CWP and the PCT at the September 2010 meetings of the following committees:

- Cheshire East Health and Adult Social Care Overview and Scrutiny Committee
- Cheshire West and Chester Health and Wellbeing Select Panel
- The Cheshire and Wirral Councils' Joint Scrutiny Committee

An initial briefing about the process used in the development of these proposals was given to the Joint Scrutiny Committee in July 2010.

Context for these proposals

As a result of changes to the way that some mental health services are funded, the PCT has identified a shortfall of £1.4 million in its budget to commission mental health, learning disability and drug and alcohol services.

CWP and the PCT have worked together over recent months to identify how services can be delivered even more effectively whilst maintaining and improving quality and ensuring that care is provided within the funding available. Both organisations are committed to ensuring that there is no negative impact on the quality of health care as a result of any changes.

The PCT and CWP have applied a prioritisation tool to all of the mental health, learning disability and drug and alcohol services that are commissioned from CWP for residents of central and eastern Cheshire. Use of the prioritisation tool ensured that the process of identifying potential service changes was fair, as all services were reviewed using the same criteria. Copies of the prioritisation tools are included in Appendix 1.

Having applied the prioritisation tools, three proposals have emerged, which are summarised below. Two of the proposals are also described in detail in Appendices 2 and 3. The proposed service changes will deliver the almost all of the recurrent savings required from 2011-12 onwards (The Willows: £561k, IAPT: £546k and Riseley Street, £245k).

Summary of proposals

1) CWP would no longer be required by the PCT to provide social support services at The Willows day centre in Macclesfield. All service users that access this service are already cared for by community mental health teams, and would be supported to use alternative day services through mainstream facilities such as colleges and local authority run schemes.

2) CWP would no longer be required by the PCT to provide learning disability respite care services from Riseley Street Macclesfield. Service users that require this specialist care would receive it from Crook Lane in Winsford.

3) CWP would redesign the central and eastern Cheshire Improving Access to Psychological Therapies (IAPT) service to make it more efficient, with no adverse impact on care for patients.

Key tests for service change

In August 2010, David Nicholson, the NHS Chief Executive, advised all NHS organisations that the Secretary of State had identified four key tests for service change, which are designed to build confidence within the service, with patients and communities. The tests, and our response to these, are as follows:

1) Support from GP commissioners

Individual GP commissioners have been involved throughout the prioritisation process and the wider GP community has been updated regularly about progress with this work through communication with the PCT's Commissioning Executive whose membership includes GPs from each of the Practice Based Commissioning Consortia. The Commissioning Executive has given their support to these proposals.

2) Strengthened public and patient engagement

There has been public and patient involvement in the development of the proposals to date through the project board for the prioritisation process, which includes representation from service user and carer groups (including LINk members). The prioritisation process has also been widely discussed at the PCT led service development group, which includes service users, and at a number of service user and carer forums including East Cheshire Mental Health Forum.

Plans to consult service users and the wider public on the proposals and their implementation are included in Appendices 2 and 3.

3) Clarity on the clinical evidence base

The clinical effectiveness and outcomes delivered by each CWP service that the PCT commissions were among the criteria considered as part of the prioritisation process.

4) Consistency with current and prospective patient choice

In the case of The Willows, patient choice will be ensured by facilitating access to services in mainstream locations and supporting organisations to ensure that service users from The Willows can access their services directly.

The proposals for Riseley Street are made in the context of a range of respite services being available in Cheshire including health respite provision at Crook Lane in Winsford local authority provided residential respite services and other options for individualised support.

The redesign of IAPT services is intended to increase efficiencies and productivity within the service and has no implications for levels of patient choice.

Consultation on proposals

Guidance is sought from the committees as to the level of consultation that is required relating to each of the proposals outlined above and described in full in Appendices 2 and 3.

The first two proposals would affect 115 service users at The Willows and 22 at Riseley Street. The PCT and CWP believe that the focus of consultation activities should be on minimising the impact of any service changes by supporting individuals and their families and carers to make a successful transition to alternative provision.

Staff consultation is already underway and will continue in line with CWP management of change policy.

Once guidance is received from the OSCs, the PCT and CWP's draft communication and engagement plans will be revised accordingly and it is envisaged that consultation about the proposals will begin in October 2010. The PCT and CWP will continue to brief the OSCs throughout the consultation period as required.

FOR RESOLUTION: Guidance is sought from the committees as to the level of consultation that is required relating to each of the proposals in order for the PCT and CWP to fulfil their obligations in relation to the Local Government and Public Involvement in Health Act.

Appendix 1: Prioritisation Process - toolkit

The first stage in the process was to score each CWP service that is currently commissioned by the PCT against a set of 10 criteria as follows . The scoring was carried out by CWP staff including clinicians and managers and submitted to the Prioritisation Steering Group.

	SCORING CRITERIA SCALE			**SCORE**
	LOW 20 points	**MID** 30 points	**HIGH** 50 points	
1. Is there evidence that the service produces an effect?	If still experimental, case series or opinion	Modest evidence that the service works	Definite experience that the service works	
2. Magnitude of benefit (incl. impact on other services – wider benefits to society)	No benefit to society (no improvement in health or life expectancy)	Moderate benefit to society (moderate improvements in health or life expectancy)	Major benefit to society (large improvements in health or life expectancy)	
3. Numbers that will benefit	Less than 10	Between 10-499	>500 people who would benefit	
4. Total cost of development	More than £500,000	Between £500,000-£50,000	Less than £50,000	
5. Patient Acceptability/strength of local feeling	Patients find the service unacceptable, no local interest	Patients find the service somewhat acceptable, moderate local interest	Patients find the service highly acceptable, massive local interest	
6. National requirement or NHS Target	If it addresses only 1 target or national requirement	If it addresses only 2/3 targets or national requirements	If it addresses only 4 or more targets or national requirements	
7. Addressing health inequality or health inequity – improving access to a service - i.e. where patients have not had service	It doesn't address inequality or inequity	It partially addresses inequality or inequity	It completely addresses inequality or inequity	
8. Only treatment or alternative	Many other treatment options with better outcomes	Other options but equivalent outcomes	No treatment options at all	
9. Innovation – demonstrates new ways of working with evidence of improved outcomes	No new ways of working	Limited new ways of working	Entirely new way of working	
10. Quality – delivers outcomes that are meaningful to patients and carers, delivered with dignity & respect	No/limited impact on meaningful outcomes	Some impact on meaningful outcomes	Significantly improves meaningful outcomes	

Each service was then impact assessed using the tool below:

	IMPACT/RISK	Insignificant	Minimal	Significant	Severe	Catastrophic
Score						
1	**Patient and Public**	No reduction in accessibility **0**	Majority of patients continue to receive a service in their locality **5**	Service still available within PCT area **10**	Limited service available in PCT. Service available only if full referral criteria met. **15**	No service available **20**
2	**Political / PCT reputation**	Media coverage- little effect on public confidence/staff morale **0**	Local media – short term – minor effect on public attitudes/staff morale **5**	Local media –long term –moderate effect – impact on public perception of PCT and staff morale **10**	National Media <3 days- public confidence in organization undermined **15**	National/International adverse publicity >3 days **20**
3	**Impact on other service providers**	No impact on other service providers **0**	Minimal increase in demand **5**	Significant increase in demand which stretches other service providers **10**	Severe increase in demand. Severely stretches other service providers **15**	Demand increases beyond service capacity **20**
4	**Financial risk of decommissioning**	No financial impact to health economy **0**	Minimal financial impact to health economy- <50K **5**	Significant financial impact to health economy £51-200K **10**	Severe financial impact to health economy £201-500K **15**	Inevitable catastrophic impact >500K **20**

All of the evidence and scores were reviewed by the Steering Group, who then agreed the proposed service changes.

Appendix 2: The Willows Day Services, Macclesfield: Substantial Variations or Developments to Services Document

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

PRO-FORMA: CONSULTATION ON SUBSTANTIAL VARIATIONS OR DEVELOPMENTS TO SERVICES: LEVEL 2

1 Title of Proposal:
Closure of the Willows Day Services, Macclesfield

2 Summary Rationale

Central and Eastern Cheshire PCT (CECPCT) have recently undertaken a prioritisation exercise of all commissioned mental heath services within Cheshire And Wirral Partnership NHS Foundation Trust (CWP), and, as the Willows offers services which are available via other social support channels, and similar services are not commissioned from CWP in other areas of the Trust, it is proposed by CECPCT that it be decommissioned

3 Outline of Proposal

Within the CWP East Adult and Older People's Mental Health Services (A&OPMH) Clinical service Line, work is in progress to redesign services to incorporate Access, Acute, Recovery & Rehabilitation pathways with a single point of access to mental health services.

The Willows is a part of the overall review of services commissioned by CECPCT; consideration has been given as to whether this is part of CWP NHS business, whether it benefits a sufficiently large number of patients to justify the overall costs, and whether there is equity of access across the CECPCT footprint.

The Willows offers day services to patients already under CPA care of a Community Mental Health Team (CMHT). It is a service which serves a small population of 115 patients based in and around Macclesfield at an annual cost of £561,000. It offers support to service users in, for example, wellness recovery action planning (WRAP), social skills training, computer literacy and horticulture, and operates a small print workshop, all in collaboration with external agencies such as Macclesfield and Reaseheath Colleges and Connexions. All of the services provided are available via mainstream Local Authority or Educational initiatives and service users could be supported to access these services. This type of day service is not available from CWP in other parts of the Trust footprint.

The proposal is to close the Willows; The Willows (based in Macclesfield) is only accessed by service users from the eastern part of the area i.e. Macclesfield but not Crewe nor Vale Royal, it serves a relatively small population of our 5332 Adult & Older People service users (currently 115 out of 1015 for Adult service users known to the Macclesfield Adult Community Mental Health Teams). These 115 people would be supported by their care co-ordinators to access alternative services as identified in their care plans which could include. Macclesfield College, Cheshire East Council (Social Care), Supported Employment, Reaseheath College, Macclesfield Volunteer Centre, Richmond Fellowship, Making Space and Macclesfield Town Football Club. Mind,

4 Consultation Process

4a.. Consultation already undertaken

The prioritisation exercise was undertaken jointly between senior representatives of CECPCT and senior managers and clinicians from the Adult and Older peoples Clinical Service Unit in CWP.

All CWP staff involved in the provision of the day service within the CECPCT area have been contacted by letter and invited to attend one of five briefing sessions regarding this and other proposed service changes. Staff briefings were delivered by Sheena Cumiskey, CWP Chief Executive, Andy Styring, and CWP Director of Operations on Thursday 05.08.10. Cathy Walsh, General Manager for the Adult and Older peoples Clinical Service was also present at all briefings to deal with queries and speak with staff at their request. A briefing for Governors was also delivered on 05.08.10.

The prioritisation process has been widely discussed at a number of service user and carer forums including East Cheshire Mental Health Forum.

The project board for the prioritisation process led by the PCT had representation from service user and carer groups via Link members.

There is also a PCT led service development group where the prioritisation process has been discussed and members have been briefed throughout the process.

4b. Proposed Consultation

If the proposal by CECPCT to decommission the day service delivered at the Willows is accepted then there will be two main aspects of consultation and further work required to be carried out.

1) Service users, Carers and Staff

Service users are their carers will be contacted individually advising them of the proposed change and accessible meetings led by the commissioner at CECPCT will be held to give people the opportunity to raise any concerns. We would explain how people will be supported to access mainstream services and the wider opportunities that this will bring. This will improve the social inclusion of people with mental health problems and contribute to challenging stigma – a key issue raised by many of CWP service users and carers.

Staff consultation will be carried out in line with Trust management of change policy.

2) Facilitating access to existing services in mainstream locations

We will work with partner organisations (eg. those listed above in section 3) to communicate the changes and to discuss the support they may need to ensure service users can access services directly (as opposed to outreach services at the willows.)

5 Timescales

From date of approval for this service change it is estimated that the service will be closed within 3 months.

Completed Pro-forma to be forwarded to Joint Overview and Scrutiny Committee for noting. Consultation and Negotiation Partnership Committee/ Local Medical Negotiating Committee for comment.

Appendix 3: Learning Disability Respite Services, Riseley Street, Macclesfield: Substantial Variations or Developments to Services Document

Cheshire and Wirral Partnership NHS
NHS Foundation Trust

PRO-FORMA: CONSULTATION ON SUBSTANTIAL VARIATIONS OR DEVELOPMENTS TO SERVICES: LEVEL 2

1. Title of Proposal:
Central & Eastern Cheshire Primary Care Trust (CECPCT) proposal is to decommission the provision of learning disability respite services delivered at 28 Riseley Street, Macclesfield

***2.* Summary Rationale**
As a result of financial efficiencies Central & Eastern Cheshire Primary Care Trust have recently notified Cheshire and Wirral Partnership Trust of a reduction in income. In order to reach decisions about how this reduction in income can be accommodated CWP and the PCT have undertaken a **'prioritisation process'** to evaluate all CWP services that are commissioned for residents in central and eastern Cheshire. All services have been reviewed using the same criteria to ensure that the process is fair and both CWP and CECPCT have made a commitment to ensuring that there is no negative impact on the quality of health care as a result of any changes.

One of the outcomes of the prioritisation process is the proposal to decommission the respite service currently delivered at 26 Riseley Street in Macclesfield and consolidate all Cheshire health respite services for people with learning disabilities onto the Crook Lane site in Winsford. .

1. Outline of Proposal
Background
There are a range of respite options for people with learning disabilities who live in central and eastern Cheshire. At present these include residential bed based services provided by CWP at Primrose Avenue in Crewe (due for closure), Crook Lane in Winsford, and Riseley Street in Macclesfield. Further residential respite services are provided by Cheshire East Council social services department at Warwick Mews in Macclesfield and at Queens Drive in Nantwich. In addition to these bed based services, people with learning disabilities and their families are able to make use of direct payments in order to fund alternative individual personalised options for support. This approach provides greater choice and flexibility than traditional bed based provision and allows families to be provided with a break from their caring responsibilities whilst still allowing people to access the support necessary for them to remain within their home environment and participate in preferred activities in familiar surroundings.

Following a previous consultation process plans are in place for the closure of the respite service provided at Primrose Avenue in Crewe and consolidation of health respite services in central Cheshire on to the Crook Lane site. The closure of Primrose Avenue is due to take place on 13th September 2010. The respite needs of all clients who currently use the service at Primrose Avenue will be met for a transitionary period at Crook Lane.

The previous consultation and planning process also confirmed eligibility criteria for health respite services provided by CWP. The agreed eligibility criteria and assessment process will soon be used to review the needs of all existing respite service users, i.e. including those who have received a service at Primrose Avenue, Crook Lane and Riseley Street. This work will commence in September 2010. Respite services provided by CWP in central and eastern Cheshire will then be allocated on the basis of the outcome of this assessment process and the resources available.

CWP will continue to provide a mix of health and social respite for an agreed period of time to allow for the transition resulting from the closure of Primrose Avenue; there is a commitment from CWP, partners in the local authority and the PCT that all people who currently use the service at Primrose Avenue will be provided with health respite services at Crook Lane during the transitionary period.

Where the assessment process in relation to Primrose Avenue service users identifies the need for health respite this will continue to be met at Crook Lane. Health and social services staff will work together to develop individual plans with timescales to provide alternative social care respite solutions for service users whose needs do not meet the eligibility criteria for health respite.

This Proposal

The PCT proposal is to decommission the respite service provided at Riseley Street and for all health respite services in Cheshire to be consolidated into a single unit and provided out of Crook Lane in Winsford. The proposal is made in the context of a range of respite services available in Cheshire including local authority provided residential respite services and other options for individualised support.

Riseley Street Respite Unit provides up to 6 respite beds to adults with learning disability. 22 clients are currently in receipt of respite care at Riseley Street. This number has been static for some time and the rate of referral for respite care at Riseley Street had reduced to one per year for the past 3 years. As a result of reduced demand, the occupancy rate for Riseley Street is running at 45%.

During the previous consultation an exercise was undertaken to test out eligibility criteria for health respite services. The purpose of this exercise was to confirm eligibility criteria and develop and agree a standardised assessment process. This exercise involved table top assessments of all health respite service users. The findings from this exercise in relation to the 22 people who use the service at Riseley Street indicated that between 2-4 clients met the eligibility criteria for health respite (based on needs of client for a specialist health learning disability service), a further 4 clients were assessed as potentially being able to be supported in social care accommodation with some Primary Care support /Specialist Health Support. The exercise identified that the remaining 16 clients respite needs could be met within a social care environment or package of respite care.

As previously stated the needs of all respite service users are shortly to be assessed against the agreed eligibility criteria and assessment process. Whilst the outcome of the forthcoming assessment process may differ from the findings of the table top exercise as described above it is probable that this will result in a significant number of people being assessed as having needs that can be met with social care respite options.

It has been identified that the environment at Riseley Street has shortfalls, for example; it is not purpose designed, offers limited ground floor accommodation and upstairs areas are inaccessible for some service users, there is no catering or housekeeping provision and nursing staff therefore do the cooking and laundry. …….Some investment has been made recently to address these shortfalls however the age, layout and fabric of the building at Riseley Street means it is more difficult and costly to achieve the changes necessary to address all its shortfalls and make it fit for purpose.

The Trust has recently made significant investments in Crook Lane to ensure the Unit meets all environmental standards and represents a comfortable environment for service users.

As previously agreed CWP will assess all people who use the respite service at Riseley against the agreed eligibility criteria (this process is due to commence in September 2010). This will provide the basis for future allocation of health respite services and initiate joint planning to provide social care respite solutions for people whose needs do not meet the eligibility criteria for health respite. It has been identified that Crook Lane will be able to meet the needs of the small number of people who require health respite services into the future.

The assessment process will identify those people using the service who do not meet the eligibility criteria for health respite. Plans will be developed to provide services to these people either via use of existing social care residential respite services or through the establishment of individualized packages of respite care / short breaks. In addition work will be undertaken with commissioners to ensure the needs of this group of people are reflected in the joint commissioning strategy for respite care/ short breaks.

The Trust is not resourced to provide a day service during periods of respite care and most service users therefore continue to attend day services whilst in respite. Changes in transport arrangements will be required to ensure that service users are able to continue to travel to and from day services during respite stays. As part of the previous consultation transport arrangements have been discussed with the Local Authority Transport Department who have indicated that, with suitable notice they could plan for rerouting of existing transport to accommodate the changes arising from the closure of Primrose Avenue. Work will be undertaken to extend these arrangements to accommodate the changes resulting from the closure of Riseley Street.

4. Consultation Process

4a. Consultation already undertaken

The prioritisation exercise was undertaken jointly between senior representatives of CECPCT and senior managers and clinicians from the learning disability Clinical Service Unit in CWP.

All CWP learning disability staff involved in the provision of respite services within the CECPCT area have been contacted by letter and invited to attend one of five briefing sessions regarding this and other proposed service changes. Staff briefings were delivered by Sheena Cumisky, CWP Chief Executive, Andy Styring, and CWP Director of Operations on Thursday 05.08.10. Adrian Moss, General Manager for the Learning Disability Clinical Service Unit was also present at all briefings to deal with queries and speak with staff at their request. A briefing for Governors was also delivered on 05.08.10.

4b. Proposed Consultation

The learning disability Clinical Service Unit senior management team will work with the PCT to consult with service users, their families, carers and other interested parties on the proposal to close Risely Street. Consultation will focus upon how the impact of these changes can be minimized, ensuring that the respite care needs of people who use the service at Riseley Street continue to be met. The consultation process will include discussion with:

- Service users and families / carers
- Local learning disability partnership board
- Local authority partners including transport departments

5. Timescales

As a result of a shortfall in the PCTs budget for mental health, learning disability and drug/alcohol services it has become imperative that CWP and CECPCT agree and implement plans for changes in services that will continue to meet the needs of the local population within the available financial envelope. It is therefore proposed that the closure of Riseley Street and transfer of health respite services in Cheshire to Crook Lane is achieved within 3 months of the approval decision.

Date of Report: 11th August 2010

Central and Eastern Cheshire NHS
Primary Care Trust

Central & Eastern Cheshire Primary Care Trust

Annual Report of the Director of Public Health 2010

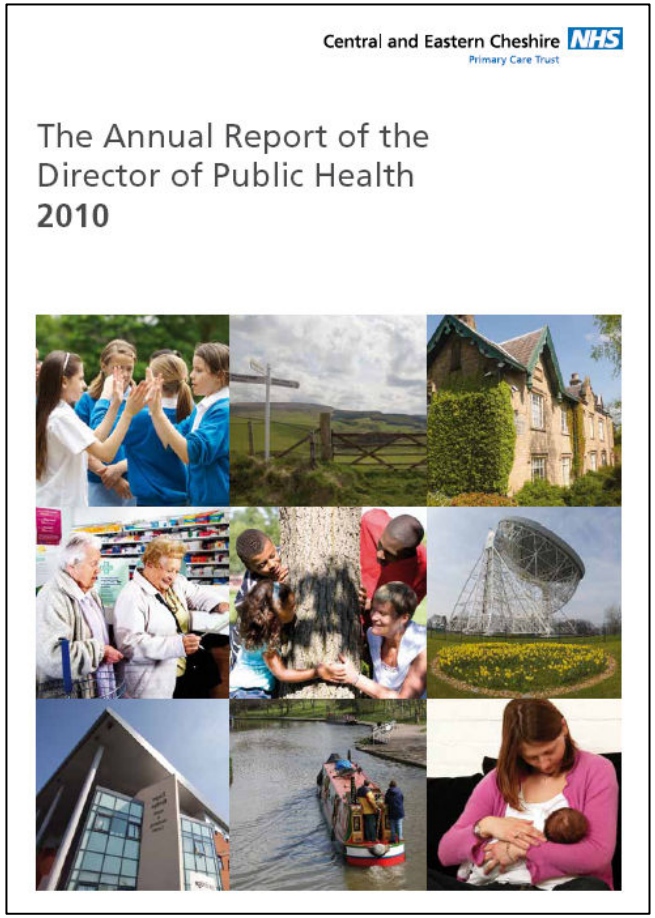
Dr Heather Grimbaldeston

Director of Public Health

Scrutiny Committee, September 2010

Theme of report:

Health Inequalities & Partnerships



Requirement: Directors of Public Health to produce a yearly report which outlines the health of the local population (on a PCT footprint)

Purpose: to inform stakeholders, prevent disease, improve health, support productivity, reduce variation

2010 Report has an emphasis on highlighting the inequalities/differences in health that exist across and within CECPCT

A 'call to arms' to all partners in health:

- ➔ the individual
- ➔ Other Statutory & Voluntary Organisation

to work together. Not just the responsibility of the NHS

Chapters in the Annual Report

- **Chapter One** overview of health of the population of CECPCT
- **Chapter Two** review of use of APHR 2009 by PBC Groups
- **Chapter Three** overview of the health of the resident populations of **9** local authority area partnerships within CECPCT
- **Chapter Four** overview of the findings of ***Fair Society, Healthy Lives*** (Marmot Review of tackling health inequalities post 2010) - and a commentary of what these finding may mean to the various partners within CECPCT
- **Chapter Five** tackling the health impacts of Worklessness
- **Chapter Six** Choosing Well to Keep Well – an overview of the impact of health behaviours and choices on services and service provision

Chapter One:
Overview of Health in CECPCT

Health information outlined under the PCT's 3 Drivers for Change headlines:

❶ Consequences of an ageing population

❷ Health Inequalities/Differences

❸ Wide gaps in life expectancy

Identified as the PCT's focus of attention towards maximising improvements in the health of the population

Chapter One:
Main Headlines: Ageing Population

CECPCT has the fastest growing ageing population in the North West

Population predicted to increase by 16% (70,200 people) between 2006 - 2031

80% of the overall increase is predicted to occur in those aged 65+

Expected proportionate increase in conditions relating to ageing such as falls and associated fractures in those aged 65+

Year	Population Forecast 65+	Estimate of Fallers @30%	Falls with injury @10%	Falls with a fracture as an injury @5%
2009	82,900	24,870	2,487	1,243
2011	87,500	26,250	2,625	1,312
2013	94,300	28,290	2,829	1,415
2015	99,000	29,700	2,970	1,485

Chapter One:
Main Headlines: Health Inequalities

Short term Action	Medium term Action	Longer term Action
Access to high quality services (NHS/Social care)	Lifestyle Issues	Wider determinants of health
Address World Class Commissioning Priority Outcomes (urgent care, CVD, stroke, cancer) Access to immunisations and vaccinations	**Address** Diet Physical Activity Alcohol misuse Breastfeeding Smoking	**Address** Marmot Report - see **Chapter Four** for six key policy areas
Key players The service contribution	**Key players** NHS and CEUA (and other key partner) contributions Local Strategic Partnership Lifestyles Sub Group	**Key players** Local Strategic Partnership collective contribution Sub-regional and regional contribution (Commission)

Chapter One:
Main Headlines: Health Inequalities

Breastfeeding

Breastfeeding initiation rates - 64% (2009-10) is lower than the national average, much lower than best performing PCTs (80%) in same ONS grouping

Link to - Childhood obesity:

Reception Year (age 4-5)

Overweight (14.8%) – higher (worse) than NW and England rate
Obese (8.6%) – lower (better) than NW and England rate

Year 6 (age 10-11)

Overweight (13.8%) – lower (better) than NW and England rate Obese (17.9%) – lower (better) than NW and England rate

CECPCT 6-8 week rate (42%) and drop off rate (22%) are better/equal to the North West and the ONS group

Chapter One:
Main Headlines: Health Inequalities

Teenage Pregnancy

2007: PCT conception rate was 37.4/1,000 (n=351) lower than England rate (41.7)

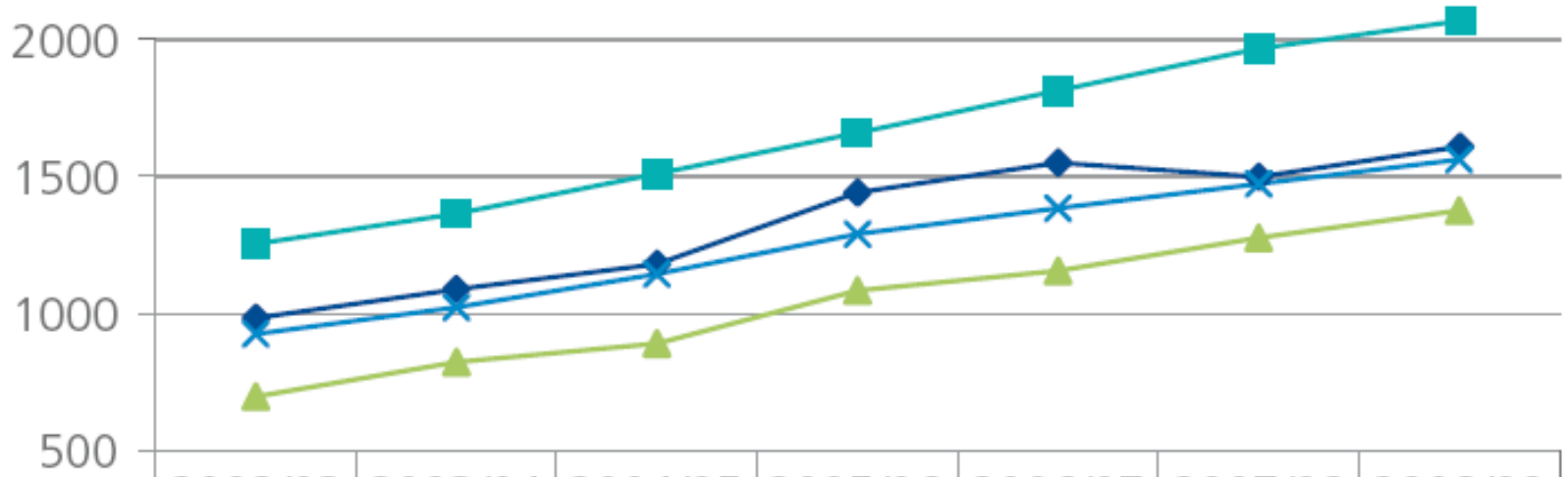
Teenage conception 'hotspot' wards are located in Crewe and Macclesfield

Strong relationship between deprivation and high teenage conception - BUT high rates cannot be completely explained by deprivation alone

Uptake of abortion varies– for period 2005-07 it ranged from just over 41% in former Crewe & Nantwich BC to over 57% in Macclesfield BC

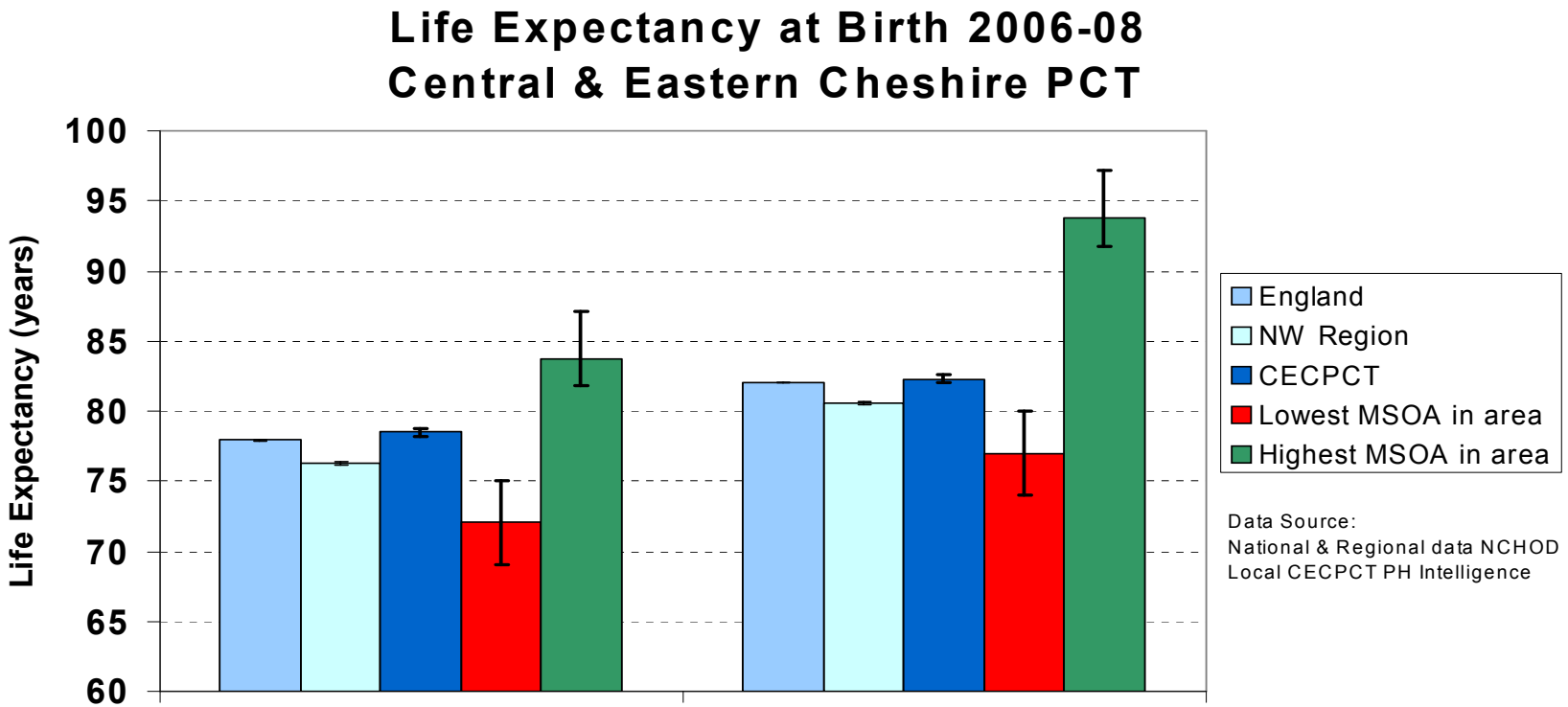
18-19 year age group where most significant rise in abortions has occurred

Chapter One:
Main Headlines: Health Inequalities



	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09
CECPCT	983	1087	1180	1441	1550	1498	1608
SHA	1254	1364	1510	1659	1814	1967	2062
ONS Peers	696	822	890	1084	1155	1276	1375
England	925	1022	1144	1290	1384	1473	1562

Chapter One:
Main Headlines: Life Expectancy



Lowest -Winsford Central (72.05)

Highest -Wilmslow Town South East (83.78)

Lowest -Crewe Central & Valley (76.99)

Highest -Macclesfield Town Tytherington (93.8)

Chapter One:
Main Headlines: Life Expectancy

CVD

36% of all deaths - approx 1,600 deaths each year

Biggest contributor to the life expectancy gap for both males and females

26% of deaths are premature (<75 years of age). PREVENTABLE with lifestyle modification

PCT variation: Male early deaths from CVD (2006-2008)

West Coppenhall & Grosvenor MSOA (Crewe) DSR 226.6 per 100,000 (9 deaths p/year)

Holmes Chapel MSOA DSR 25.8 per 100,000 (<5 deaths p/year)

LAP Variation: Male early deaths from CVD (2006-2008) Crewe

West Coppenhall & Grosvenor MSOA DSR 226.6 per 100,000 (9 deaths p/year)

St Marys & Wells Green MSOA DSR 55.1 per 100,000 (<5 deaths p/year)

31% of these premature deaths would be eliminated if the health experience of residents living in the most deprived MSOA was the same as the least deprived

Chapter One:
Main Headlines: Life Expectancy

CANCER

26.4% of all deaths– approx 1,160 deaths each year

2nd biggest cause of all deaths - BUT main cause of premature death

50% of cancers are PREVENTABLE with lifestyle modification

Breast, Colorectal and Lung cancers - main forms of cancer that cause premature death

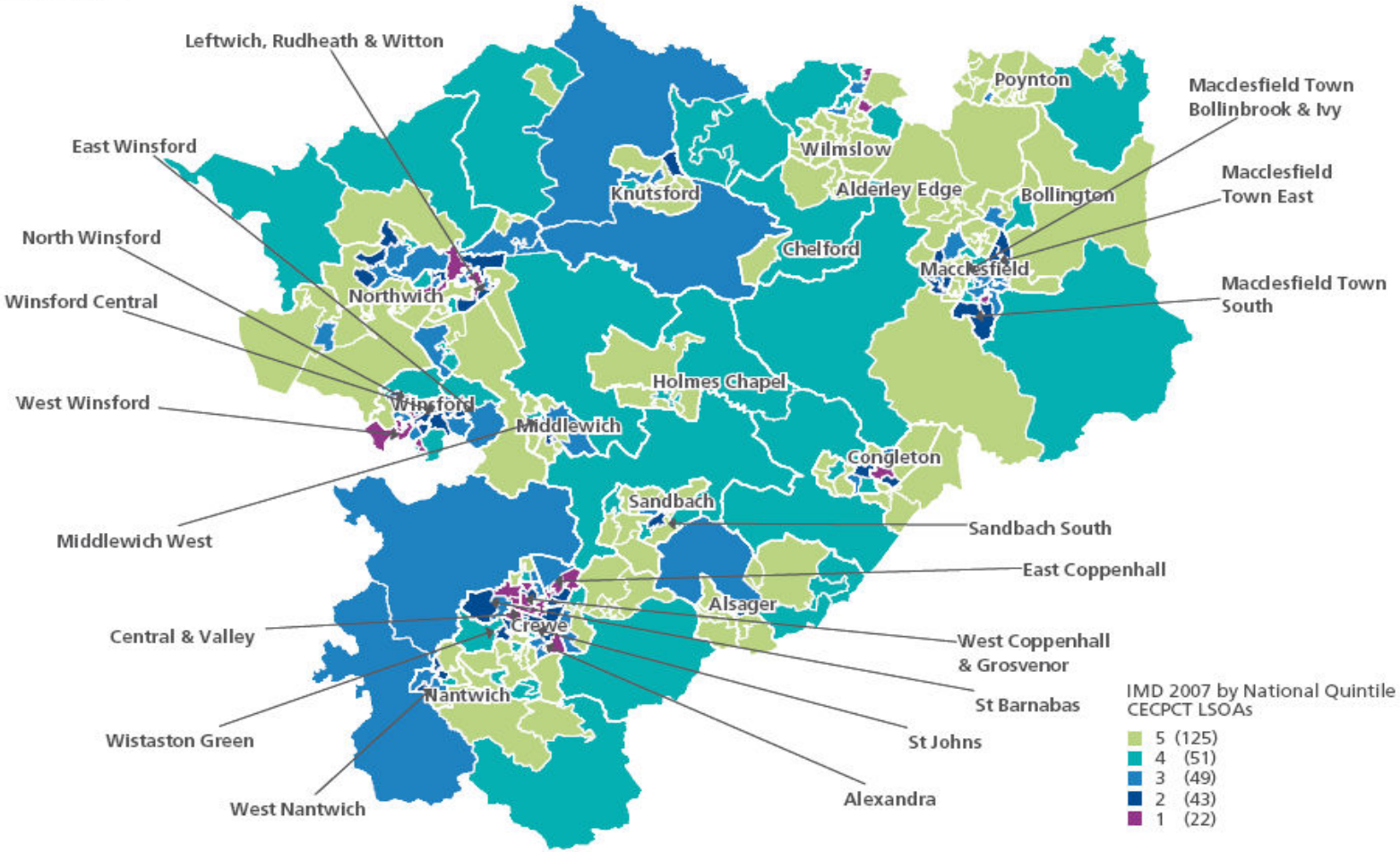
There has been a steep rise in the number of new cases of lung cancer in women

The three largest and most deprived towns in CECPCT (Crewe, Macclesfield, Winsford) have double the incidence of lung cancer than occurs in other communities

CECPCT has a 5% higher incidence of breast cancer than nationally – two of the three towns in CECPCT with the highest incidence are affluent towns (Knutsford, Wilmslow) – a historical low uptake of breast and cervical screening

Chapter One:
Main Headlines: Life Expectancy

Figure 20: Central and Eastern Cheshire Primary Care Trust Lower Super Output Areas by Index of Multiple Deprivation 2007 quintile with Spearhead Middle Super Output Areas labelled

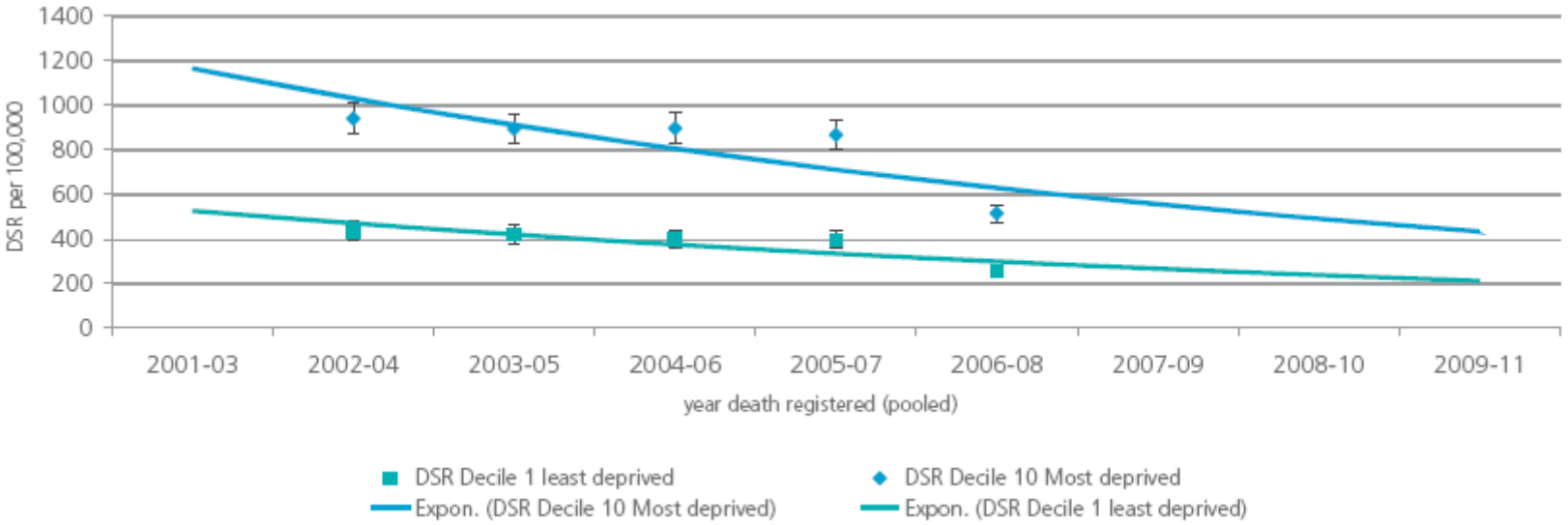


Chapter One:
Main Headlines: Life Expectancy

Deprivation

MSOAs within CECPCT with low life expectancy rates also encompass some of the more affluent populations

Review of mortality trends by deprivation deciles show that whilst death rates are reducing in our most deprived 10%, the reduction is slowing and levelling off in the least deprived 10%



Chapter Two: APHR 2009

Purpose of the 2009 report:

- set out information on local health needs and health care activity for by practice
- help inform the PBC groups and practices to redesign and commissioning local services
- be a tool for PBC groups to engage with the communities they service

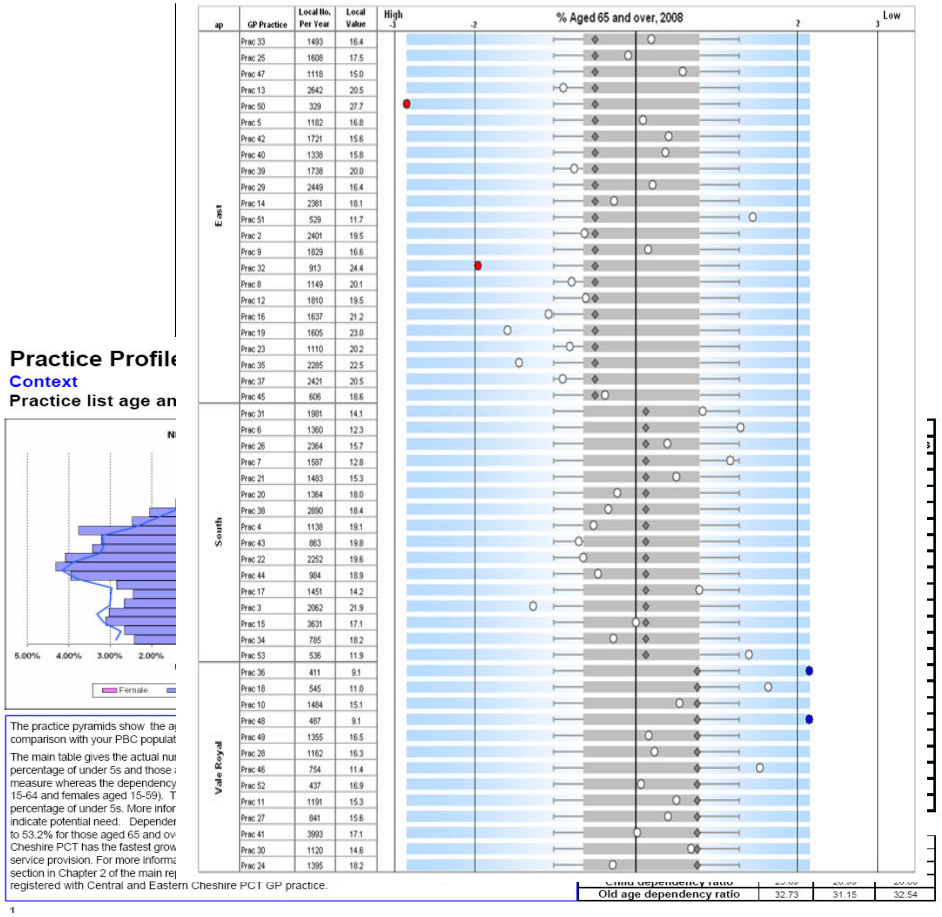
Produced 3 products-

Report

Individual practice profiles

Technical appendix – z-score spines

Charts allow comparisons between practices as well how practice compares to PBC group and PCT



Chapter Two: APHR 2009

Feedback from the 3 PBC groups about the APHR 2009 has been very positive:

Eastern Cheshire PBC Consortium

"The success of effective clinical commissioning relies on timely, accurate and relevant information that clinicians can use to improve patient services.

The 2009 Annual Public Health report has been an important tool for the East Cheshire PBC board in developing it's commissioning strategy. It has given GPs a wider perspective on our population and it's health needs.

This has helped us focus in on areas where we feel, as clinical commissioners, we can make a difference to people's health.

The partnership between Public Health and Primary Care will hopefully, with support from the PCT, continue to develop for the benefit of patients and the public"

Dr Paul Bowen
McIlvride Medical Centre
Chair, Clinical Commissioning Executive,
Chair, Eastern Cheshire PBC consortium

Chapter Three: Health of Area Partnerships

Provided an overview of the health and health needs of CECPCT residents who live within the 7 Local Area Partnerships (LAPS) of Cheshire East Council and 2 out of the 5 Area Partnership Boards of Cheshire West & Chester Council

Supports the development of the area partnerships by setting out information on local health and health care activity so as to:

enable area partnerships to recognise local health issues that cause variations in health / health experience

Inform area partnership priorities to tackle health inequalities

Chapter Three: Health of Area Partnerships

Commentary in Chapter 3, supported by Technical Appendix, provides information to the 9 area partnerships on/around 85 indicators:

13 Context Indicators

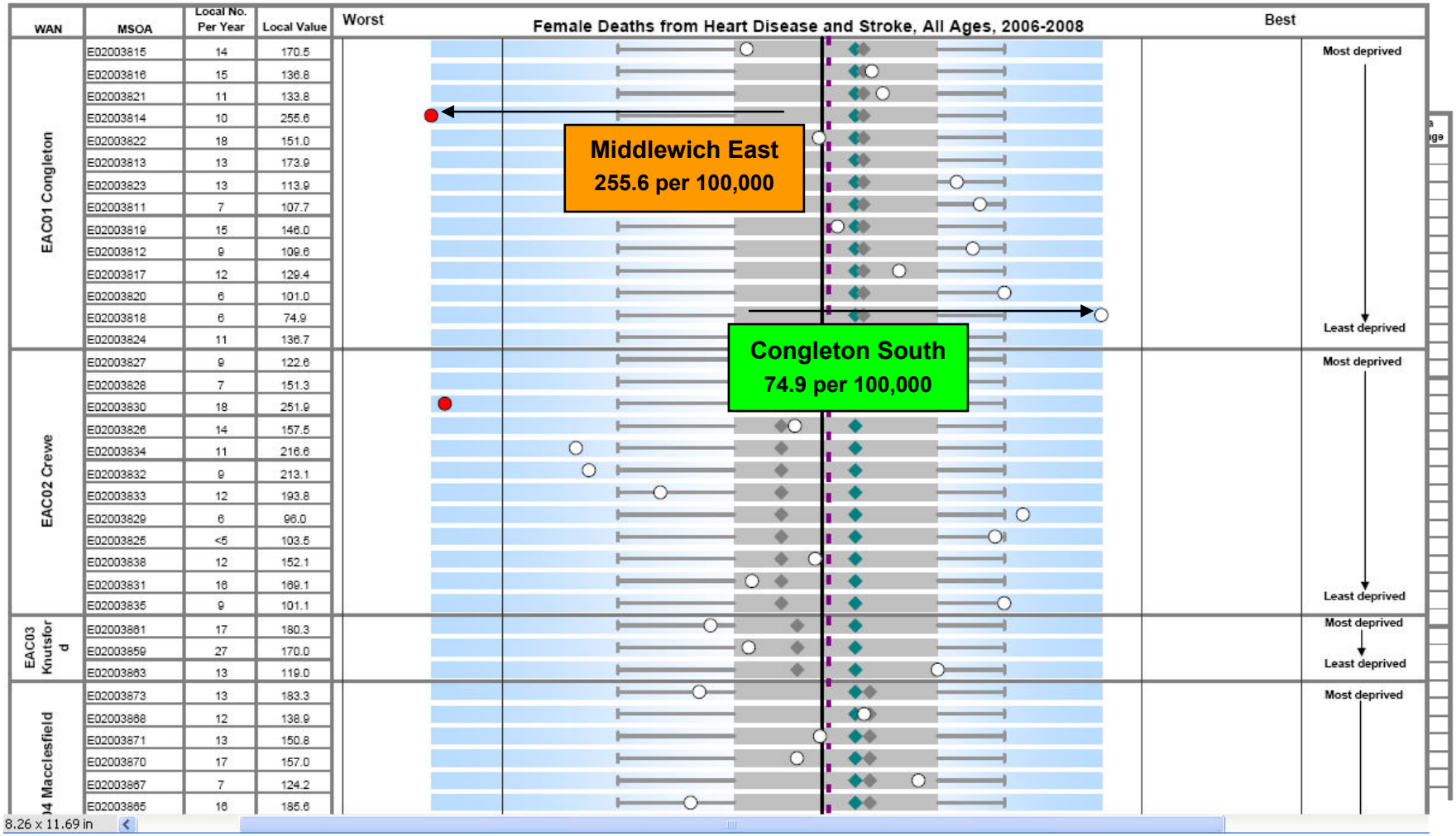
14 Life Expectancy and cause of Death Indicators

13 Lifestyle and risk factor indicators

14 Hospital Activity Indicators

31 Disease prevalence and other health indicators

Chapter Three: Health of Area Partnerships



WAN	MSOA	Local No. Per Year	Local Value
EAC01 Congleton	E02003815	14	170.5
	E02003816	15	136.8
	E02003821	11	133.8
	E02003814	10	255.6
	E02003822	18	151.0
	E02003813	13	173.9
	E02003823	13	113.9
	E02003811	7	107.7
	E02003819	15	146.0
	E02003812	9	109.6
	E02003817	12	129.4
	E02003820	6	101.0
	E02003818	6	74.9
	E02003824	11	136.7
EAC02 Crewe	E02003827	9	122.6
	E02003828	7	151.3
	E02003830	18	251.9
	E02003826	14	157.5
	E02003834	11	216.6
	E02003832	9	213.1
	E02003833	12	193.8
	E02003829	6	96.0
	E02003825	<5	103.5
	E02003838	12	152.1
	E02003831	16	169.1
	E02003835	9	101.1
EAC03 Knutsford	E02003861	17	180.3
	E02003859	27	170.0
	E02003863	13	119.0
J4 Macclesfield	E02003873	13	183.3
	E02003868	12	138.9
	E02003871	13	150.8
	E02003870	17	157.0
	E02003867	7	124.2
	E02003865	16	185.6

8.26 x 11.69 in

Congleton LAP

Key facts related to health and wellbeing

Population: Main causes of death (2006-2008)

Circulatory Disease & Cancer

Middlewich East

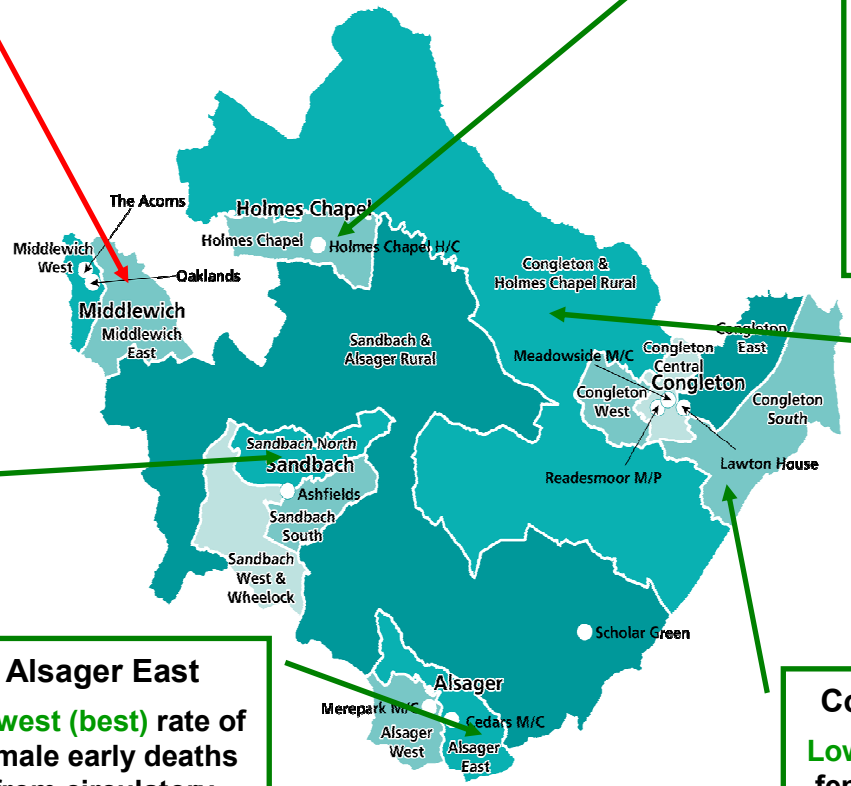
Highest (worst) rate of female deaths from circulatory disease within CECPCT
255.6 per 100,000

4th highest (worst) rate of female early deaths from circulatory disease within CECPCT
95.4 per 100,000

Homes Chapel

Lowest (best) rate of male deaths from circulatory disease within CECPCT
101.8 per 100,000

Lowest (best) rate of male early deaths from circulatory disease within CECPCT
25.8 per 100,000



Sandbach North

2nd lowest (best) rate of male deaths from cancer within CECPCT
107.0 per 100,000

2nd lowest (best) rate of male early deaths from cancer within CECPCT
107.0 per 100,000

Congleton & Holmes Chapel Rural

3rd lowest (best) rate of male deaths from cancer within CECPCT
109.0.0 per 100,000

Alsager East

Lowest (best) rate of female early deaths from circulatory disease within CECPCT
6.3 per 100,000

Congleton South

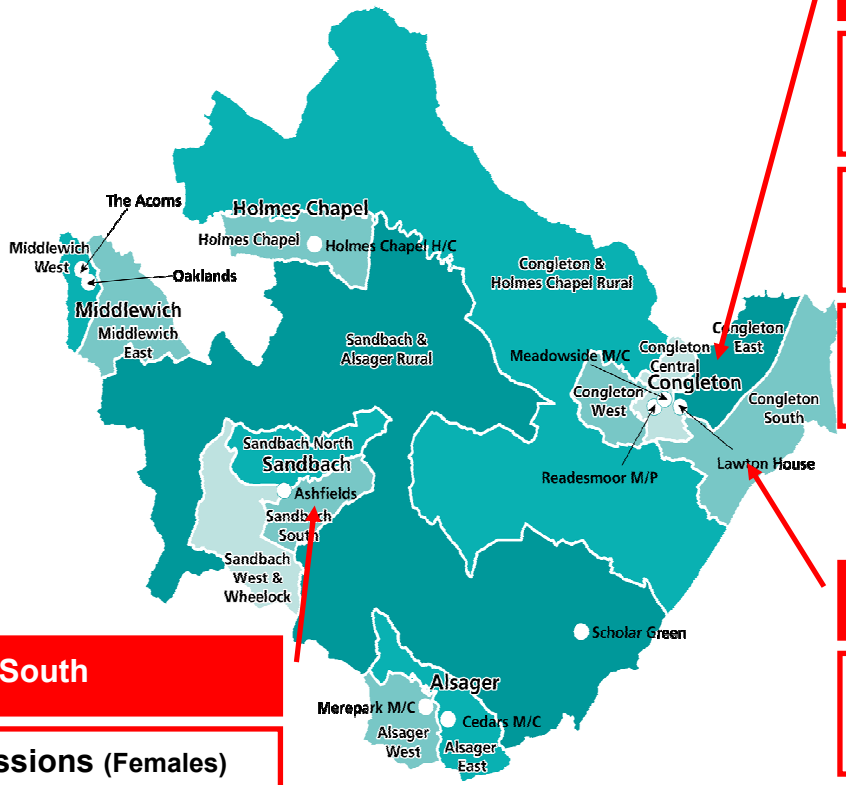
Lowest (best) rate of female deaths from circulatory disease within CECPCT
74.9 per 100,000

Data source: ONS SYOA Population Estimates, 2006-2008

Congleton LAP

Key facts related to health and wellbeing

Population: Hospital Activity (2008-2009)



Congleton East

A&E Attendance (All Ages)

Highest (worst) DSR rate in PCT (47935.0 per 100,000)

A&E Attendance (Under 20's)

Highest (worst) DSR rate in PCT (49642.3 per 100,000)

Alcohol- related admissions (Males)

Highest (worst) DSR rate in LAP (1309.1 per 100,000

Sandbach South

Alcohol- related admissions (Females)

Highest (worst) DSR rate in LAP (861.7 per 100,000

Congleton South

A&E Attendance (Over 65's)

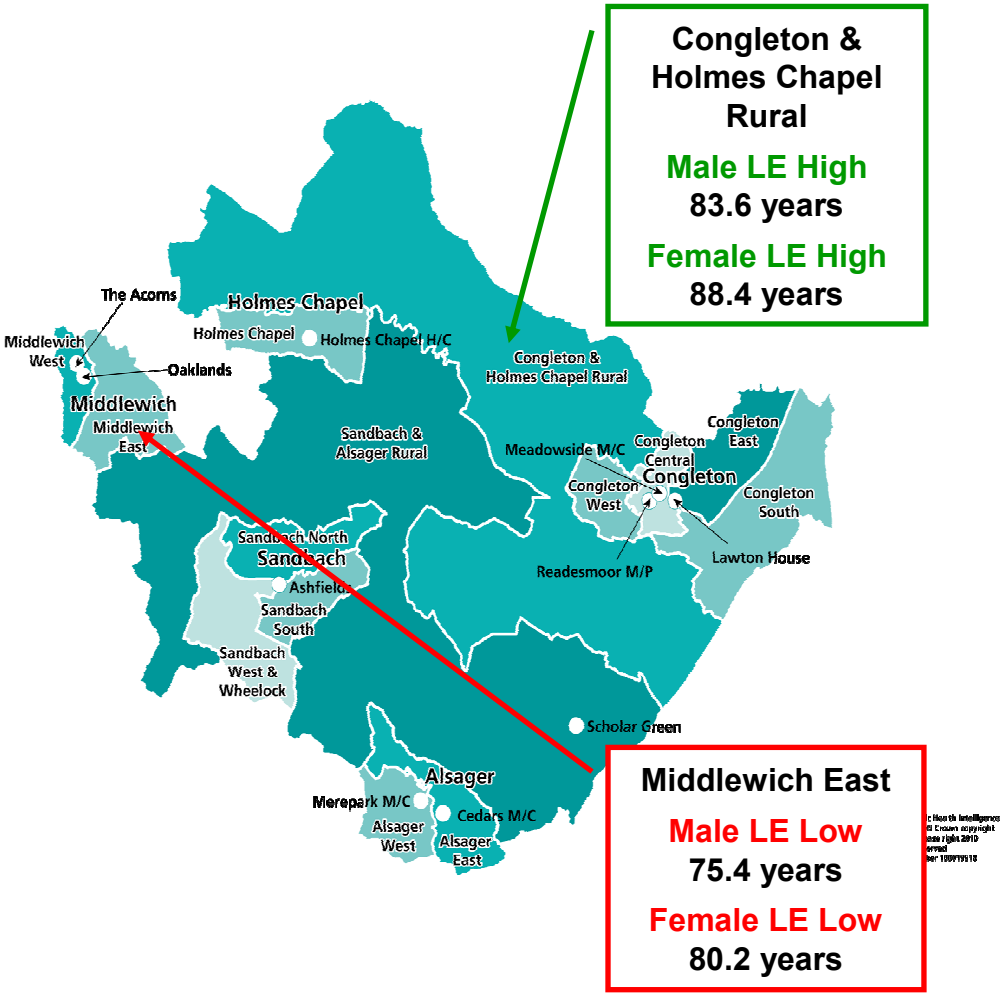
Highest (worst) DSR rate in PCT (55554.4 per 100,000)

Data source: A&E CDS, NHS Postcode Directory, ONS SYOA Population Estimates mid-2008

Congleton LAP

Key facts related to health and wellbeing

Population: Life Expectancy (LE)



LE (Years)	LAP	CEUA	CECPCT	England
Male	78.9	78.7	79.0	77.4
Female	83.1	82.5	82.5	81.6

4.2 year gap between average Male and Female LE

Congleton & Holmes Chapel Rural MSOA Female LE 2nd highest (best) in CECPCT

8.2 year gap between best and worst Male LE by MSOA

8.2 year gap between best and worst Female LE gap by MSOA

There is not a strong relationship between lower life expectancy and residency in areas of higher deprivation

Data source: SYOA Population Estimates, 2006-2008, ONS Life table Template

Chapter Four: Marmot Commentary

2008 Sir Michael Marmot asked by Government to review best global evidence on reducing health inequalities

Asked to produce a set of evidence based recommendations to inform strategic direction for next 10 years

February 2010 ***Fair Society, Healthy Lives*** published

Adopted a **'life course'** perspective for tackling health inequalities - actions need to **start before birth** and continue throughout all stages of life to **retirement**

Chapter Four: Marmot Commentary

APHR Chapter 4 provides recommendations to local partners on high level policy actions that can be taken around each policy objective in Fair Society, Healthy Lives:

Policy Objective A
Give every child the best start in life

Policy Objective B
Enable all children, young people and adults to maximise their capabilities and have control over their lives

Policy Objective C
Create fair employment and good work for all

Policy Objective D
Ensure a healthy standard of living for all

Policy Objective E
Create and develop healthy and sustainable places and communities

Policy Objective F
Strengthen the role and impact of ill-health prevention

Chapter Four: Marmot Commentary

Policy Objective A

Give every child the best start in life

Recommendations for Local Action:

Agency	Recommendation
Central and Eastern Cheshire Primary Care Trust (Commissioners)	Maternity and child health commissioners refer to the policy recommendations in determining contracts with "providers" of health care services. Note what the Report calls "proportionate universalism"
Cheshire East Unitary Authority Cheshire West & Chester Unitary Authority	Consider how integrated children's commissioning plans refer to and take into account the policy recommendations. Consider, as part of any children's services re-design, plans which take into account the policy recommendations
Joint Strategic Needs Assessment (JSNA) Improving the health of children is already a priority identified in the Cheshire East JSNA.	Ensure commissioners have access to information on "the social gradient" for a range of health, social care and education indicators (as defined in Local Area Agreement (LAA)) in order to determine proportional investment of resources
Practice Based Commissioners (PBC)	PBC commissioning plans reflect priority to early years development
Local Strategic Partnerships (LSP)	Sustainable Community Strategy reflects importance of this policy objective and is reflected in LAA indicators. The Children's Trust's plans should take into account the policy recommendations
Local Area Partnerships / Area Partnership Boards	Neighbourhood / community delivery plans reflect actions to support disadvantaged families
Third Sector	Maximise support for families / carers who need it the most
Private Sector / workplaces	Support family friendly and flexible working practices. Providers of childcare do so to high quality standards

Chapter Five: Health Impacts of Worklessness

Describes the impact that 'worklessness' has on health and a snapshot of what is being done locally to address this

Recognition of the significant contribution and inter-related way that employment arrangements and work conditions have on the development of social inequalities in health

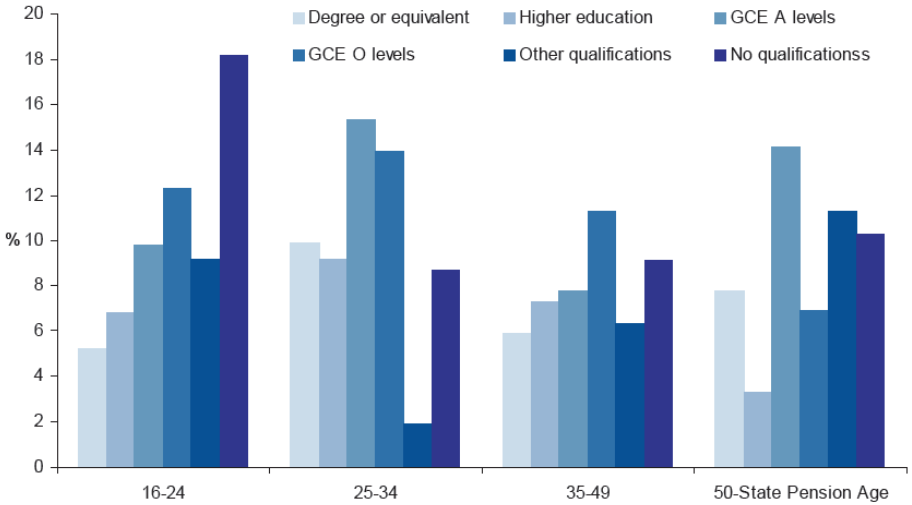
Links to POLICY OBJECTIVE 3 of *Fair Society, Healthy Lives* – 'Create fair employment and good work for all' and its priority objectives:

- **improve access to good jobs and reduce long term unemployment across the social gradient**
- **make it easier for people who are disadvantaged in the labour market to obtain and keep work**
- **improve quality of jobs across the social gradient**

Chapter Five: Health Impacts of Worklessness

Current Picture

As a result of the current recession the unemployment rate in all age groups nationally has increased - however the increase has been most acute among young people (16 - 24)



Concern

Evidence indicates that young people who experience long term unemployment are at significant risk of experiencing:

- **Unemployment in later life**
- **Experience a reduced income by up to 12-15% some 20 years later**

Affect on future earning caused by unemployment at an early age can cause 'income inequality' which is associated with unequal life expectancy and incidence of illness

Chapter Five: Health Impacts of Worklessness

Risky health behaviours

Men who experience long term unemployment before age of 33 are more likely to report risky health behaviours (smoking, little exercise, low fruit & veg) compared to those who have not – including those from more advantaged backgrounds

Alcohol

Job loss due to work establishment closure can trigger problematic drinking which increases risk of alcohol related hospitalisation in 1 in 5 men and 2 in 5 women

Long durations of involuntary employment (3+ years) in young adulthood predict heavy drinking and more frequent drinking at ages 27-35

Suicide

1% increase in unemployment associated with 0.79% rise in suicide in people aged 65 years and under

Larger increases in unemployment (>3%) in a year) associated with 4.5% rise in suicide rates

1981 was last time such a rise in unemployment (3.6%) - suicide rates went up to 2.7%

Suicide rates in young unemployed men substantially higher than those in employment

Younger claimants are more likely than older claimants to claim for mental health reasons

A persons health can deteriorate further the longer they remain on benefits

Chapter Six: Choosing Well to Keep well

Expansion of the regional Choose Well Concept

Start of identifying – to partners and public - where waste (in health services) can occur nationally and locally and suggests how it could possibly be avoided or reduced

Emphasis on how we are all 'partners in health' and the need to work together to reduce unnecessary expenditure and manage demand to allow the most efficient and effective use of available resources

Chapter Six: Choosing Well to Keep well

Areas highlighted included:

Services

Medications - use wisely

£2 million worth of unwanted or unused prescribed medication returned to community pharmacies within CECPCT each year

£60,000 a year cost to PCT to incinerate returned medicines

Ambulance Services - reduce demand

£10.5 million spent by PCT between 2009-2010 on 48,540 callouts

£2.2 million of this spent on *'Not Serious, Not life threatening'* condition call outs

Falls are the reason for nearly ¼ of all ambulance call outs within PCT

Make an Appointment – Keep your appointment

Cost of a missed appointment is £17

During the period Jan - May 2010 1,240 GP appointments were missed at the 6 GP practices of Waters Green Medical Practice, Macclesfield –avg of 69 per month

Equivalent of £21,080 lost

Chapter Six: Choosing Well to Keep well

Lifestyles

Alcohol

In CECPCT, between 2002-2006, 22,228 alcohol related admissions to hospital

£31.5 million a year cost to PCT for treating alcohol related problems

Estimates that alcohol is a factor in 35% of all A&E cases during the week, up to 70% at weekends

Sexual Health

Consequences of risky sexual health behaviour (emotional and financial)

Chlamydia – 1 in 10 sexually active young people who are tested

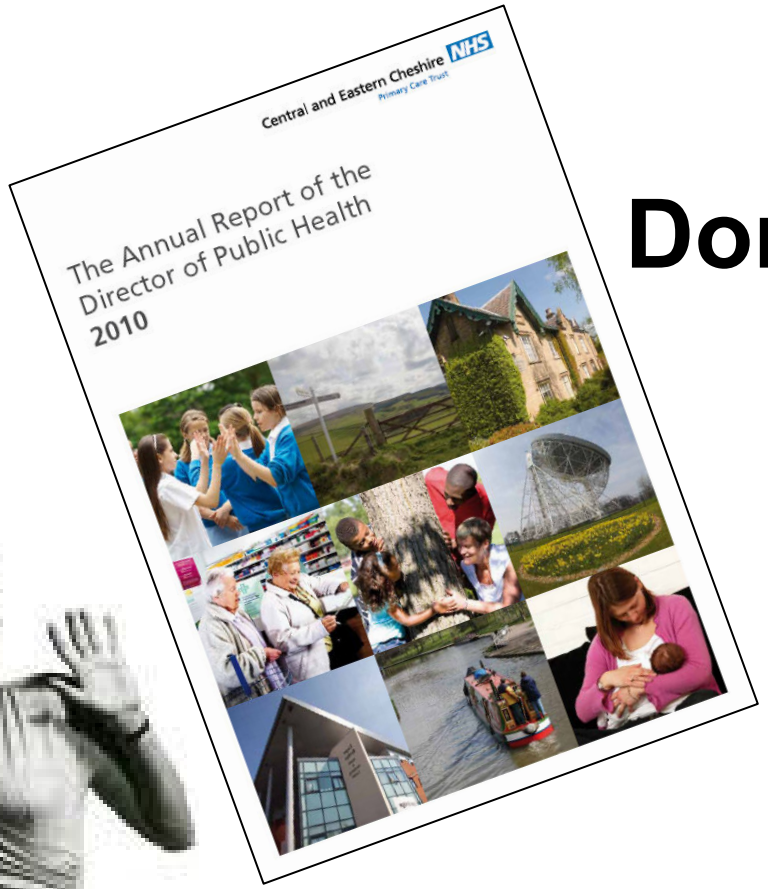
£9,000 cost on fertility treatment to repair damage caused by Chlamydia if left undiagnosed

Teenage Pregnancy – avg of 320 teenagers becoming pregnant each in CECPCT

£1000 cost to local economy per teenage conceptions

£1,500 cost associated with delivery of each live birth

What Next?



Don’t be afraid of it

What Next?

- **Digest**
- **Discuss**
  (presentations)
- **Decide – does it fit; what more?**
- **Prioritise**
- **Act**
- **Review**
- **TOGETHER**

THANKYOU

CECPCT Annual Report of the

Director of Public Health 2010

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CHESHIRE EAST COUNCIL

Health and Adult Social Care Scrutiny Committee

Date of Meeting:	9 September 2010
Report of:	Ruth Galvin, Head of Business - Public Health, Central and Eastern Cheshire Primary Care Trust (CECPCT)
Subject/Title:	Report on Joint Strategic Needs Assessment

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1 Report Summary

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

1.2 the progress made in developing the Joint Strategic Needs Assessment for Cheshire East;

1.3 the headline findings of a Joint Peer Review of the JSNA by Local Government Improvement and Development (formally Improvement and Development Agency) and the PCTs internal auditors: Merseyside Internal Audit

2 Recommendations

2.1 That:
(a) The Scrutiny Committee note the contents of the JSNA website and the work in the PCT and Local Authority that it has influenced. The PCT and Local Authority to enhance their joint work in order to progress and update the content of the JSNA and implement the recommendations of the joint review;

(b) The Scrutiny Committee note the contents of the joint review of the JSNA and its early findings; once the full report is available the JSNA steering group will set key performance indicators and implement the recommendations of the review;

3 Reasons for Recommendations

3.1 To progress work of the JSNA in order for robust intelligence and data is available to enable planning and commissioning of services in the context of emerging national policy changes in how health and health care services are commissioned in the future.

4 Wards Affected

4.1 All

5 Local Ward Members

5.1 All

6 Policy Implications

6.1 The recommendations aim to support the development of the JSNA in the light of major public sector reform and a new Health Bill and Public Health White Paper (latter due Dec 2010)

7 Financial Implications

7.1 Not known at this stage.

8 Legal Implications (Authorised by the Borough Solicitor)

8.1 New statutory role for Local Authorities – details to be published.

9 Risk Management

9.1 Risks to be identified

10. Overview of the JSNA

10.1 In 2007 the Local Government and Public Involvement in Health Act placed a duty on upper-tier local authorities (or unitary Councils) and Primary Care Trusts to undertake Joint Strategic Needs Assessment (JSNA). At that point two Joint Strategic Needs Assessments were developed reflecting the different needs of the Cheshire West and Chester and Cheshire East areas using a common process and approach.

10.2 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 and leading to agreed commissioning priorities that will improve outcomes and reduce health inequalities.

10.3 Since the last JSNA report to the Overview Scrutiny Committee the two JSNAs in Cheshire West and East have separated and the Cheshire East JSNA has developed a clear identity. The JSNA steering group has been jointly chaired by the Director of Public Health and the Director of People.

10.4 The improvements to the JSNA have been recognised in the World Class Commissioning assessment and JSNA information and intelligence has influenced and underpinned a number of key plans and strategies. The JSNA

WebPages are now hosted by Cheshire East Council Website. The pages have been expanded, further populated and improved.

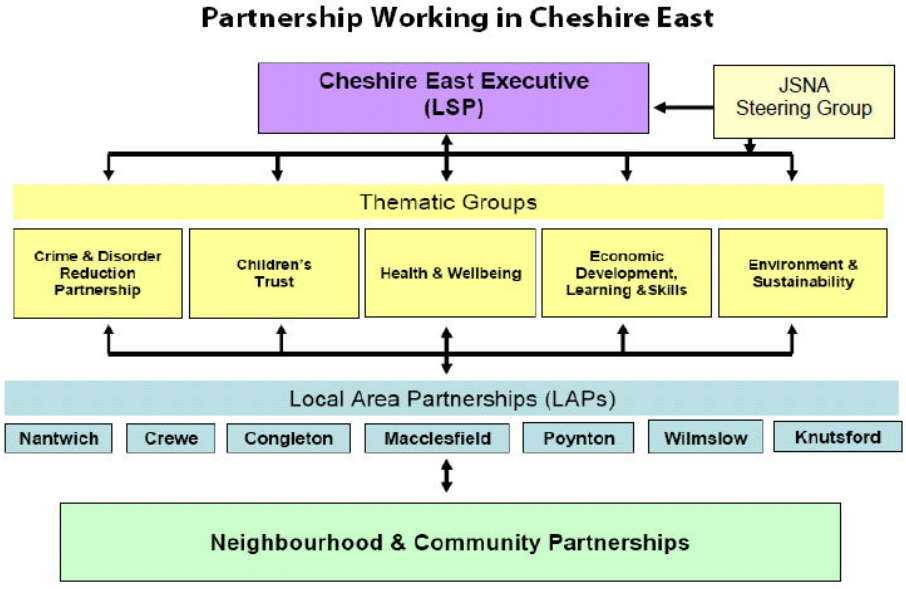
10.5 From September 2010 the JSNA governance, structure and content will evolve again. This is as a result of the retirement of the Director of People at Cheshire East Council. The Head of Adult Social Services will assume the role of joint chair. As well as these governance arrangements there will be progression in the approach and monitoring of the Cheshire East JSNA. This follows the recent Peer Review by Local Government Improvement and Development and the PCT internal auditors who, at the request of the two host organisations set recommendations to develop the JSNA further in preparation for its future role as a result of structural changes to the NHS.

11 The JSNA and the LSP Structure

11.1 The JSNA Steering group is jointly chaired by the Director of Public Health and Head of People/Adult Social Care. Senior Commissioning and service leads from both organisations attend plus data intelligence and thematic group representation which includes members from the 3rd sector.

11.2 On 11th May 2009 Dr. Heather Grimbaldeston, Director of Public Health, presented a report to the Executive Board of the LSP about the progress and the commissioning of the JSNA. In response to the recommendations in that report the LSP Executive Board agreed that the LSP should be the body formally to commission the JSNA. It also resolved that the JSNA Steering Group should be requested to report on its progress to the LSP at six monthly intervals.

11.3 The next report to the LSP is due on 6th September 2010. The joint chairs have outlined key recommendations to widen the scope of the JSNA to move towards becoming a single portal into a rich, and multi-dimensional bank of data for all commissioners.



12 Development of the content and structure of the JSNA information on the web-pages linked to the core data set

12.1 The JSNA has been a web-based tool since it commenced in 2008. This allows it to be dynamic with sections of information and intelligence being updated regularly.

12.2 Since the last JSNA report to the scrutiny committee the JSNA WebPages have been migrated from the PCT website to Cheshire East Website with an improved format. This maximises the audience and provides consistency with the JSNA footprint.

12.3 Further developments have been made to the WebPages lay out. With background information about the JSNA a section for users to more easily identify key findings of the JSNA and priority measures. Updated and additional JSNA Chapters on topics outlined in the core data set have been included.

12.4 A community voice information section has been added which incorporates consultations/surveys and user views linked to JSNA topic chapters. A needs assessment section has been introduced which displays all in-depth needs assessments undertaken. A data section is also available which will enable all interested parties to access and use data for further needs analysis as required.

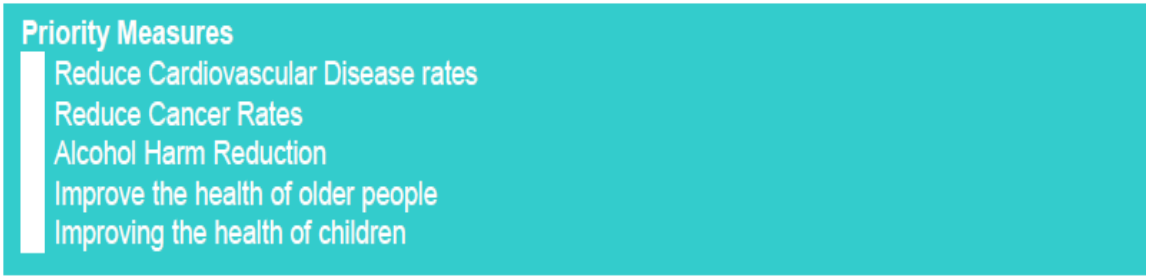
12.5 The chapter lay out of the JSNA is organised under the following sections:

- Demography
- Social and Environmental Factors
- Lifestyle Factors
- Burdens of ill health and disease
- Children and young people
- Older People
- Services

12.6 These sections are derived from the nationally prescribed layout of the “JSNA core data set” and each section has a series of chapters linked to an indicator on the core data set. As the chapters interlink a section may include a chapter featured in another section of the JSNA WebPages for ease of navigation, for example a chapter on births appears in the Demography section and the Children and Young Peoples section. Indicators from the core data set are supplemented with additional, locally relevant information to add depth and insight into the needs of our population.

12.7 The website can be accessed through the following link:
www.cheshireeast.gov.uk/community_and_living/local_strategic_partnership/jsna

13 Production of JSNA Executive Summary January 2010 The Executive Summary outlines the challenging health and social care findings from the JSNA. The top 5 priority measures for Cheshire East are:



14 JSNA influencing strategic planning and commissioning of services

14.1 There is clear line of sight from the findings of the JSNA and the PCT Commissioning Strategic Plan 2010. The JSNA also underpinned the Local Authority Sustainable Community Strategy.

14.2 Extensive health data has been produced to provide a comprehensive picture of the Health of the population in each of the Local Partnership Areas (LAP). This information and intelligence is being utilised to underpin LAP plans. The JSNA is currently providing extensive information and intelligence to build a pharmacy needs assessment.

14.3 The JSNA information has supported the development of the dementia strategy/plan it is currently supporting the older peoples strategy and the child poverty strategy.

15 JSNA Review Background

15.1 At the end of quarter 4 2009/10 the JSNA steering group asked Merseyside Internal Audit (MIAA), the PCT auditors to conduct an audit of the JSNA to focus on how the steering group could improve on or establish more effective means of monitoring the use of the JSNA and its impact on the ways in which services are planned and commissioned. The intention was for the steering group to set key performance indicators based on the outcomes of the audit.

15.2 At the beginning the audit the JSNA steering group were approached by the Improvement and Development Agency to carry out a Peer Review of the JSNA. The peer review involved outside professionals from other PCTs and Councils reviewing Cheshire East JSNA against a set of agreed Key Lines of Enquiry.

15.3 The steering group agreed that it was appropriate that the audit and the peer review became a joint review of the JSNA. The review focused on different aspects of the JSNA and interviewed a number of key staff in the PCT and Local Authority as well as reviewing the JSNA material and WebPages.

16 JSNA Review Key findings

The preliminary results of the joint review were fed back to key staff on 13th August. A full report is due in September. The review looked at 3 key areas.

16.1 Key area 1: Undertaking the JSNA:

Area	Strengths	For consideration
Leadership & Ownership	Good awareness among executive members and senior officers of the JSNA. Leader of the council and PCT Chair understand the strategic importance of the JSNA. There is ownership by the LSP Executive Board. Strong leadership by the steering group chairs and the JSNA has been signed of by PCT Board	Retirement of one of the joint chairs. Limited / Varied engagement at commissioning manager and middle manager level. Limited evidence of the JSNA influencing services and plans
Strategy & Plan alignment	Commitment to agreed shared priorities Clear and growing links between JSNA and a range of key strategies/documents e.g. • Sustainable Community Strategy; • Annual Public Health Report • GP Plans • Pharmacy Needs Assessment Ambitions for the JSNA to be the platform for joint intelligence, informing all investment and planning decisions	How can the JSNA become the central feature of an intelligence pool? Does the JSNA need to be more fully part of the planning and strategy arrangements?
Partnership working: strengths	Positive examples of partnership working – e.g. pooled budgets for people with learning difficulties Clear recognition that partnership working is vital to tackling differences in health and improving health outcomes Partners have a good understanding of the health of the local population and where differences in health exist from the JSNA Local Area Partnerships are recognised as having a major part to play in tackling differences in health inequalities	The JSNA is not yet seen to be driving improved outcomes The views of the council and the PCT mirror each other; both believe their partners could do more to be effective Different understanding of 'commissioning' Lack of co-terminosity and relative immaturity of the council seen as barriers to partnership working Little evidence of wider engagement with or involvement of wider council departments, NHS providers, other statutory bodies or the voluntary and community sectors
Involvement& engagement:	Range of mechanisms in place to reflect diverse voices "Community voice" section included on the JSNA website 7 Local Area Partnerships (and 2 APBs)	The community, voluntary and charitable sector has not been fully involved in the design and preparation of the JSNA Concern that over reliance on LAPs potentially excludes some community voices such as migrants, newer communities and more deprived communities Separate approaches to community engagement at the PCT and Local Authority

16.2 **Key area 2: The content**

Area	Strengths	For consideration
Data & intelligence	Ambitious plans for the JSNA Good use of the national dataset Development of statistical LAP analysis Use of information outside the core data set o Information on observed and expected disease prevalence using GP QOF data	Primarily health data focused and not at this stage fully reflective of the wider evidence base (Council collaboration to JSNA webpage) Data and information sharing arrangements Balance between qualitative and quantitative data Reliance on single PCT data analyst Lack of granularity of information Recognition of cost vs needs analysis How to go from data to the local story and from the local story to options and priorities? How can data and information sharing arrangements be improved / strengthened?
Format & presentation	JSNA website used frequently "Opportunities for the community to contribute to JSNA and its development via the web master Clear and logical flow and structure Commissioning team contribution to populating website	JSNA is largely technical in its focus and presentation and not accessible to a wide range of readers Does not reflect the precursors of inequalities and opportunities to address them Challenge in relation to converting data into future action

16.3 **Key area 3: Using the JSNA**

Area	Strengths	For consideration
Commissioning and decision making	JSNA being used to inform a range of plans (e.g. GP Cluster plans via Annual Public Health Report) PCT commissioning engagement with Public health throughout JSNA development Used to validate existing plans (e.g. older people commissioning)	Still early days! JSNA is beginning to inform commissioning decisions but this is not common or extensive practice across the Council or the PCT Lack of commissioning capacity, skills and awareness Taking action on the basis of knowledge about health inequalities Expectation that the LAPs will play a major role in tackling health inequalities – but no resources identified to support them to do so Is JSNA influencing de-commissioning? How to balance investment in health improvement with investment in the care of older people? What processes of decision making would help this?

17 Taking the review forward

17.1 The JSNA steering group await the full report of the peer challenge review in order to review the full recommendations and develop key performance indicators.

17.2 The peer review has provided Cheshire East with an opportunity to review what's working well and where improvements need to be made on the JSNA. Whilst there has been an element of 'looking back' the peer challenge brings benefits and added value in how we undertake JSNA in the future, enabling the Local Authority and the PCT to be well positioned in preparing for future changes due to public sector reform and the new Health Bill and Public Health White Paper (due at the end of the year).

17.3 The peer review group have offered to work with JSNA Steering Group to take forward the issues highlighted and complete action planning

18 Recommendations / Actions

The Committee is asked to

a) Note the progress of the Joint Strategic Needs Assessment for Cheshire East;

b) Consider the preliminary results of the joint peer review of the JSNA

19 Access to Information

19.1 The JSNA web-pages can be accessed using the following link:
www.cheshireeast.gov.uk/community_and_living/local_strategic_partnership/jsna

19.2 A copy of the presentation outlining the initial findings of the JSNA review can be obtained by contacting
Name: Ruth Galvin
Designation: Head of Business - Public Health, CECPCT
Email: ruth.galvin@cecpct.nhs.uk

CHESHIRE EAST COUNCIL

Health and Adult Social Care Scrutiny Committee

Date of Meeting:	9 September 2010
Report of:	Davina Parr, Associate Director of Public Health, Central and Eastern Cheshire Primary Care Trust (CECPCT)
Subject/Title:	Review of Health Inequalities in Cheshire East

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1.0 Report Summary

1.1 This report provides an overview of health inequalities in Cheshire East – what is meant by health inequalities, what is known about health inequalities and what actions are being taken in partnership to tackle them.

2.0 Recommendations

2.1 That:

(a) the Scrutiny Committee note the approach and work being undertaken to date through the Local Strategic Partnership and key stakeholders on addressing and reducing health inequalities;

(b) the Scrutiny Committee note the contents of the CECPCT Annual Report of the Director of Public Health 2010 as its central theme is partnership working to reduce health inequalities; Scrutiny Committee endorse and support the recommendations made in Chapter 4 in particular noting high level actions which can be taken locally across a range of partnerships to reduce health inequalities;

(c) the Scrutiny Committee note the planned work on health inequalities in the next four months – a *Living Well in Cheshire East Statement of Intent Charter* for partners to sign up to and align their future direction of travel in the context of a new commissioning landscape; and a one day Conference on 12th November 2010 to launch the Charter, gather together key partners within or with an interest in Cheshire East to hear key speakers from Department of Health (DH), Local Government Improvement and Development (formerly IDeA), Royal College of General Practitioners, Voluntary Sector North West to communicate forthcoming policy changes and implications / opportunities. There will be a **'call to action'** for partners on an agreed way forward – through organisational sign up to the Charter

3.0 Reasons for Recommendations

3.1 To progress work on health inequalities in the context of emerging national policy changes in how health and health care services are commissioned in the future.

4.0 Wards Affected

4.1 All

5.0 Local Ward Members

5.1 All

6.0 Policy Implications

6.1 The recommendations are aimed at improving health outcomes and reducing health inequalities set within the context of major public sector reform and a new Health Bill and Public Health White Paper (latter due Dec 2010)

7.0 Financial Implications

7.1 Not known at this stage.

8.0 Legal Implications (Authorised by the Borough Solicitor)

8.1 New statutory role for Local Authorities – details to be published.

9.0 Risk Management

9.1 Risks to be identified

10.0 Background

10.1 In the recent publication, ***Tackling Health Inequalities: 10 Years On – A Review of developments in tackling health inequalities in England over the last 10 years*** (DH, May 2009), progress is described against the Acheson report, lessons learned and future challenges. The key message is **much achieved, more to do**

10.2 Central and Eastern Cheshire Primary Care Trust's **World Class Commissioning Strategic Plan** sets out a number of priority outcomes for the local population including improving life expectancy and reducing health inequalities.

10.3 A report to Cheshire East Council Cabinet in November 2009, endorsed the need for a collaborative approach to improving the health and wellbeing of our communities and approved the establishment of a **Cheshire East Council Working Group** (engaging all Council services) to contribute to the drafting of a local Health Inequalities Plan.

10.4 *Fair Society, Healthy Lives*, the Strategic Review of Health Inequalities in England Post 2010 **(the Marmot Review)** published in February 2010 proposes an evidenced based framework for reducing health inequalities from 2010. The framework includes policies and interventions that address the social determinants of health inequalities ***(tackling the "causes of the causes***") such as income, living and working conditions, built environment and employment.

10.5 The Cheshire East Local Strategic Partnership Executive endorsed a local framework for tackling health inequalities at its meeting on 22nd February 2010. The framework takes three key strands:

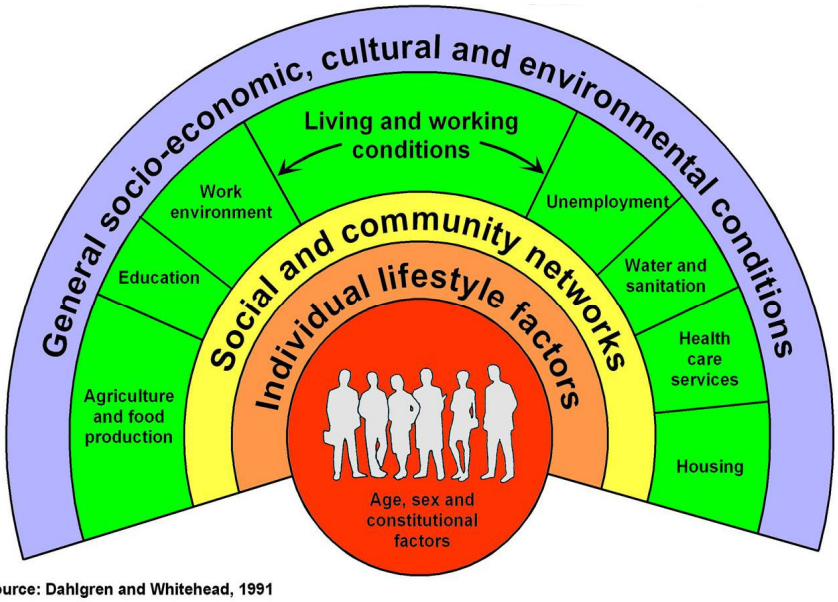
a) Improve access to health and social care services (***the services people use***)
b) Support healthier lifestyles (***the lives people lead***)
c) Tackle the wider factors which impact on health such as housing, employment, transport, education, employment (Marmot Review – ***the causes of the causes***)

10.6 The **LSP Health and Wellbeing Thematic Partnership** established in September 2009 is the lead partnership for facilitating actions to support healthier lifestyles and tackle the wider determinants of health. Dr Heather Grimbaldeston, Director of Public Health chairs this group supported by public health colleagues from the PCT and health and wellbeing colleagues from Cheshire East Council.

11.0 A Common Understanding of Health Inequalities

11.1 'Health inequality' can be referred to as the **gap or variation** in health status, and in access to health services, between different social and ethnic groups and between populations in different geographical areas.

Figure 1: Factors which influence health outcomes and health inequalities



Source: Dahlgren and Whitehead, 1991

11.2 The "rainbow" model shown at Figure 1 highlights the existence of ***wider determinants of health*** (Marmot refers to as the ***"causes of the causes"***) that may be beyond the direct influence of the individual, affecting the wider environment. An individual's social and community networks impact on these factors and links the rainbow between individual lifestyle factors and living and working conditions. This further guides our thinking towards a community engagement and development approach to tackling health inequalities. Health is, therefore, seen as a **resource** for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capacities.

11.3 In his report, ***Fair Society, Healthy Lives***, Marmot further adds that reducing health inequalities is a matter of ***fairness*** and ***social justice***. There is a social gradient in health – the lower a person's social position, the worse his or her health. Action should focus on reducing the gradient in health. To reduce the steepness of the social gradient actions must be ***universal***, but with a ***scale and intensity that is proportionate to the level of disadvantage***.

12.0 What we know about Health Inequalities in Cheshire East

12.1 **The CECPCT Annual Report of the Director of Public Health 2010** places great emphasis on the role of partnership working to address and reduce health inequalities. This includes a comprehensive overview of what we know about health inequalities in Cheshire East. In summary:

12.2 **Chapter One** gives an overview of the health of the whole population of CECPCT and the main health issues affecting them, with a particular focus on those conditions that contribute to the causes of local inequalities in health.

12.3 **Chapter Two** reviews the impact of the CECPCT Annual Report of the Director of Public Health 2009 and how it has been utilised by Practice Based Commissioning groups.

12.4 **Chapter Three** highlights the health of the resident populations of the seven Local Area Partnerships and two Area Partnership Boards within CECPCT with brief comparisons between the differences within and between these area partnerships, and finishing with recommendations identifying key areas for development.

12.5 **Chapter Four** provides an overview of the findings of the Marmot Review on tackling health inequalities post 2010 as published in *Fair Society, Healthy Lives* and a commentary on what these findings may mean to the partnerships within CECPCT who have a responsibility for improving health and tackling health inequalities.

12.6 **Chapter Five** explores further one of themes of the Marmot Review - Worklessness - and how it can affect the health of the population, as well as examples of how CECPCT is tackling worklessness to support an improvement in health and well being.

12.7 **Chapter Six** provides information to our working partners and the general public on the impact that health behaviours and choices have on providing health services that are currently provided through the Primary Care Trust.

12.8 **A Technical Appendix** is also provided containing more detailed health information about each of the area partnerships.

12.9 Copies of the CECPCT Annual Report of the Director of Public Health 2010 can be accessed via www.cecpct.nhs.uk. Follow the route: Home > About Us > Public Health

12.10 **Appendix 1** provides an extract from the CECPCT Annual Report of the Director of Public Health 2010, providing data on life expectancy and what we know impacts on differences in life expectancy.

13.0 Partnership Actions to Reduce Health Inequalities in Cheshire East

13.1 Using the framework for tackling health inequalities as agreed by the LSP Executive (refer to 10.5 above), listed below are a number of examples of actions and services which have been implemented in the past year which have impacted on health outcomes.

13.2 **Improve access to health and social care services (*the health services people use*)**

Examples of NHS commissioned services:

1. **Primary prevention – Stop Smoking Services** have been refocused to areas of deprivation. We have successfully maintained our quit rate in Routine and Manual Groups. We employ a Polish speaking Stop Smoking Advisor to support our high numbers of Polish migrant workers in Crewe – 47% quit rate in this target group (2009-2010) has been achieved through this service
2. **Primary Prevention** – **Uptake and duration of breastfeeding** – we saw differences between our two maternity units at Leighton Hospital and Macclesfield District General Hospital and using £98,000 from a successful bid to DH, we're targeting two areas where rates are low (Crewe and Winsford). Work includes progressing BabyFriendly accreditation with both maternity units, employing two Breastfeeding Support Workers and a social marketing insight programme obtaining views of mothers, their partners, professionals and local businesses in public areas.
3. **Primary Care –incentives for GP practices in areas with the worst health** to identify and treat people with Coronary Heart Disease. Payments to GP practices were weighted for socioeconomic deprivation to address health inequalities. Headline results for the first year include improved health outcomes such as 32, 254 people believed to be at high risk of developing cardiovascular disease were screened and assessed and interventions put into place where necessary; 100% of GP practices developed a disease register and a system of annual review for patients at risk of developing diabetes. Cardiovascular disease screening has developed into the

mechanism through which the PCT implements the DH NHS Health Check Programme.

4. **Secondary Care – The Treat and Return Programme** was established to improve patient flow between secondary and tertiary care, to improve access, to maximise the use of beds at all units and reduce the inequalities of provision through the system. The average length of stay for cardiology patients has reduced as they now have fast access to Tertiary Centre services, reducing the inequalities in provision and improving the overall revascularisation rate.

13.3 **Support healthier lifestyles (*the lives people lead*)**

Examples of Partnership Activity:

1. **Cheshire East Smoke Free Alliance** – work on behalf of Smokefree North West to identify smoking rates and attitudes towards the use of tobacco amongst the Polish community. Published work helped to inform delivery of services. In Cheshire East a Polish speaking Stop Smoking Advisor was recruited.
2. **Alcohol Social Marketing Project** (see Appendix 2 on partnership success stories)
3. **Health Impact Assessment** one day workshop delivered on 5th July 2010 with a view to establishing a HIA Steering Group to assess major plans and strategies for positive health benefits and to identify and mitigate any negative health impacts.

13.4 **Tackle the wider factors which impact on health such as housing, employment, transport, education, employment (Marmot Review – *the causes of the causes*)**

Examples of Local Strategic Partnership Activity:

1. **The Health and Wellbeing Thematic Partnership** has been meeting since September 2009 with a membership of representatives from the PCT, the Fire and Police Services, the local authority and the third sector. The Partnership has focused upon the LAA indicators that sit within it's 'basket'; on providing leadership within the LSP on health (for example the Chair (PCT Director of Public Health) briefed the LSP Executive in November 2009, presentations to the other four thematic partnerships are being planned and members of the Partnership have been proactive in the consultation on the Sustainable Community Strategy and the 2009 refresh of the Local Area Agreement.
2. **Cheshire East Council Health Inequalities Group** - This group has been established with representation from all appropriate Council Services to develop a Council wide approach to health inequalities that integrates effectively with the LSP Health Inequalities Framework. Work that is already underway and has an impact on health inequalities has been audited and mapped against the policy objectives of the Marmot Review. This provides a baseline of activities inherited by the new authority, gaps in activity and priorities for future action. The Group will also lead on workplace health for the Authority.
3. **Local Area Partnerships** - To engage the LAPs and ensure their commitment to reducing health inequalities in each area, the PCT has produced detailed analyses of health data on a LAP by LAP basis. This has been shared with all LAPs during their May - July 2010 meeting cycle as part of a "Health Inequalities / Marmot Roadshow" that the PCT and Cheshire East Council have delivered in partnership. Through this process and follow up activities and support, the LAPs will be able to take into account the health needs of their local communities and build into the Local Area

Plans appropriate actions to help reduce the health inequalities in their communities. LAP presentations are available on the Cheshire East JSNA webpage and CECPCT Public Health webpage

4. **Focus on Alcohol** - The need to reduce alcohol harm has been clearly identified as a priority in the Joint Strategic Needs Assessment and 2009/10 refresh of the Cheshire East Local Area Agreement. The Chief Executive of Cheshire East Council is acting as Champion to lead improvements in this area. The LSP Health and Wellbeing Partnership is accountable for overseeing the drive to reduce alcohol harm, but other partnerships have a role to play, for example the Crime and Disorder Reduction Partnership. The LSP's Alcohol Harm Reduction Strategy is being finalised and was endorsed at a Summit event in July 2010, where action planning was also undertaken by partners. The **Sub Regional Health Commission** has been established and is focusing upon alcohol as a priority, bringing opportunities to learn from good practice in neighbouring authorities and to add value through working in partnership.
5. **Work on Comprehensive Area Assessment** – although CAA has been abolished the PCT and Cheshire East Council undertook a review of health inequalities as part of the preparation with Audit Commission inspectors in the run up to this years CAA. Whilst no official feedback was provided, informal feedback indicated that no red flags would have been given for health inequalities – that the Audit Commission were confident of the work being undertaken locally to reduce health inequalities.

13.5 Additional stories of successful actions and services to improve health outcomes are outlined in **Appendix 2.**

14.0 Future Work on Health Inequalities in Cheshire East

14.1 In view of the Coalition Government's policy proposals for the reform of the NHS, it is important to maintain the momentum on actions to reduce health inequalities. In preparation two activities are planned for the remainder of the year, in advance, but mindful, of the publication of the National Public Health White Paper (due Dec 2010). These are the publication of a Cheshire East Health Inequalities Statement of Intent Charter and a Cheshire East Health Inequalities Conference to be held on 12th November 2010.

14.2 The Cheshire East Health Inequalities Statement of Intent Charter to be known as **"Living Well in Cheshire East – a Statement of Intent/"** is a short user friendly summary of the major challenges in relation to improving health outcomes and reducing health inequalities in Cheshire East. It will make recommendations for GP commissioners, the Local Strategic Partnership; local communities, public health, local authorities and new Health and Wellbeing Boards. The aim is for key partners in the *new world* to "sign up" to the Statement of Intent and to agree on and set the future direction of travel including new ways of working, for example, an asset approach to supporting healthy communities. A first draft is expected by mid October 2010.

14.3 A date of **Friday 12th November 2010** at (venue tbc) has been set for a Conference to bring together key stakeholders in the new world (as referenced above) to be entitled **"Living Well in Cheshire East – a call to action to reduce inequalities".** The aim of the event is to bring together a range of high profile speakers to set out the future direction of travel and future challenges and how partnerships can support work to improve health outcomes and reduce health inequalities. At the event we will be

looking for partners to sign up to the Charter**.** Details of the event and joining instructions are to be issued.

15.0 Preparing for the future – headlines for new Public Health Services

15.1 The forthcoming Health Bill will support the creation of a **new Public Health Service**, to integrate and streamline existing health improvement and protection bodies and functions, including an increased emphasis on research, analysis and evaluation.

15.2 **PCT responsibilities for local public health including health improvement will transfer to local authorities**, who will employ the Director of Public Health, jointly appointed with the National Public Health Service.

15.3 A **ring-fenced public health budget will be allocated** (to Local Authorities) to reflect relative population health outcomes, with a new "health premium" to promote action to reduce health inequalities and improve population-wide health. The Director of Public Health will be responsible for health improvement funds allocated according to relative population health need.

15.4 Each **local authority will take on the 'function of' joining up the commissioning of local NHS services, social care and health improvement'** by bringing together partners to agree *local priorities* for the benefit of patients and taxpayers, informed by community and neighbourhood needs.

15.5 Fuller details regarding this and other implications for the wider NHS commissioning and provider landscapes will be outlined at a forthcoming Council Cabinet meeting.

16.0 Conclusion

16.1 During the past year there has been focused activity through the Local Strategic Partnership and through the actions of key stakeholders to both identify and describe differences in health outcomes and take action to reduce these differences. This work has been backed by national policy and guidance on the evidence of what works to support healthier communities.

16.2 In light of the forthcoming Health Bill and Public Health White Paper, it is important to retain the momentum and action on health inequalities generated so far. A number of recommendations are proposed for Scrutiny Committee.

17.0 Access to Information

The background papers and Powerpoint presentations relating to this report can be inspected by contacting the report writer:

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Appendix 1 – Extract from the CECPCT Annual Report of the Director of Public Health 2010 – Chapter 1 – Section on Life Expectancy

Life Expectancy

Life expectancy is a fundamental measure of health outcome. The PCT has a significantly higher male and female life expectancy than the North West region figures. Although the CECPCT life expectancy rate is higher than the England average in both sexes, only the male life expectancy is significantly higher. Both the local male and female life expectancies have increased between 2005-2007 and 2006 - 2008.

Figure Seventeen: Life Expectancy for England, Northwest and Central and Eastern Cheshire Primary Care Trust

Area	Males (years)				Females (years)			
	2005-07	2006-08	change	%change	2005-07	2006-08	change	%change
England	77.7	77.9	0.3	0.4%	81.8	82.0	0.2	0.3%
North West	76.0	76.3	0.3	0.4%	80.5	80.6	0.1	0.2%
CECPCT	78.1	78.5	0.4	0.5%	82.1	82.3	0.2	0.2%

Source: National Centre for Health Outcomes Development

To inform priority setting and to identify the geographical areas of concern regarding male and female low life expectancy and the factors that influence it, the PCT in 2009 combined Middle Super Output Area's (MSOA) into five equal groups based on the overall life expectancy. This approach:

- created a local PCT 'spearhead MSOA group' which identified those MSOA areas where there is a low life expectancy for either male or females whose poor health experience needs to be the focus of further attention and;
- enabled the PCT, and its partners, to look at the various factors that influence life expectancy such as poor lifestyles and access to services and deprivation.

The movement between the life expectancy value within the Spearhead MSOA's have been calculated for 2005-2007 and for 2006-2008.

Figure Eighteen: Central and Eastern Cheshire Primary Care Trust Spearhead Middle Super Output Area Group Life Expectancy by Male and Female, 2005-2007 and 2006-2008

MSOA Name	Male Life Expectancy			Female Life Expectancy		
	2005-07	2006-08	Movement	2005-07	2006-08	Movement
East Coppenhall	71.6	72.7	↑	78.7	79.4	↑
Central & Valley	72.2	73.7	↑	77.9	77.3	↓
West Coppenhall & Grosvenor	73.0	74.2	↑	83.0	81.6	↓
St Barnabas	73.6	74.2	↑	78.3	78.9	↑
Alexandra	75.0	74.2	↓	81.3	80.9	↓
St Johns	76.6	74.9	↓	79.0	80.7	↑
West Nantwich	77.9	78.4	↑	80.0	81.3	↑
Wistaton Green	78.1	78.5	↑	79.5	82.0	↑
East Winsford	73.3	74.7	↑	78.8	79.7	↑
Winsford Central	73.6	73.3	↓	78.5	76.6	↓
West Winsford	74.8	77.5	↑	79.8	81.4	↑
Leftwich, Rudheath & Witton	75.3	75.2	↓	80.0	80.5	↑
North Winsford	75.6	79.2	↑	81.2	80.7	↓
Macclesfield Town South	73.6	74.3	↑	80.2	80.1	↓
Macclesfield Town East	75.5	78.9	↑	80.9	81.4	↑
Macclesfield Town Bollinbrook & Ivy	77.4	76.8	↓	79.5	81.2	↑
Sandbach South	74.3	76.4	↑	80.0	83.0	↑
Middlewich West	78.8	78.4	↓	79.8	80.6	↑

Spearhead MSOA for males only Spearhead MSOA for females only Spearhead MSOA for male and female
Source: Public Health Mortality File, Annual District Deaths Extract ONS MSOA Quinary Population Estimates

This process has been done across all areas to ensure that any significant changes are picked up, regardless of whether an MSOA is designated a 'spearhead' or not. No significant decreases between the two periods in either male or female life expectancy was identified.

This method demonstrated that whilst the overall CECPCT life expectancy rate is good, it masks the large internal variations that exist between the MSOA areas that make up the new strategic Local Area Partnerships and Area Partnership Boards that are within the PCT boundaries. The summary below shows the gap in life expectancy calculated at MSOA level for 2006 - 2008:

- **11.5 years in Men**
  Range: 72.7 years East Coppenhall (Crewe) to
  84.2 years Wilmslow Town South East
- **16.5 years in Women**
  Range: 76.6 years Winsford Central to
  93.1 years Macclesfield Town Tytherington

When 95% Confidence Intervals are calculated there is still a significant difference in males (7.9 years) and females (7.2 years) between the highest and lowest life expectancy.

Causes of premature death that affect the Life Expectancy rate

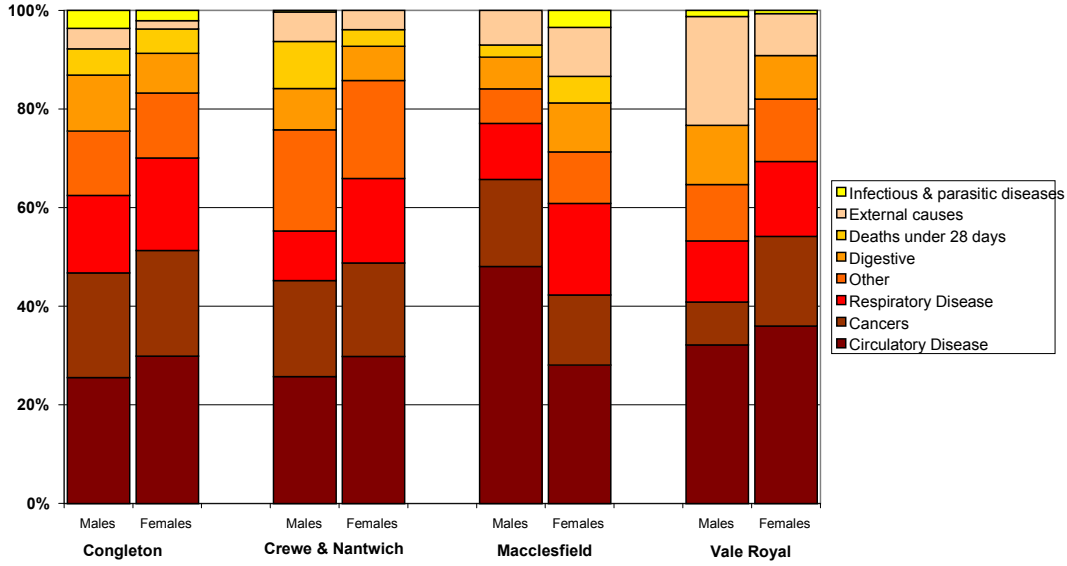
The main causes of premature death that account for the gap in life expectancy between the most deprived and least deprived quintiles within CECPCT are the largely preventable diseases of CVD and cancer.

Cardiovascular Disease
Nearly 36% of all deaths within CECPCT are a result of CVD. This equates to approximately 1,600 deaths from CVD each year. CVD is the biggest contributor to the life expectancy gaps experienced by both males and females (range 25.6% - 48.1%) within all the four former district council areas within CECPCT (**Figure Nineteen**).

Approximately 26% (1,245) of deaths are premature and could be preventable with lifestyle modification. Almost a third (31%) of these premature deaths would be eliminated if the health experience of residents living in the worst (most deprived) MSOA was the same as the very best (least deprived).

Premature mortality (under 75s) from CVD has been reducing within the PCT however there remains a large inequality gap between the best and worst experiences within the population when analysed by deprivation index or geographical areas (town areas and MSOAs).

Figure Nineteen: **Main causes of death contributing to the life expectancy gap between the most deprived and least deprived quintile within Central and Eastern Cheshire Primary Care Trust 2005-2007**



Source: Health Inequalities Intervention Toolkit. London Health Observatory. http://www.lho.org.uk/LHO_Topics/Analytic_Tools/HealthInequalitiesInterventionToolkit.aspx

Cancer

26.4% of deaths are a result of cancer. This equates to 1,160 deaths from cancer per annum. Although cancers are the second biggest cause of all deaths in CECPCT following CVD they are the main causes of premature death and therefore have a considerable impact on life expectancy. 50% of cancers are preventable with lifestyle modification (smoking, obesity and alcohol), increased awareness, early detection and improved care.

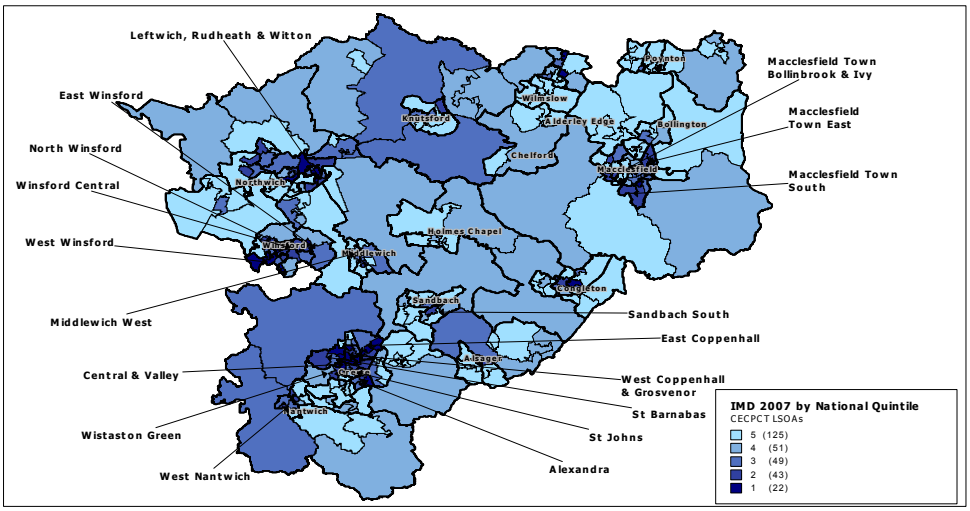
Breast, colorectal and lung cancers are the main forms of cancer that cause premature death within CECPCT. The position locally is that:

- there has been a steep rise in the number of new cases of lung cancer in women which has also contributed to an increase in cancer mortality among women under 75. Although in part this reflects the consequences of unhealthy lifestyles in the past, it also emphasises the need to continue to focus on smoking cessation and the early detection of cancer
- analysis of lung cancer incidence between 2005-2007 show that the three largest and most deprived towns within the PCT (Crewe, Winsford and Macclesfield) have double the incidence of lung cancer than occurs in other communities
- the PCT has a 5% higher incidence of breast cancer than nationally, which reflects the generally affluent status of our population. Two of the three communities with the highest incidence of breast cancer are affluent towns (Knutsford and Wilmslow) that have a historically low uptake of breast and cervical screening
- our 1-year survival for lung, colorectal and breast cancer is in the best 25% of PCTs, as is 5-year survival for lung, prostate and breast cancer
- recent improvements in survival from colorectal cancer are leading to reductions in mortality from this disease in both men and women
- 1-year survival rates for prostate cancer have not improved since 2002 and in fact have slipped compared to other PCTs. It is likely that our 5-year survival rates for prostate cancer will also start to be affected soon

Deprivation

Across the PCT most of the local "town" areas have relatively less people affected by income deprivation than the national average, except in Winsford where it affects both children and older people and in Crewe where children are affected. More significantly, there are three fold percentage differences in income deprivation between our "town" areas. This contributes to poor health and health inequalities which are closely linked to life expectancy.

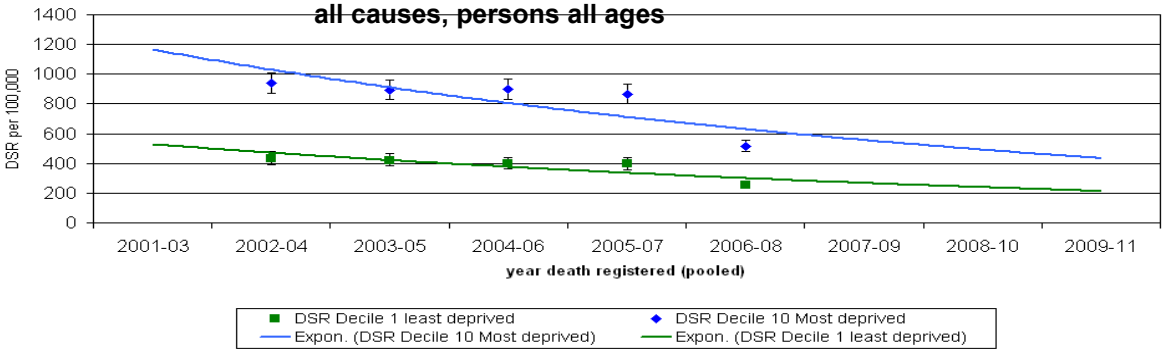
Figure Twenty: **CECPCT Lower Super Output Areas by Index of Multiple Deprivation 2007 Quintile with Spearhead Middle Super Output Areas labelled**



Whilst higher levels of deprivation are generally associated with a lower life expectancy and are a cause for the 'gap' in life expectancy rates experienced by males and females residing in more deprived MSOA areas compared to the least deprived MSOA areas, MSOA's within CECPCT with low life expectancy rates do encompass some of the more affluent populations.

A review of mortality trends by deprivation (**Figure Twenty One**) shows that whilst death rates are reducing in our populations living within those MSOA's that are amongst our 10% (decile) most deprived locally, the reduction is slowing and levelling off in our population who live within those MSOA's that are amongst our 10% (decile) least deprived locally.

Figure Twenty One: **Mortality within Central and Eastern Cheshire Primary Care Trust from all causes, persons all ages**



Source: ONS Annual District Death Extracts and Mid-year Population Estimates (Local), Compendium of Clinical and Health Indicators (National Centre for Health Outcomes Development)

Appendix 2 – Success Stories – Actions to Reduce Health Inequalities and Improve Health Outcomes

Success Story 1 - links to LAA National Indicator 39 – Alcohol Related Hospital Admissions

Cheshire and Merseyside Public Health Network (ChaMPs) Alcohol Social Marketing programme

The Travellers Rest pub on Cross St in Macclesfield won't be just a usual local for the 6 week period from 14th November to 18th December 2009. It's the chosen venue for an innovative social marketing trial aimed at helping men be more health aware and realise the effect that alcohol may be having on their physical and emotional wellbeing.

ChaMPs Public Health Network in partnership with Central & Eastern Cheshire PCT and Cheshire East Council have devised the trial which makes confidential health checks available in the pub to males aged between 35 and 55 who are routine and manual workers. The trial is part of the overall alcohol social marketing programme which aims to reduce levels of hazardous drinking, and potentially prevent future alcohol related hospital admissions.

ChaMPs is working in partnership with local brewery Robinson's, who are backing the campaign and have suggested the Travellers Rest, run by Landlady Jane Christian, as the ideal pub for the trial to take place in.

With the strapline, "Drink a little less, see a better you", the initiative encourages men to book in for a general health check and think about the effect that drinking may have on them. It asks them to 'Wind down' and consider swapping an alcoholic drink at the end of the night for lower alcohol drinks or soft drinks.

The first phase will see posters, washroom media, and a wind down promotion of reduced price shandy and a free slice of toast offered at the pub in the from Monday to Thursday in the evenings. A quiz was held in the pub on Thursday, 12th November to launch the initiative to the locals and a local media launch during the 1st week of December to generate interest and raise awareness. Those men who sign up to receive further information on health issues and tips on reducing their alcohol consumption were also entered into a prize draw to win a driving experience. The health check covered key issues such as cholesterol, height and weight, blood pressure, blood sugar and general lifestyle issues.

Following the trial, the University of Chester will be carrying out an evaluation to see how it has worked. If successful the programme will be rolled out mid-end of January across other pubs in the Cheshire and Merseyside area.

Although the programme is focused on encouraging the target audience to change their own behaviour, some may access their local GP or Alcohol services for extra support to change their drinking behaviour or address other lifestyle or health issues

The campaign received significant local and national media, for example:
http://www.guardian.co.uk/society/2009/dec/09/mens-health-services-pub

Further information can be found on the CHaMPs website: www.nwph/champs

Success Story 2 – links to LAA National Indicator 125 – Achieving independence for older people through rehab / intermediate care and deferred NI Healthy Life Expectancy at age 65.

The Next Steps Scheme Innovation – Improving Discharge from hospital for older people

The Next Steps scheme was launched at Leighton Hospital Crewe in March 2008 in order to improve access to support and local services for those aged 60+ on discharge from hospital whilst also providing a range of bespoke health promotion information, selected by older people. The Next Steps bag includes both core information supporting healthy ageing and local information which signposts to useful community-based services.

Sourcing the information for the Next Steps bag is undertaken by the Next Steps Steering Group, led by Cheshire East Council, Central and Eastern Cheshire PCT and Mid-Cheshire Hospitals Foundation Trust. The task of filling the bags for distribution is done by volunteers from the Hilary Centre, a centre for people with physical and sensory disabilities, providing meaningful engagement as well as a vital support role.

Following the distribution of the bag, which is carried out by trained hospital volunteers, a simple questionnaire is sent to bag recipients to obtain user feedback on the impacts of the Next Steps scheme. The vital information provides segmentation information, showing for example, who uses what types of information and how.

During the first 12 months of the scheme approximately 700 Next Steps bags have been distributed to people leaving hospital. Following a 40% response rate to the follow-up questionnaire 93% of males and 78% of females stated that they found the Next Steps bag useful.

The Next Steps bags cost just 7p each. This cost includes all resources, plus packing and delivery to hospital and distribution to patients – meeting the aim of the scheme to be low cost, high impact. The ongoing evaluation has demonstrated that patients have had home adaptations carried out, joined exercise classes, followed a healthier diet etc. as a result of following up information given to them through the Next Steps bag, potentially reducing the cost to health and social care. Evaluation of the scheme has also revealed that patients have taken lifestyle advice from the bag information where they would have previously seen their GP for this information.

From an initial investment of £1000, the potential cost savings to the NHS and Social Care are significant.

Based on the cost of GP appointment of £25, potential costs savings of 700 saved GP appointments = £17,500

Based on the cost of inpatient stay for an older person, per day = £340, potential cost savings of 700 saved bed days = £238,000

We know that on average, 93% of recipients who receive a bag use the information, so that would put savings between, £16,275 and £221,340.

Moving On To Phase Two Of The Next Steps Scheme

Evaluation from the first phase of the Next Steps scheme has proved to be invaluable in developing and stream-lining the information contained in the Next Steps bag and working processes for the next stage of the scheme's development.

Phase Two of the Next Steps Scheme launches during February 2010, at Leighton Hospital Crewe, Macclesfield General Hospital and Victoria Infirmary, Northwich.

The innovation and success of the Next Steps Scheme has been recognised through CECPCT, Cheshire East and MCHT being chosen as regional finalists for the Health & Social Care Awards for this scheme

CHESHIRE EAST COUNCIL

Health and Adult Social Care Scrutiny Committee

Date of Meeting:	9 September 2010
Report of:	Fiona Field, Director of Governance and Strategic Planning, Central and Eastern Cheshire Primary Care Trust (CECPCT)
Subject/Title:	Equity and Excellence: Liberating the NHS – July 2010

Background

The Government's ambition is for health outcomes and quality health services that are as good as anywhere in the world.

It is committed to the NHS' core values of a comprehensive service, available to all, free at the point of use, based on need not ability to pay.

The White Paper 'Equity and excellence: Liberating the NHS", published on 12th July 2010, sets out proposals for the NHS to become a truly world-class service that is: **easy to access**, treats people as **individuals** and offers care that is safe and of the **highest quality**. The White Paper is out for consultation until 5 October 2010. Five further papers have been released supporting the Paper, all are consultation documents with the same closing date as the overview White Paper.

Liberating the NHS
The Vision

The vision is for our NHS to:

- Put patients at the heart of everything that we do
- Achieve outcomes that are among the best in the world
- Empower our clinicians to deliver results based on the needs of patients

"No decision about me, without me"

- Patients will be put at the heart of everything that we do: that means giving them real choice about where and, in some cases, how they are treated
- They will be able to access comprehensive information on many aspects of health allowing them to rate hospitals and clinicians according to the quality of care they provide

- They will be given a stronger voice through the introduction of a new consumer champion, HealthWatch

- They will benefit from better health outcomes through a relentless focus on continuously improving the clinical outcomes that really matter, not on inputs or processes

Healthcare outcomes in England that are among the best in the world

- We will achieve this by maintaining a clear focus on continuously improving clinical outcomes, rather than monitoring inputs or processes.

- Targets without clinical justification will be removed - quality standards will become the foundation for commissioning care, payment systems, and inspection processes ie 4 hour waiting time for A & E has been removed, 18 week target is no longer mandatory.

- Our clinicians and scientists are as good as anywhere in the world and will help us to meet this challenge

Empowering clinicians to deliver results

- Decision making about healthcare services will be given back to clinicians, in partnership with patients, for example through groups of GPs commissioning services for their local communities

- Clinicians will be set free to make decisions about care based on patients' needs and to achieve the best outcomes

- A new independent NHS Commissioning Board will allocate and account for NHS resources, lead on quality improvement, and promote patient involvement and choice

- NHS Trusts will become Foundation Trusts and be given more freedom

- Monitor will be developed into an economic regulator and the Care Quality Commission will act as a quality inspectorate across health and social care

Supporting Paper - Transparency in outcomes – a framework for the NHS
- (25 questions in consultation document)

Key messages

- The proposed principles that will guide the development of the NHS Outcomes Framework are:
  - Accountability and transparency
  - Balanced

  - Focused on what matters to patients and healthcare professionals
  - Promoting excellence and equality
  - Focused on outcomes that the NHS can influence but working in partnership with other public services where required
  - Internationally comparable
  - Evolving over time

- The NHS Outcomes Framework will include a balanced set of outcome goals spanning effectiveness, patient experience, and safety.

- Developed five outcome domains that attempt to capture what the NHS should be delivering for patients

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

- Each domain will identify an overarching outcome indicator or set of indicators, improvement areas & quality standards.

Supporting Paper - Commissioning for patients - (34 questions in consultation document)

Key messages

- Commissioning of NHS services by local consortia of GP practices, supported by an independent NHS Commissioning Board, will mean that decisions on how money should be spent on healthcare are always clinically led.

- In their role as patients' expert guides through the health system, GP consortia will work closely with secondary care, community partners and other health and care professionals to design joined-up services that are responsive to patients and the public.

- All GP practices will be part of a consortium. They will have flexibility to form consortia and use resources in ways that they think will secure the best healthcare and most cost-efficient outcomes for their patients and local community.

- Consortia will be supported and held to account for the outcomes they achieve and for responsibility of NHS resources by the NHS Commissioning Board.

- The government will empower healthcare professionals to be leaders of a more autonomous NHS.

- GPs rather than Primary Care Trust managers will decide how to use NHS resources to get the best health care and outcomes for their patients.

- This is about placing the financial power to change health services in the hands of those NHS professionals whom the public trust most.

- Commissioning by GP consortia will mean that the redesign of patient pathways and local services is always clinically led and based on more effective dialogue and partnerships with other health and care professionals

- Giving more responsibility and control over commissioning budgets will help GPs consider the financial consequences of their clinical decisions.

Supporting Paper - Local democratic legitimacy in health - (18 questions in consultation document)

Key messages

- One of the defining principles of the Government is to push power away from Whitehall to those who know best about what will work in their communities - GPs, working with other healthcare professionals, and local authorities.

- Public to have a greater say in decisions that affect their health and care, and a clear route to influence the services they receive – “no decisions about me – without me”.

- Enhanced role for local authorities role in integrating the commissioning of local health, social care and public health services to meet the needs of individuals and families using the services.

- Elected councillors and councils will have a new role in ensuring the NHS is responsible and answerable to local communities.

- Local authorities will develop a powerful local voice in the form of local HealthWatch - a new way for patients and the public to shape health services and exercise genuine choice through feedback.

- Local strategies for health, social care and health improvement will be co-produced by Local Authorities and GP consortia to ensure that commissioning is joined where it makes sense for the patient and is undertaken in an accountable way.

Supporting Paper - Report of the arm's-length bodies review

Key messages

- The Department's arm's length bodies have made significant contributions to improvements in health and care.
- Government has made a commitment to reduce significantly non-front-line costs across the Department, NHS and its arm's length bodies
- Of the overall anticipated savings of £1bn, over £180m is expected to come from the ALB sector by 2014/15
- The Report of ALB Review sets out proposals for each of our arm's length bodies. Will be engaging with key stakeholders on how these changes will be implementing over the next few months.
- In future, arm's length bodies' independence will be exercised within the confines of clear and agreed functions. This is in line with the Government's wider commitment to increase transparency and accountability across government.
- The new Arm's-length Bodies sector will
    - Simplify national landscape — reducing the number of ALBs; with the bodies which remain carrying out only those functions which need to be done at a national level
    - Be streamlined
    - Be aligned with the changes in the wider health and social care system
    - Significantly reduce non-front-line costs
    - Deliver their services in most cost efficient and effective way — giving value for money for the taxpayer
    - Have greater accountability and transparency

Supporting Paper - Regulating healthcare providers - (21 questions in consultation document)

Key messages

- Puts forward proposals to free up foundation trusts to innovate for improved outcomes and services by:
    - removing the statutory private income cap to give trusts opportunities to expand the services they offer to patients - but ensuring that they remain focussed on providing NHS services

- removing statutory borrowing limits that are not imposed on voluntary or private providers

- making it easier for a foundation trust to merge or take over another trust

- giving more flexibility to foundation trusts to allow greater staff and patient involvement – with the possibility of some smaller organisations being led only by employees

- Monitor will become the economic regulator for the NHS, sitting alongside the Care Quality Commission (CQC) who will continue to regulate quality. It will be responsible for:

    - licensing providers of NHS services in an integrated and streamlined registration and licensing regime with the CQC

    - setting tariff prices for NHS services

    - promoting competition so that the NHS gives patients the best possible services and outcomes, and ensuring a level playing field for providers

    - supporting commissioners in ensuring that services for patients are maintained when providers fail

Additional Action - Establishing HealthWatch

Establishing HealthWatch

- SHA engagement leads to facilitate further detailed engagement around the arrangements and function for 'HealthWatch'. This work will directly feed into the development of policy and legislation to be put before parliament in the autumn.

- The arrangements and functions for 'HealthWatch' is currently being developed around seven themes. Each theme includes a number of more detailed questions that those contained within either the Commissioning for patients or Local Democratic Legitimacy in Health. These themes are as follows:
    - Relationships
    - The expanded role of LINks as local HealthWatch
    - National / Local consistency of approach
    - Embedding patient voice
    - Independence and accountability
    - Transition
    - Governance

What will happen next?

- Documents published and seeking views on:
    - The NHS Outcomes Framework – 19 July 2010 (25 questions)
    - Commissioning for patients – 22 July 2010 (34 questions)
    - Local democratic legitimacy in health – 22 July 2010 (18 questions)
    - An Arm's Length Body Review – 26 July 2010
    - Freeing providers and economic regulation – 26 July 2010 (21 questions)

- Later in the year views will be sought on:
    - The NHS information strategy
    - Choice
    - Education and training

- Feedback is being sought widely to the consultation

- Deadline for responses – **11 OCTOBER 2010**

- You can find out more at www.dh.gov.uk/liberatingthenhs

Local Democratic Legitimacy in health document:

The PCT and Cheshire East Council are undertaking a joint piece of work to consider the proposals, answer the 18 questions and suggest further improvements before further national guidance is issued.

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